Patients For Patient Safety US

Submitted by Patients for Patient Safety US
Prepared for the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Regarding AHRQ/HHS Office of Strategy
June 13, 2025

Dear Subcommittee,

Patients for Patient Safety US (PFPS US) appreciates the opportunity to submit testimony on the FY 2026 Labor/HHS Appropriations bill.

PFPS US is a patient and family led network of individual patient safety advocates and strategic partner organizations working to elevate patient safety as a public health priority in the United States. Although led by users of care, our nationwide network includes a wide range of stakeholders: patients, family caregivers, healthcare providers, researchers, educators, employers, systems safety experts and stakeholder organization leaders, all dedicated to expediting the systemic changes needed to reduce preventable health care harm.

PFPS US and its partners strive to create a healthcare system that prioritizes the safety and well-being of every patient across health care settings. Improving safety and accountability for safety of care will also reduce unnecessary health care spending, waste, and associated taxpayer burden. Our policy priorities align with CMS's emphasis on transparency, measurement, and public reporting, fortified by patient/family engagement, as drivers of improvement.

- For FY2026, we respectfully request that the Subcommittee:
  Preserve and strengthen Patient Safety Research and Solutions Implementation, whether at AHRQ or within the proposed HHS Office of Strategy, and
- **Increase dedicated funding for diagnostic safety and quality improvement from $20 million to $35 million.**

Preserve and Strengthen Patient Safety Research and Solutions Implementation

The Trump Administration has pledged to "Make America Healthy Again." We write to say: it cannot be done unless the very places where Americans seek help and healing are free from preventable harm. Patient safety must be seen as a pillar of our national health well-being strategy.

Each year, over **one in four patients** experiences a medical error across hospital, ambulatory, and residential care settings, yet there is no coherent infrastructure to see it systemically and stop it.[i] This epidemic of harm has been normalized despite its impact on well-being and significant costs to government and taxpayers.

We believe that must change.

We understand that the reorganization of HHS offices and divisions launched by Secretary Kennedy aims to consolidate programs that serve the same targe populations and gain administrative efficiencies for taxpayers. We are, however, deeply concerned that Congress's modest investment in research and programs – particularly those that have been led by AHRQ – that are fundamental to preserving and improving patient safety, may be lost.

Imagine a hospital where infection rates are climbing again, because the proven safety programs they once relied on— like AHRQ supported CUSP toolkits and training -- have disappeared. Picture a rural clinic forced to abandon promising diagnostic tools for conditions like sepsis and cancer – already a major challenge in rural areas --because pilot programs were cut midstream. Envision an emergency department where a grandmother's life is lost because communication failures between the doctors, nurses, and laboratory— once addressed with national TeamSTEPPS training from AHRQ — are now left to chance.

This is not a distant or dramatic scenario. It is the real risk we face if the patient safety portfolio maintained by AHRQ for the last 20 years, disappears. For decades, AHRQ has been the nation's quiet engine for patient safety, providing frontline clinicians, hospitals, and patients with practical, evidence-based strategies to save lives. It has driven down healthcare-associated infections, improved teamwork and communication, and launched groundbreaking efforts to reduce diagnostic errors.

We point out that health care harm is not just a moral or clinical concern; it is also a massive driver of waste. Unsafe care contributes billions of dollars annually to unnecessary healthcare spending — through missed or delayed diagnoses that allow diseases to progress to more expensive stages, preventable ICU stays, avoidable readmissions, and long-term health deterioration from cascading care complications. Safety is the sine qua non of high-value care. A healthcare system that fails to prioritize and prevent avoidable harm cannot credibly claim to be advancing value for patients or for taxpayers.

If patient safety is a strategic priority, as it should be, its programs and authorities must be *explicitly protected and expanded* — not absorbed silently or diminished. If HHS intends to relocate AHRQ patient safety activities, as well as its grantmaking and contracting authorities, to the Office of Strategy, we urge Congress to require a clearly defined mission, named leadership, and protected appropriations for patient safety research, implementation, and accountability.

We believe that Congress should preserve and strengthen its commitment to patient safety, and hope that you keep its importance in mind as you consider the Labor-HHS appropriations bill.

Invest in Diagnostic Excellence

PFPS US particularly prioritizes support for improving diagnostic quality and safety, which goes largely unreported now and is hidden from public health statistics.

Imagine: a 19-year-old champion athlete whose stroke was missed in the emergency room… he can now only communicate by blinking; a 12-year-old girl whose fatal infection was mistaken for the flu and not caught in time; a new father whose malignant cancer pathology results were never communicated to

the family, leading to his untimely death; a healthy 75-year-old woman who went blind from a rare but easily treatable disease that could have been diagnosed with a simple, inexpensive blood test—these are among the tens of thousands of patients annually who suffer serious, preventable harms from diagnostic errors.

Diagnostic errors affect more than 12 million Americans each year and likely cause more harm to patients than all other medical errors combined. Diagnostic errors alone are responsible for an estimated **500,000 to 795,000 deaths and serious harms annually** — numbers that rival or exceed other leading causes of death.[ii] Serious harms affect one third of these patients. Permanent disability or death can result from missed opportunities to treat dangerous diseases like stroke, infection, or cancer early on, before it is too late. Additional harms and costs result from inappropriate use of diagnostic tests and incorrect treatments for diseases not actually present. Diagnostic harm is now a leading driver of medical liability exposure.

A 2015 study by the National Academies of Sciences, Engineering, and Medicine, “Improving Diagnosis in Medicine”, called diagnostic error a massive "blind spot" in the national effort to improve health care quality and safety, and concluded that “improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative.” Research to fix this problem could save tens of thousands of lives and cut societal healthcare costs by more than $100 billion per year. PFPS US has been pleased to support the slow-but-steady growth in Congressional appropriations to AHRQ that are explicitly designated for diagnostic safety and quality improvement work. The current appropriated level is $20 Million. Relative to its public health footprint, diagnostic errors are likely the most underfunded research area in medicine. To really make an impact, that work should be funded to at least the level of the Healthcare Associated Infections (HAI) portfolio over the next few years. **This year PFPS US and our partners respectfully request the sub-committee to dedicate $35 Million in the Labor/HHS bill to Diagnostic Excellence.**

The return on new investment in research to eliminate harms from diagnostic error will be substantial. There are already promising new solutions in the research pipeline for specific, commonly misdiagnosed conditions (including stroke, sepsis, and cancer) that could eliminate tens of thousands of patient harms and billions of dollars in wasted testing and avoidable hospitalizations each year in the US.
We commend Congress for recognizing diagnostic safety as a national priority and urge you to expand this commitment.

Patients for Patient Safety US respectfully asks the subcommittee to give this non-partisan issue its full support, because it affects all of us. Research to improve diagnostic safety and accuracy will put life-saving tools, methods, and processes into the hands of clinicians, practices, patients and systems.

PFPS-US stands ready to support the Subcommittee’s ongoing efforts to protect patients, reduce waste, and build a safer, more transparent health care system. We would welcome the opportunity to brief members or staff further.

Respectfully submitted.

[i] DHHS, Office of Inspector General, multiple reports available at https://oig.hhs.gov/reports/featured/adverse-events/. See also, Bates DW, Levine DM, Salmasian H, Syrowatka A, Shahian DM, Lipsitz S, Zebrowski JP, Myers LC, Logan MS, Roy CG, Iannaccone C, Frits ML, Volk LA, Dulgarian S, Amato MG, Edrees HH, Sato L, Folcarelli P, Einbinder JS, Reynolds ME, Mort E. The Safety of Inpatient Health Care. N Engl J Med. 2023 Jan 12;388(2):142-153. doi: 10.1056/NEJMsa2206117. PMID: 36630622, available at https://www.nejm.org/doi/full/10.1056/NEJMsa2206117

[ii] Newman-Toker DE, Nassery N, Schaffer AC, Yu-Moe CW, Clemens GD, Wang Z, Zhu Y, Saber Tehrani AS, Fanai M, Hassoon A, Siegal D. Burden of serious harms from diagnostic error in the USA. BMJ Qual Saf. 2024 Jan 19;33(2):109-120. doi: 10.1136/bmjqs-2021-014130. PMID: 37460118; PMCID: PMC10792094.