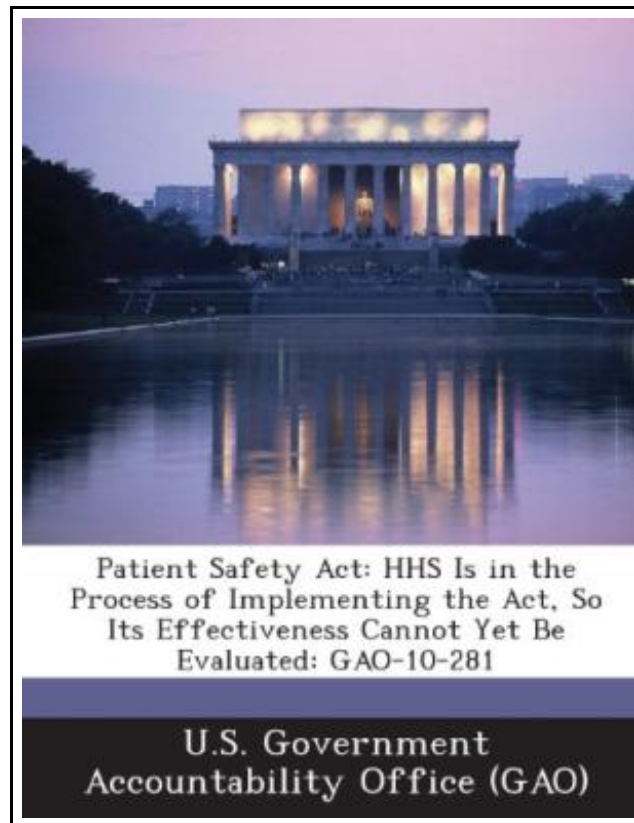


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(Prof. Antone Olson II)*

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BiblioGov. Paperback. Book Condition: New. This item is printed on demand. Paperback. 34 pages. Dimensions: 9.7in. x 7.4in. x 0.1in.The Institute of Medicine (IOM) estimated in 1999 that preventable medical errors cause as many as 98, 000 deaths a year among hospital patients in the United States. Congress passed the Patient Safety and Quality Improvement Act of 2005 (the Patient Safety Act) to encourage health care providers to voluntarily report information on medical errors and other events--patient safety data--for analysis and to facilitate the development of improvements in patient safety using these data. The Patient Safety Act directed GAO to report on the laws effectiveness. This report describes progress by the Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) to implement the Patient Safety Act by (1) creating a list of Patient Safety Organizations (PSO) so that these entities are authorized under the Patient Safety Act to collect patient safety data from health care providers to develop improvements in patient safety, and (2) implementing the network of patient safety databases (NPSD) to collect and aggregate patient safety data. These actions are important to complete before the laws effectiveness can be evaluated. To do its work, GAO interviewed AHRQ officials and their contractors. GAO also conducted structured interviews with officials from a randomly selected sample of PSOs. This item ships from La Vergne,TN. Paperback.



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