

GAO Highlights

Highlights of [GAO-16-308](#), a report to congressional requesters

Why GAO Did This Study

While millions of Americans benefit from the medical care they receive each year, this care also has the potential to harm patients. Medical care can be unsafe when it leads to adverse events, such as infections. Such adverse events occur even though evidence indicates that some could be reduced or eliminated through implementation of evidence-based patient safety practices.

GAO was asked to review information on the implementation of patient safety practices in hospitals. This report describes (1) key factors that affect hospitals' implementation of evidence-based patient safety practices and their reported effects on adverse events; (2) the types of programs health care payers use to promote hospital patient safety and their reported effects on adverse events; and (3) gaps, if any, that experts identify in the available information on patient safety practices. GAO interviewed patient safety experts and officials from six selected hospitals, six selected insurers, and officials from CMS and AHRQ. GAO selected the hospitals based in part on their performance on certain quality measures related to patient safety and selected the insurers because they operated relevant patient safety programs. The information GAO obtained on the hospitals and insurers is not generalizable. GAO also reviewed literature on the field of patient safety research.

In commenting on a draft of this report, HHS generally agreed with GAO's findings. GAO also received technical comments from HHS and incorporated them as appropriate.

View [GAO-16-308](#). For more information, contact Linda Kohn at (202) 512-7114 or kohnl@gao.gov.

February 2016

PATIENT SAFETY

Hospitals Face Challenges Implementing Evidence-Based Practices

What GAO Found

The six selected hospitals in GAO's study identified three key challenges that affected their efforts to implement evidence-based patient safety practices. Patient safety practices, such as using proper antiseptics, can reduce or eliminate adverse events, which GAO defined as events such as infections that harm patients and result from the medical care patients receive rather than patients' underlying diseases or conditions. Officials from selected hospitals identified the following challenges in implementing patient safety practices:

- 1) *Obtaining data to identify adverse events in their own hospitals.* According to hospital officials, obtaining useful information on adverse events can be challenging because, substantial time and resources are required to gather the necessary data, among other things.
- 2) *Determining which patient safety practices should be implemented.* Officials noted that they face challenges identifying which evidence-based patient safety practices should be implemented in their own hospitals, such as when only limited evidence exists on which practices are effective. For example, officials from one hospital told GAO that the hospital tried several different practices in an effort to reduce patient falls without knowing which, if any, would prove effective.
- 3) *Ensuring that staff consistently implement the practices over time.* Officials from the selected hospitals told GAO that the hospitals face challenges ensuring that hospital staff consistently implement the hospitals' patient safety practices; for example, hospitals must constantly monitor results to detect potential implementation problems.

Officials reported taking various actions to address these challenges, and some reported that their actions led to reductions in adverse events. For example, officials at one hospital noted a 40 percent reduction in certain infections over 1 year after they hired a new infection control nurse.

CMS and selected private insurers have pay-for-performance programs that provide financial incentives for hospitals to improve the quality of their care, including reducing adverse events. CMS, the Agency for Healthcare Research and Quality (AHRQ), and some of the private insurers in GAO's study also have nonfinancial programs to help hospitals improve patient safety that provide technical assistance and other support, such as providing data on best practices found in hospitals, access to peer-led training, and other guidance. AHRQ identified a 17 percent reduction in certain adverse events from 2010 through 2014, which likely resulted from multiple factors.

Patient safety experts GAO interviewed and related literature identified gaps where better information could help hospitals, including information on (1) the effects of contextual factors on the implementation of patient safety practices in different hospitals, (2) detail on the experiences of and strategies used by hospitals that have implemented patient safety practices, and (3) improved techniques for measuring the frequency of certain adverse events.