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Mark Masselli: This is conversations on healthcare I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret I'm looking forward to our annual Weitzman Symposium this week on the campus of Wesleyan University in Middletown Connecticut where we gather some of the top thought leaders in health innovation to explore new ways of delivering healthcare and improving patient outcomes.

Margaret Flinter: Well that's right Mark it's the eighth annual symposium and I think you hit the right note, it's about innovation but innovation was something to show for in the way of outcomes that's what were focused on in our own community health center here in Connecticut and on the show as well. In fact some of this year's participants have been guest on the show Dr. Sanjeev Arora is the founder of the project echo telemedicine program in New Mexico a program that we've learn from and replicated here in Connecticut and with partners across the country and seeing some great success with that.

Mark Masselli: Also Dr. Joe Selby will be participating this year, he's the director of the new patient centered outcome research institute also known as PCORI which was created out of the Affordable Care Act, the center is collecting evidence based research to improve the patient experience and patient outcomes.

Margaret Flinter: With so much change underway in the healthcare arena there's also quite a bit of disruption and the time of tremendous opportunity, yes we find new pathways to improve care and Mark I would argue a good time for consumers as well, which we all are.

Mark Masselli: And our guest today has been overseeing research on ways to improve patient safety which still pose a real problem for this country Dr. Carolyn Clancy is the Director of the Agency for Healthcare Research and Quality at the department of Health and Human Services.

Margaret Flinter: Dr. Clancy's agency just released a report on new guidelines for patient safety practices it's titles making healthcare safer to which looked at a decade of data on patient safety practices in healthcare once they are working to improve patient safety and also looks at those that haven't yield a great results the report offer some recommended guidelines for hospitals and other practices to pay close attention too, if we're going to have the impact we want on the high cost of medical errors both in suffering and cost.

Mark Masselli: Some a hundred thousand patients die each year due to medical errors and it's estimated that a -- about a third of the 2.7 trillion spend on healthcare in this country is actually wasted, so this is a very timely and an important report.

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Margaret Flinter: And our Lori Robertson will check in from FactCheck.org and we'll see what untruth she's uncovered in health policy circles this week.

Mark Masselli: But no matter what the topic you can hear all of our shows by Goggling CHCradio and as always if you have comments e-mail us at CHCradio.com or find us on Facebook or Twitter, we'd love to hear from you.

Margaret Flinter: We'll get to our interview with Dr. Carolyn Clancy in just a moment.

Mark Masselli: But first here's our producer Marianne O'Hare, with this week's headline news.

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Marianne O'Hare: I'm Marianne O'Hare with this healthcare headlines. Health and Human Services secretary Kathleen Sebelius is on the hunt for money, needed to roll out the healthcare law. Congress has repeatedly rejected the Obama administration's request for additional funds to help with full implementation of the Affordable Care Act,

so the Health and Human Services secretary is on the hunt for donations from those in the industry to help inform the public about the healthcare law, while the move is draw on criticism from some members of congress adding inquiry HHS officials say the request is within the secretary's right as long as she doesn't as for funds of subordinates. Spokesman Jason Young added a special section in the public health service act allows the secretary to support and encourage offers to support nonprofit groups working to provide health information and conduct other public health activities. Maybe transparency is a good thing the state of Oregon became the fourth state in the nation to publicly post health insurance rates for 2014 two of the companies posting rates quickly lowered their projected plan proposals for the coming year when they saw the cost of other plans that were proceed on the exchange, there has been some concern that healthcare law would cost insurance rates to spike mightily due to the healthcare law. Medicaid roles are about to grow under the Affordable Care Act good number of states are expanding Medicaid to provide health coverage for additional folks living near the poverty line but access Is still a real problem **(4:13 Inaudible)** new service survey practices nationwide and found fewer than 50% of practices will take on Medicaid patients even fewer specialist as well. The traditional low reimbursement rate being sighted as a reason, I'm Marianne O'Hare with this healthcare headlines.

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Mark Masselli: We're speaking today with Dr. Carolyn Clancy Director of the Agency for Healthcare Research and Quality at the department of Health and Human Services, they have just released making healthcare safer to a follow up to their original report that offers a critical analysis of recommended practices to improve patient safety in healthcare. Dr. Clancy is an internist in health service researcher and has been the director of a AHRQ also known commonly as AHRQ since 2003. She's a member of the institute of medicine and is an elected master of the American college of physician and is an associate editor of the publication health service research. Dr. Clancy welcome back.

Dr. Clancy: Thank you.

Mark Masselli: Back into conversations on healthcare. Carolyn your agency is -- its mission is to improve the quality safety and efficiency of healthcare in this country and the idea of patient safety took an additional urgency since a release of the ground breaking report to error is human in 1999, with expose the true scope of medical errors leading to an estimated 100.000 deaths a year in this country and your department launched its own investigation into the problem and released making healthcare safer in 2001. The record recommended a number of patient safety practices AHRQ has just released its follow up to that initial report making healthcare safer too, which has a number of new evidence base recommendations can you take a look at the journey that you've been on and what sort of progress has been made since the launch of the patient safety movement.

Dr. Clancy: What we've learn is that, we've learn a lot more about what can go wrong, but we've also learn just how incredibly important it is to understand how to make it right, not just what to do but understanding how to do it, so that the right thing is the easy thing to do when it gets done routinely but sometimes it called reliable healthcare. Probably our biggest success has been a program called CUBSP which stands for comprehensive unit base safety program. And this is a deceptively simple or apparently simple when you look at it, it looks like just the check list, but it's really all about changing the culture, it's about team work and it's about collecting of very small amount of data, so that people can see how they're doing. And what we've seen is better than a 40% reduction in serious healthcare associated infections, we've also seen some successes in hospitals in terms of door-to-balloon time, this is when you have an acute event that might be a heart attack part of it is about making sure that a whole large extended team works together almost like a little symphony. And we've seen dramatic improvements on that, most of the areas where we've seen improvements have been hospital base because it's a little easier to find and to see but we're clearly steeping up the focus on outpatient care now.

Margaret Flinter: Well Carolyn underlying all of our daily activity, you know, somewhere in the background there's policy often that's driving and certainly in this many year since we of course have the major event of the passage of the affordable care act, and certainly within the affordable care act are the focus is on coverage, there is much that has to do with improving the quality of care and patient safety. So perhaps share with us what's some of those directives are, how are they shaping the work that you're now doing at our ---

Mark Masselli: Well you know one of the best kept secrets about the Affordable Care Act that's just how many provisions in that bill are all about improving the quality safety and delivery of healthcare in general. So some of the broad directives are an alignment of payment incentives to reward the right care, some of those previsions established a new innovation center at the centers for Medicare and Medicaid, services which actually sponsors demonstrations that linked dramatic improvements in quality to changes in payment, it's easy to say let's pay a different way but you got to figure out actually how to do that too. And very importantly one of the previsions which is my personal favorite actually directs the secretary of health and human services to submit to the congress a strategy for quality or a national strategy of quality improvement in healthcare, this is a first and it has provided a foundation for all of our efforts across HHS in very strong partnership with states and the private sector. And essentially what the strategy says is are over arching aims are better care, better health, healthcare can be a very strong partner in making sure that our communities and people are healthy as possible and the third aim is getting to Affordable Care not by cutting services but by actually accelerating those innovations.

Mark Masselli: Dr. Clancy I do want to get back to your statement earlier about changing culture, in the 2001 report making healthcare safer AHRQ issued a list of standard patient safety practices that should be adopted by medical practices and hospitals across the country. But a number of the recommendations received a fair

amount of pushback from the medical community, what were some of the problems with early adoption of these patient safety practices.

Dr. Clancy: The prevailing and predominant culture at that time was -- it is not okay, to share when you made a mistake. So people were very, very fearful, hospital leaders were not having frank conversations about how care could be safer, and that has change quiet dramatically. Now what we hear from people is how do I do that, really the ground breaking study that we funded on healthcare associated infection that associated with central lines, **(10:30 Inaudible)** kind of heavy duty Ivy lines, actually change people's ideas about what was possible, and by collecting just a little bit of data and getting feedback every quarter, you know, it was like rocket fuel. So it's very, very important to show what interventions are effective so that -- that clinicians can focus on those connectivity's and avoidable harms that are most likely to be successful.

Margaret Flinter: Well from a consumer point of view, I'm not sure that folks generally would understand how do you go about analyzing the various patent safety practices that you looked at to identify what processes actually yield better outcomes and maybe you can share with us a little bit what practices have you seen that yield the best safety results.

Dr. Clancy: How we went about evaluating practices was to actually talk to people in the frontlines and get their input, as well as patients about which patient safety practices we should give priority for revealing and this in depts. reviews assess this types of practices by asking the following questions. First how important is the problem, what is the patient safety practice, why should this practice work, what are the possible harms so if we see something that indicates but it's actually worth in a variety of different types of situations that gives them a lot of confidence that it's generalize **(11:55 Inaudible)** or that it will play in **(11:57 Inaudible)** so the CUBSP program is a, you know, clearly outstanding example of a strongly encourage to kind of practice. Some of the other strongly encouraged practices include things like interventions to reduce the use of **(12:14 Inaudible)** because they are often associated with infections bundles which is sort of a series of steps that include check list, hand hygiene really simple but really, really important. And very importantly interventions that have multiple components that are used to, prevent pressure **(12:36 Inaudible)** commonly know, a very, very important source of **(12:41 Inaudible)** and there are now hospital systems that have gotten their rate of **(12:46 Inaudible)** down zero.

Mark Masselli: We're speaking today with Dr. Carolyn Clancy director of the agency for healthcare research and quality, they've just released making healthcare safer to a follow up to their original report released a decade ago that offers a critical analysis of recommended practices to improve patient safety in healthcare, what's your thought about training the next generation of healthcare practitioners to the evidence based in the models that you have, is that making its way quickly enough back into the system of education so that these new upcoming generations are adopting this early on.

Margaret Flinter: It's a little bit like success breed success, the state of Michigan and all the hospitals there who are participating Dr. Pronovost work have dramatic success in reducing of very serious type of healthcare associated infection, which by the way has about a 25% mortality rate, you know, when people see those results they say it looks like hospitals of all sizes and shapes in Michigan it work for them, we could try this too and now we know that over 1200 in this country have actually tried it and have had exactly the same kinds of dramatic results. Now in terms of training I'm very, very optimistic about that, very importantly before you can practice medicine in this country you have to be clinically trained in the residency program, so these have been a credited for many, many years but, each individual program gets its own accreditations and a team would come in to look at each one but the teams that come in don't necessarily talk to each other until now. And the group that a credits hospital actually got into this because they were responding to a report that the institute of medicine did on work hours for residence, because we had published research showing that, very, very long shifts without sleep or associated with a much higher likelihood of serious errors, so they put together a task force on work hours, well it turned out you couldn't really separate out the problem of work hours from all of the other factors involved in hospital care that led to safety. And what grew out of that was a new approach to accreditation where each institution actually gets one over arching visit, to find out how the various residency programs work together in safety, what does the CEO know about this and so forth and that is really a see change in how we evaluate this programs.

Margaret Flinter: Well Dr. Clancy patient safety and the outcome for the patient is our highest goal, certainly we're all very conscious of cost and of the money that is lost and wasted when we have errors. As we see the accountable care organizations forming as a results of the affordable care act this group practices and hospitals and providers who are sharing information and resources to improve outcomes and reduce cost, wonder if you'd comment on how you report assist this organizations, this accountable care organizations and practices everywhere for that matter achieve this improved incomes but also control cost and is that something that you're monitoring, at AHRQ we are certainly monitoring that very closely, so for this effort that I mention before connected directly to the national quality strategy the partnership for patients which is a nationwide effort to dramatically improved, the safety of care for people in hospitals, we actually had to go over this practices very, very carefully and importantly satisfying **(16:28 Inaudible)** that we had some good estimates about what it would cost to actually put some of this practices into place, the accountable care organizations is a new model of integrating care which really does change the incentives but often times you know for improving patient safety, you need to put some money in upfront so you might need to have some training programs, you might, actually need to higher some additional people, so in a practical world you need to know am I really going to save very much money from the safety gains and the reason we think this is so important again it's very practical when resources are limited, it really helps to target efforts around interventions likely to give the biggest banks for the buck. And It helps organizations make priorities in their own environment, when they're having a lot thrown at them, it also helps organizations assess what capacity they have, so for example sometimes you might need to hire an additional couple of people, other times you may have people who could

very easily meet the needs of a particular patient safety program, so we think it's very important to be as clear as possible about the cost, but we still have a lot more to learn in that area.

Mark Masselli: Dr. Clancy AHRQ's role is primarily a research agency, at the department of health and human services it wasn't really design to have the power to enforce the list of new guidelines for patient safety practices. So what other tools are you using in ways of monitoring and incentivizing more wide spread adoption of these safety principles and how do you inspire a participation of the broader healthcare community.

Margaret Flinter: You're right that we're a research agency we don't pay for care, we don't regulate it, we don't provide it. Now on one level that gives us little power on the other hand it means, that virtually all stakeholders trust the evidence when we say that something works, and so they find that invaluable, because of the national quality strategy, that provides a fantastic framework for us to systematically and sort of automatically provide this information to our colleagues at CMS to private sector payers who are very interested in seeing what they can do, to motivate people to make changes. You probably maybe aware that four and a half years ago, the Medicare program essentially said we're going to change how we pay hospitals and we are not paying extra for patient harms that could have been avoided and that really, really got people's attention, engaging patients is really, really critical as well, now you always have to be a little bit careful here because you don't want to convey the message at all that we healthcare professionals can't figure it out, so it's up to you now. But patients can be a very vital source of information when things don't go well, another very successful project focused on avoiding readmissions. This was called project Red it was published about four year ago randomize trial the best kind of study design we think and involve the use of an additional nurse and pharmacist, and what they have done since then is to developed a computer avatar that looks like a nurse and when I first heard about this I had a tiny bit of skepticism my father at that point in time was in and out of the hospital a lot and I should have imagined him falling -- falling asleep in front of a computer screen like he did with the TV. But it's much more interactive than that, you have to keep touching the screen to indicate that you're understanding and so forth, you can go back many, many times and hear the same information again if you didn't get it. And this follow up after discharge we found that, that makes a huge, huge difference and dramatic reductions in readmissions, we're also sponsoring a new kind of organization there was a new law pass called patient safety organizations these are organizations that work with hospitals, doctors and other healthcare organizations to identify where they're having the most problems with avoidable harms, and to evaluate the impact of interventions to reduce those. So our hope was all of this because these organizations will be sharing data with our ARHQ and we internal will be publishing it every year, is that we will stop seeing the really tragic situation where, you hear about a very tragic patient safety event, and then it happens again two weeks later. So getting to the notion that we can think about commonality and investigates system wide fixes particularly for medication errors is very, very important, in terms of, you know, the -- where is research going from here, I think if anything more focus on the how, how do I

do that, as well as the context because you really want to know that patient safety practices or sufficiently reliable but they can literally work everywhere and anywhere and a very strong focus on an inventory care settings. And we have so much technology and capability now of providing care at home but you can also see where that could be a recipe for disaster if thing aren't done really well, so we're very much looking forward to anticipating what is a need right now but also what is likely to be a growing future needs.

Margaret Flinter: We've been speaking today with Dr. Carolyn Clancy director of the agency for healthcare research and quality at the department of health and human services on their just released making healthcare safer to a critical analysis of recommended practices that improve patient safety in healthcare, you can see the report and learn more about their work by going to AHRQ.gov Dr. Clancy thank you so much for joining us today on conversations on healthcare.

Dr. Clancy: My pleasure.

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Mark Masselli: At conversations on healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy Lori Robertson is an award winning journalist and managing editor of FactCheck.org a non partisan a nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week.

Lori Robertson: Well Mark and Margaret, several readers has asked us whether congress was attempting to exempt itself from the Affordable Care Act the short answer is no, there's no legislation in congress calling for an exemption from the law in fact law makers in their stake face additional requirements that most Americans don't have to meet, they have to switch their insurance coverage from the federal employees help benefits program to the healthcare exchanges, created by the law this requirement was added to the law by republicans when it was being debated. But now they're reportedly as concern on Capitol Hill about whether federal contributions to the premiums can continue as usual without some kind of legislative change, law makers in their staffs would be the only employees of a large employer in the exchanges, which are design for the currently uninsured and small businesses, that's where this exempt claim comes from. A report by political says that secret talks were being held by law makers to change the requirement to get insurance through the exchanges, but again no bill has been introduced, numbers of congress and their staff would be subject to the requirements to have insurance or pay a fine, just as everyone else is. And that's my Fact check for this week I'm Lori Robertson, managing editor of FactCheck.org.

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have FactCheck.org's Lori Robertson check it out for you here on conversations on healthcare

Margaret Flinter: This is conversations on healthcare I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli peace and health.