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Invited Testimony of

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Imagine that the U.S. is confronted with a deadly disease that claims nearly 100,000 victims a year; 2.5 million lives over the last quarter century. Researchers developed a new therapy that nearly eliminated the disease. The researchers received $900,000 in funding from the Agency for Healthcare Research and Quality, implemented the therapy in Michigan Hospitals and nearly eliminated disease, or at least two subtypes of the disease that account for most of the deaths, throughout the state saving about 2000 lives and $200 million each year. If provided on a national level, this therapy would have the potential to save more lives than virtually any other medical discovery in the last quarter century. To put this scenario in context, **583,298** died from AIDS in the U.S.in the past 25 years and 14,561 patients died in 2007.

If this therapy was a drug or device, the market would respond and very quickly spread the therapy throughout the U.S. Private companies would produce it, sell it and compete with each other. As a result, its costs would come down and quality would go up, lives would be saved, jobs would be created and the inventor would be wealthy and perhaps get a Nobel prize.

The disease is real, the disease is deadly and the disease is costly. It is healthcare acquired infections (HAI). And the equally real therapy was not a drug or device. It was a safety program. A program that summarized evidence into checklists, measured infection rates and used tools to improve teamwork and safety culture. Yet, the therapy did not spread to all 49 states. Patients are dying needlessly. We are fortunate now that after a GAO report, AHRQ provided support to implement the therapy in 10 states and private philanthropy provided us support to implement it in 18 more.

Yet we need to reflect why the market failed, why this therapy did not spread throughout the U.S, why patients continue to die needlessly. I believe there are two primary reasons. The first reason is because these deaths are largely invisible to patients, to payers, and to legislators. We lack valid and transparent reporting of these infections and as a result the infections and resulting deaths are viewed as inevitable rather than preventable. As part of the GAO report on healthcare infections, states were surveyed about their use of the MI program. All 50 states said they are using the “Pronovost checklist” yet only 11 states monitor rates of infections and none are a low as MI. We need to make these needless infections visible, we need to make the rates of infections transparent and valid and we need to do what the SEC did in 1934 for the reporting of financial data; ensure their accuracy.

There is tension regarding the extent to which we should take a regulatory or free market approach to financial markets, to public education and to healthcare. I think this is a false choice; we need wise regulation to make valid information transparent, we need regulation that makes knowledge markets efficient so that companies compete on performance not on misinformation and partial truths. Unfortunately, partial truths or flat out lies are the norm rather than the exception in monitoring healthcare quality. The reporting of healthcare quality data is comparable to the reporting of financial data prior to 1934 when accounting lapses seen with Enron are the norm rather than the exception.

The second reason the MI intervention was not spread to other states was that our public investments in the science of healthcare delivery are woe fully inadequate. Healthcare acquired infections (HAI) killed about 7 times more people than AIDs in 2007. Yet that year the Federal Government spent $23 billion on domestic and global HIV activities with $2.6 billion for HIV/AIDS research. Though welcome and overdue, the stimulus package included 50 million for HAI. The entire budget for AHRQ was $300 million. The investments to improve quality of care in general and HAI in specific are glaringly inadequate for the magnitude of the problem.

Indeed, we generally invest a penny on health services research for every dollar we spend finding new genes or new drugs. The public is paying for this lack of investment with their lives. This is not to say that we should reduce our investments in basic and clinical research; we need to increase them to keep the U.S the world's leader in biomedical science, to reduce death and suffering of our citizens and to create jobs and stimulate the economy. Yet, we need to substantially increase our investments into the science of healthcare delivery to ensure patients actually receive the life saving discoveries, to learn how to reduce costs and suffering. These investments will have the largest impact on saving lives reducing suffering and reducing costs of care. We need to substantially increase investments to AHRQ to enhance the science of healthcare delivery, we need to invest in the CDC to help monitor and reduce these infections and we need to support states to implement these life saving interventions.

We believe the effort to replicate the MI project across the U.S can be the model for large scale improvements in quality and reductions in cost of care. Indeed, it is by far the most successful quality improvement intervention to date. If spread across the U.S, it could have more lives than virtually any other intervention in the last quarter century. Progress in reducing HAI over the last decade has been slow or for most infections unknown. Pay for performance alone has proven an anemic mechanism to improve quality. Coordinated under the Secretary of HHS, congress could invest in CDC to measure these infections and summarize the evidence how to prevent them, invest in AHRQ to learn how to efficiently and effectively implement the evidence and reduce preventable deaths and dollars, and support states to help implement this program.

We need a investments to ensure that the MI program can be spread throughout the U.S and to ensure a pipeline of new programs; programs in which agencies within HHS, consumers, providers, states, payors and insurers collaborate toward a common goal of eliminating these infections. No one group alone is likely to make progress. We know have to do this; we have done it in MI, we are doing it in 10 states. Yet we need financial support to put it across the U.S.

We also need to correct the root causes regarding why the markets failed and why the simple, inexpensive and life saving MI therapy did not spread across the U.S. We need to ensure that valid information about quality of care and HAI are accurate, transparent and public. Just like in the financial markets, this will not happen voluntarily. We need you to create the equivalent of the SEC to ensure the reporting of healthcare quality data especially HAI are accurate.

Finally, we need investments in AHRQ to support training of people who can do this work and to create a pipeline of new programs, that when coupled with payment reform, will save lives and dollars.

A few years ago, 18-month-old Josie King died from preventable mistakes including a HAI at one of the world's best hospitals: my hospital, Johns Hopkins. On the four-year anniversary of her daughter's death, her mother, Sorrel, looked me in the eye and asked: If Josie was admitted to Johns Hopkins today, would she be less likely to die today than she was four years ago?"

I started telling her about our commitment to safety, listing all the quality and patient safety projects we were doing, and explaining the challenges with measuring quality. She abruptly and appropriately cut me off. She did not care what we were doing. She wanted to know if care was safer. She wanted robust evidence. Unfortunately, I could not give her an answer; we cannot give the U.S public an answer. I believe Sorrel and the public deserve one. With your help, we can answer her with a resounding yes.

Healthcare acquired infections (HAI) are common, costly and lethal.

HAI do not discriminate. Their victims are people of all races and ethnicities, young and old, rich and poor, in every state in the country. Yet these infections and the ensuring deaths and costs are largely preventable.

As shared in previous congressional hearings, I am concerned that we are not making more rapid and widespread progress toward reducing deaths from healthcare acquired infections. Four years after our success in Michigan, AHRQ provided financial support to the American Hospital Association and our research team at Johns Hopkins to replicate what we did in MI in a subset of hospitals in 10 more states. Philanthropists provided support directly to my research team to replicate the intervention in additional states. Using CDC estimates, we can assume that nearly 500,000 people died from HAI during the interval between our remarkable success in reducing these infections at Hopkins and in Michigan, and any additional support to share what we had learned.

Much as the debate regarding the financial crisis explores the virtues of a regulatory versus free market approach, so too does the debate to improve patient safety and prevent healthcare acquired infections. I believe this is not an either or choice. We need to regulate and centralize components of the work that provide accountability, monitor progress toward national quality and patient safety goals, and summarize knowledge. It is inefficient and ineffective for individual hospitals to do this. Yet we should encourage free market /local innovation regarding how to realize the goals.

My research team used these principles to reduce catheter associated bloodstream infections in intensive care units at Hopkins and across Michigan. We accessed central resources at the CDC as we summarized clinical evidence and standardized outcome measures. We accessed AHRQ resources as we studied the evidence around knowledge transfer and developed a method to translate clinical evidence into common practice, and we collaborated with state hospital associations to implement the program within their states. We are now collaborating with Consumers Union to mobilize consumers to help spread this program across all 50 states, to make infections rates visible and to prevent these needless deaths. It is a model that could substantially reduce many types of infections within the next decade.

Programs to improve safety, like our interventions to reduce infections, are often "faceless" and invisible in the ebb and flow of hospital activities. The victims of infections or any healthcare error, however, are never without faces, or stories, or compelling challenges. Josie King is but one of 100,000 deaths.

We know precious little about healthcare quality and patient safety. We *do know* healthcare is increasingly expensive; we can give you detailed cost reports, because we have standardized measures and regulated practices for reporting financial performance. We cannot tell Sorrel that Josie is less likely to die. The national report on healthcare quality is less than informative. In the ten years since the IOM report *To Err is Human* raised healthcare quality and patient safety to the level of national priority, we have made only minimal progress, and for most clinical diagnoses, we do not even measure performance.

Yet during those same ten years, advances in biomedical sciences have been astounding. Thanks to recent discoveries, AIDS is now a chronic disease and we have cured many childhood cancers. In just 13 years, an international collaboration between governments, scientists and private industries sequenced the entire human genome, all 3.2 billion letters with 99.99% accuracy. The results are publically available so that scientists around the world can use the information to develop new therapies.

How do we explain this dichotomy between the success of biomedical science and the failure of patient care? It is because we have failed to view the delivery of healthcare as a science.

For every dollar of federal health care research funding that goes towards learning how to better treat and understand disease, only one penny goes towards learning how to better care for patients. While it is essential that we continue to enhance funding for basic and clinical research, we need a more balanced research portfolio -- a portfolio in which we view quality and safety research as *essential to,* rather than separate from, basic and clinical research. We need to eliminate the gap that exists between what we learn in a lab and what actually reaches the patient. We must have a method to create standards and to measure and track our progress with measures that are meaningful and valid to those providing care, to those receiving care and to those paying for care, for resources are too scarce and patient safety is too precious to ignore.

Five years ago, wrong-site surgery – one of the most visible and troubling errors -- was incorporated into the National Quality Forum "Never Events" list. Reducing these errors became a national patient safety goal and hospital accreditation standards were established to guide local hospital efforts. Yet these standards were developed based on common sense, not science, without evidence of their benefit or costs, and without a valid method to monitor their effectiveness. Since the standards were introduced, reports of wrong site surgery have increased yearly. We do not know if this is due to better reporting, if the interventions do not work, or if they are not used correctly. However the results are not encouraging, and the public, the payers of healthcare and the providers of care deserve better.

We need to approach patient safety the same way we approach curing a disease, through rigorous scientific research that produces hard data with clear measurable results. We need to set explicit goals, summarize evidence into clear standards, develop measures and monitor performance with

valid, reliable data, and work to improve teamwork and communication so evidence can be implemented. Across the U.S, consumers do not now the rates of HAI at their local hospitals, consumers cannot select hospitals based on better outcomes because the information is either not collected, not transparent or inaccurate. Insurers and payors are limited in their ability to implement pay for performance and value based purchasing because that lack valid measures of quality. There is wide bipartisan support that paying less for lower quality care and more for higher quality of care is essential health reform. Yet payment reform will not work without valid data on the quality of care and without support for programs like the one in MI to support improvements in quality. Without these investments, improvements in quality and cost will remain elusive.

Our successful work in Michigan applied the model to reduce on type of HAI - central line associated blood stream infections (CLABSI) -- a type of infection that kills between 30,000 and 62,000 people a year and results in nearly 3 billion in excess costs. Prior to our study, little was known regarding how many of these infections were preventable.

We approached the problem scientifically. In phase 1, we reviewed empiric data and selected five key procedures that would most likely prevent these infections. We compiled these procedures into an easy to follow checklist. We identified potential barriers to using the checklist and developed tactics to overcome those barriers so we could optimize compliance. We then pilot tested the intervention at Johns Hopkins and measured performance. We nearly eliminated these infections.

In phase 2, AHRQ provided a matching grant to help us pilot test the program in the state of Michigan. Within three months of implementing the interventions, the median rate of infection in the 103 participating ICUs plummeted to 0, and has stayed at 0 for 4 years. These infections were reduced by 66%. The work was not easy; it required hospital leaders, doctors and nurses to implement interventions, improve teamwork, and monitor performance. But the results were well worth the investment. In just one year, the reduction in infections was estimated to have saved the hospital system millions of dollars and thousands of lives. All of this happened with a $900,000 investment from AHRQ.

In phase 3, we are trying to implement this program across the U.S., state by state, hospital by hospital. Thanks to funding from AHRQ we are working ` with the American Hospital Association to implement this life saving program in 10 hospital systems in 10 states. Additional philanthropic support donated to my research team at Hopkins will permit us to reach another group of states. Most states are trying to reduce these infections, but they need support in order to be efficient, and to rigorously measure and improve performance. Through this effort, researchers, AHRQ, CDC, state hospital associations and individual hospitals are collaborating rather than competing, recognizing their interdependence rather than independence, and ensuring integration rather than fragmentation. Indeed, this approach can be a model not just to eliminate CLABSI, but also to address other healthcare acquired infections and other types of preventable harm.

Similarly, the National Association of Children's Hospitals and Related Institutions (NACHRI) is developing efforts to bring this same program to pediatric centers in the United States. Indeed, my wife, Marlene Miller, is leading these efforts. They used our model, developed pediatric

specific standards and have impressive results in reducing infections in pediatric ICU's. Just as with our adult program, they struggle to fund, organize, implement and measure improvement.

There are many ills that befall the U.S. healthcare system; healthcare associated infections are but one. The fragmented approach to reducing these infections and the invisible or inaccurate monitoring of their rates points to a deep problem with our healthcare system; vague or non-existent performance standards, poor or absent and often invisible measures of performance, misaligned financial incentives, fragmented and under resourced labors all cripple efforts to improve quality, reduce costs and implement health information technology.

Our ability to produce measured and sustained reductions in infections and costs in MI point to a possible way forward.

Reducing these infections could be a polio campaign for the 21st century ~ and we need one. These infections are common, costly, and often lethal. We know how to reduce them, yet support for this improvement has been left to a haphazard patchwork of local, regional and national efforts involving clinical, operational and policy levers. No one could argue that whatever the clinical effectiveness of such efforts, the inefficiency is glaring. A coordinated national effort to eradicate these infections should be an immediate priority. The CDC has the ability to measure infections in all states; the intervention knows no state bounds, and patients in all 50 states are dying needlessly from these infections.

I believe our model offers tremendous potential for use on a broad scale. In the model, we centralize development of evidence-based clinical standards, measures and data collection standards for a nationally relevant set of patient safety goals. The CDC has a mechanism to measure infections and summarize evidence regarding how to prevent infections and AHRQ summarizes evidence and program regarding how to ensure patients actually receive the best evidence; how to ensure an efficient knowledge market. These Federal agencies can couple with states to innovate regarding how to prevent these infections. In this model with standardized national measurement, we can hold healthcare organizations accountable for improving quality, we can align payment to incentivize quality care, and we can advance the science needed to improve healthcare delivery, so that learning does not need to take place one patient, one physician, and one hospital at a time. In this model, payers, consumers, insurers, administrators, clinicians and regulators, work together to solve the problem. Now that we have a proven system that can measure and prevent harm, we should align payment policies to support safe care.

Yet there is no support to create, develop and implement programs to realize this model. From the original AHRQ investment in Michigan, in addition to nearly eliminating CLABSI, we also nearly eliminated ventilator associated pneumonia (VAP). The rate in the state was reduced by 70%, remains low three years after the intervention, and saved thousands of lives and millions of dollars. Why is there no mechanism to spread this life and cost saving intervention across the country; largely because we lack regulatory requirements to make the rates of these infections accurate, transparent and broadly available and because we have not invested in eliminating them. From the CLABSI effort we learned how. CDC can develop a national measurement system and summarize clinical evidence, AHRQ can summarize how we ensure patients actually receive the evidence and coordinate efforts with states, states can recruit hospitals to implement, innovate and evaluate the intervention, CMS can align patient policy, and consumers can drive healthcare organizations to improve quality.

We need support for research to ensure that patients actually receive life saving therapies, to ensure that children and the elderly receive these therapies and to ensure that your skin color or your gender does not determine whether you receive a life saving therapy. If we want to make progress, we have to view these as primarily scientific rather than political issues. With wise investments, we can help ensure that the citizens of your states do not die from preventable healthcare acquired infections, we can support the CDC to summarize evidence for how to prevent infections and develop a national measurement system, we can support AHRQ to summarize evidence regarding how to implement the evidence and coordinate state by state efforts, we can support states to monitor infections and partner with hospitals to eliminate them, we can provide Sorrel King a clear answer that Josie is less likely to die.

While the investment in comparative effectiveness research is wise and overdue, it is insufficient. Knowing what to do is insufficient. We must also ensure that patients actually receive evidence-based therapies, we must ensure an efficient healthcare knowledge market, and we must eliminate preventable harm. This will require a similar investment in knowledge translation.

The intervention to reduce CLABSI in MI saved more lives than virtually any other medical intervention in the last 3 decades, saved hundreds of millions of dollars per year and cost about $1 million for 2 years. The return on investment is between 200 and 400 fold. Why are we not making these life saving investments? We can translate evidence into practice, we can prevent healthcare acquired infections and we can prevent needless deaths and cost of care; we have done it. We need you to provide support to ensure these programs can be spread across the country and to ensure that we can develop new programs.

Our national failure to view the delivery of healthcare as a science is also a significant factor in our limited success in learning from mistakes that do occur.

Though it took over nine years, we are now close to having a voluntary mechanism for reporting healthcare errors at a national level. Yet we do not know how to learn from the errors that will be reported. There is no national infrastructure to learn from common, costly and lethal mistakes that are beyond the capacity of any single health system to fix. For example, in all of the 6,000 U.S. hospitals, patients sometimes get epidural pain medicine connected to an intravenous catheter, a potentially lethal error. The intervention to prevent this error is to encourage doctors and nurses to be more careful, to reeducate staff. Assume this education takes one hour: imagine the costs of reeducating all the doctors and nurses in the country and now imagine the probability that the education will work. Current methods for learning from this type of mistake are form over substance. They waste time, money, energy and the good will of caregivers who know they are human and will likely make the mistake again.

There is a better way. We learned it from aviation. In aviation, they recognized that is foolish to have individual airlines investigate and learn from mistakes in isolation. They formed a public private partnership called The CAST (The Commercial Aviation Safety Team). The industry works together to prioritize the greatest risks, investigate them thoroughly and implement interventions that work. Most of the interventions are product redesign. We need cast in healthcare. We need to get the manufacturers to design the catheters so that the epidural and intravenous catheters do not fit together. We need to eliminate the possibility of making this mistake rather than hoping that re-education will work. Yet there is no mechanism to bring

administrators, clinicians, regulators, and device makers together in healthcare to accomplish this. We have a small planning grant from the Robert Woods Johnson Foundation (RWJF) to pilot this concept. All parties are eager to participate. Yet we need federal leadership. We need your wisdom, your expertise and your support.

We also need to ensure that the information provided to the public regarding the quality of care is accurate. Truth in data matters. Our current system for reporting quality of care data is neither sufficiently standardized nor accurate. We need the equivalent of the SEC for reporting healthcare quality data.

Anyone who has fallen for a false ad or sales pitch surely knows that information about a product is only valuable when it's truthful and credible. Much if not most of the current financial crisis can be traced back not to a lack of information so much as a flood of complex but literally *in*credible information gushing through the markets. As a result, most ordinary people – even some experts -- are unable to figure out what's going on, or to identify enough credible, complete and accurate information to guide good choices in making financial decisions. They are rightly clamoring for stricter enforcement of good accounting principles and standards of operation that everyone can find and easily understand.

Yet, the financial crisis highlights the need for wise regulations to ensure truthful information. For the most part, financial markets provide accurate data. They do not do so voluntarily but rather they are regulated to. In 1934, Franklyn Delano Roosevelt established the Securities and Exchange Commission (SEC) to ensure accurate reporting of financial data. Form this, emerged trained professionals who report financial data, explicit rules for what and how to report, audits to ensure accuracy, and accountability with penalties when organizations or individuals deviate from the rules. As a result, our capital markets are much more efficient than they would be without the SEC and the public has trust that the information provided by companies is truthful.

Shockingly, perhaps, we're seeing the same challenges rising in healthcare: globs and gluts of information and claims about "quality of care," but few standards for gathering such information and even fewer guides for helping ordinary people understand what the information means. Healthcare generally lacks trained professionals to report quality of care data, rules regarding what to report, audits to ensure the reports are accurate or penalties for those who digress. The reporting of healthcare quality care is reminiscent of the pre SEC era.

Catalyzed by evidence of poor hospital safety and remarkable variations in patient outcomes and what treatments work best, hospitals and health care businesses are falling all over themselves to report "quality measures" on their websites. State and federal government agencies are issuing "performance" scorecards on individual physicians and hospitals. And hospitals and other health care providers are using those scorecards to market their services on websites, in glossy brochures, on billboards, and on TV.

Yet research shows that there is no assurance of the accuracy of their claims, because the measurement of quality in health care is neither standardized nor consistently reliable. Indeed, hospital reports about quality of care are held to no higher standard than the advertising of toothpaste or washing machines.

Examples of the health care information problem are easy to find. One hospital Web site reported that the institution saved 242 lives during 18 months. But how they made this estimate (what kind of patients were counted, how many and did they count people who were really sick or not very sick) were not reported. Another hospital Web site claimed that 90% of patients with pneumonia were screened and given pneumococcal vaccination, whereas a government web site (CMS's Hospital Compare) on the same day reported that only 64% of patients at that hospital were vaccinated. It's possible the hospital percentage is right, because CMS sometimes has delays getting data, but because the Web site failed to disclose its statistical and fact-gathering standards (such as dates of data collection, sample size, or the confidence interval), it's impossible to know. Another hospital reported the ratio of central line–associated bloodstream infections and ventilator-associated pneumonia compared with "CDC national averages." Yet the hospital did not provide the benchmark rates used, which vary by intensive care unit type, the number of patients evaluated, and the time period. Not surprisingly, this hospital's performance was great, with both a ventilator-associated pneumonia ratio and a central line–associated bloodstream infection ratio of 0. But how long have the rates been zero? A day? A week? A year? Does this mean that patients will never get these infections at this hospital? Without more information, who knows?

Profit-oriented private enterprises that report on the quality of care are completely unregulated and because their rating methods are proprietary, opaque and more promotional than scientific, they frequently misinform or confuse the public. For example, not one hospitals was listed on all three high profile ranking systems; the U.S News and World Report's list of top 20 hospitals, Health Grades list of the top 50 hospitals, and JD Powers list of the top 20 hospitals. If they are accurately measuring hospital quality, how can that be? Other companies create lists of "best hospitals" and "best doctors" and sell services to those they help gain public recognition as top performers. As such, most U.S Hospitals now boast they are part of at least one "top" list, evoking echoes of Garrison Keilor's Lake Woebegone where all the children are "above average."

Information collected by the Federal government is generally thought to be more robust than other sources. For example, data collected by the Center for Medicare and Medicaid Services (CMS) related to often lethal blood stream infections and the costs of treating this medical complication show that between 30,000 to 62,000 people die of these entirely preventable infections yearly in the U.S at a cost of $2-3 billion. Yet CMS, and many states, measure these infections using notoriously inaccurate hospital billing data even though another federal agency, the Centers for Disease Control collects much more accurate clinical data.

Such incomplete or misleading reports about quality-of-care measures pose significant risks to patients, clinicians, and insurance companies. Patients might choose care according to misinformation and make poor decisions. Health care organizations may become overconfident about the quality of care provided, reduce or eliminate improvement efforts and increase the risks of preventable harm. Payers may mistakenly provide financial rewards, channel patients to low-quality clinicians, or make inaccurate inferences about the value of the care they purchase.

Clearly, the public deserves better. Public reporting of quality measures should have at least the same reporting standards as the reporting of financial data, along with enforcement of those standards, to reduce bias, assure professional oversight of data collection, and assure regular auditing. Organizations that gather, report and publicize health care quality measures must be held accountable for e accuracy.

At the very least, the Federal government can and should do for heath care what it began to do in 1934 for financial data: ensure its accuracy and transparency. When healthcare has valid measures, healthcare markets can compete on quality. The U.S public should have confidence that the information they have about hospital quality is accurate, timely, understandable and continuously improving. Just like in the financial markets, this is not likely to happen without wise regulation. Without accurate and transparent data, the healthcare market will not improve quality.

One of the greatest interventions to facilitate healthcare reform would be to create a Healthcare version of the SEC; an independent, self funding, authoritative entity that could ensure accurate healthcare data. Whether reviewing a financial report, analyzing a mortgage contract, or reading a scientific report about global warming or a medical discovery, we assume the information is accurate. When it is not, disaster strikes. The fall of Enron, the Madoff ponzi scheme, and much of the financial crisis occurred from inaccurate data. Indeed, much of the financial crisis resulted from inaccurate data leading to an inefficient knowledge market. Because truthful information is fundamental to the functioning of markets, society has created safeguards to ensure their accuracy. Perhaps the greatest example is the reporting financial data.

Investors generally have confidence that the figures in financial reports are correct. The Securities and Exchange Commission designated and authorized the Financial Accounting Standards Board (FASB), an independent body, to establish and improve standards for financial accounting and reporting. The FASB recognizes that "standards are essential to efficient functioning of the economy because decisions about the allocation of resources rely on credible, concise, transparent and understandable financial information." Such standards provide investors, creditors, auditors, with credible, transparent, and comparable financial information. These standards force organizations to comply with generally accepted accounting principles (GAAP) in reporting data.

Through our work, we have learned that we can improve quality and reduce costs. Current efforts are too isolated, too weak on science, and too limited in focus. This will not get us where we need to go. There is something we can do to change this: to we can save lives and dollars, we can provide Sorrel an answer: is Josie less likely to die?

Specific suggestions for Improving Healthcare Quality and Patient Safety:

1. **Support AHRQ and CDC to expand the MI project across all 50 states and replicate the program to eliminate other types of healthcare acquired infections.**
   Support collaborative efforts among CDC, AHRQ, and states to work to eliminate the major causes of healthcare acquired infections within 10 years. It is neither effective nor efficient for individual hospitals to go it alone. Fund research under AHRQ so that rather investing a penny in quality for every dollar in basic and clinical research we have a more balanced

portfolio; Imagine the gains in quality and reduced costs if we increased the ratio to a quarter for every dollar.

2. **Create an Institute for Healthcare Delivery**
   This institute, similar to the human genome project, should link provider organizations, insurers, payers, and regulators to design, implement, and evaluate interventions to improve quality, reduce costs of care, and implement Health Information Technology. This institute would inform the science of healthcare delivery. Though the focus on comparative effectiveness is important and needed, it will do little good to know what therapies to use if we do not couple that with science to ensure that patients actually receive them.

3. **Coordinate public and private efforts to improve quality of care**
   A "supra agency" should be established to facilitate and monitor integration of inter-agency activities to address deficits in the quality of U.S. healthcare. The agency should report directly to the Secretary of HHS. Such an agency could coordinate setting national priorities for quality of care and patient safety, creating measures toward those goals, summarizing evidence, developing strategies, and monitoring progress toward the goals.

4. **Build capacity**
   Support training in quality improvement methods for physicians, nurses other clinicians and administrators in order to improve the delivery of healthcare across the U.S. At most academic medical centers, there are hundreds of faculty who can teach genetics, hundreds who can teach physiology, yet a precious few, if any, who can teach safety. This needs to change if we are to make and sustain progress.

5. **Develop national standards for the reporting of healthcare quality data.**
   The federal government should do for the reporting of quality data what the SEC did in 1934 for the reporting of financial data: ensure its accuracy.

The health care community nationwide from the federal government to state and local governments to hospitals, providers, corporate purchasers, and the insurance industry has some learning disabilities that time and research have uncovered. Those disabilities have real, lasting, and deep consequences for patients, health care providers, and all of the third party payers. Any efforts to improve, revise, or strengthen the way health care is delivered in the US that do not address these disabilities will be far less effective than if fixing them were a central part of reforms. The administration and Congress have seen that investments in IT for example will help to address some of the challenges long term. However, if the people in and operating the systems cannot take the data available from IT improvements and learn from it, the investments will not pay off. With standards from the healthcare SEC, they can require HIT vendors to collect accurate data about healthcare quality.

President Obama suggested the new administration would restore science to its rightful place… raise health care's quality... and lower its costs. To achieve this goal, programs that work -- such as the model to reduce blood stream infections -- should be expanded, and those that do not work should end. Paraphrasing our president, those of us who provide healthcare, and those who

manage the public's dollars need to spend wisely, reform bad habits, and do business in the light of day. Healthcare business is now conducted the dark of night.

Substantial improvements in healthcare quality and costs are possible. For too long we have lacked clarity of purpose and the commitment to invest the necessary resources to make this vision a reality. We can save 100,000 lives a year, we can build capacity to address other ills, and we can reduce costs. We have a model in MI. We need to your support to spread it to all 50 states and to create a healthcare SEC so that quality is accurate and transparent. Courageous leadership must hold all stakeholders accountable for results. My hope and expectation is that together we find this courage.