Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, it's April and Congress still hasn't resolved last year's budget and another deadline looms large and the political process in Washington has swung at a high gear over which program should be cut and to what extent, and there is uncertainty at this point is to whether democrats and republicans can come to an agreement on funding the government. President Obama has called the housing senate leaders into the White House trying to avert a government shutdown. And then again, we are looking forward to the 2012 budget battle and it's kicked off this week, the GOP Budget Committee Chair, Paul Ryan has proposed a rather ambitious plan, which he claims to save 2.2 trillion from health care over the next decade.

Margaret Flinter: Well Mark, that certainly was a headline grabbing figure, 2.2 trillion from health care over the next decade is certainly very substantial. And of course, it was inevitable that some of those savings would come from repealing the Affordable Care Act. The Congressman Ryan and his committee estimate that that would save $1.5 trillion and certainly be consistent with what the majority party hits said they wanted to do.

Mark Masselli: Well, these are numbing figures, and there is going to be a lot of reconciliation of these numbers, and burning of the midnight oil is going to be a happening at the Congressional budget office, because you remember Margaret, under the Affordable Care Act, they actually said that we would save $210 billion over the next 10 years.

Margaret Flinter: That's right. And the plan has been put forth as we understand that also cost for Medical Malpractice Reforms with the projection that that would save $43 billion, and you remember that a lot of people didn't feel the Affordable Care Act went far enough to introduce Medical Malpractice Reforms to the system. But the real surprise to me anyway called for major changes to Medicare which I thought was the third rail and nobody would touch it.

Mark Masselli: Well, there have been a lot of private groups who have been saying that the Congress needed to stand up and address these issues. Certainly, representative Ryan has in his proposal whether or not it is against traction or one of the items is that he wants to increase Medicare eligibility and raise the age level to 67 years of age.

Margaret Flinter: That's right, which tells us that we should enjoy what we are doing because we are going to do it for a long time, and he has put forth the plan to privatize Medicare for those 55 and younger starting in 2021, so really this affects the next generation of seniors more than today's. It would call for premium support in which the government would pay only 8% of the Children

Insurance Premium for seniors with more help for low income and sicker people. And just like private insurance works today, if you want better coverage or more comprehensive coverage, you could kick in some more money.

Mark Masselli: Here at Conversations on Health, we will be keeping an eye on representative Ryan's proposal and the entire 2012 budget process as it impacts health reform. Clearly, one of the issues in terms of saving money will be the conversations that are going around the country about improving patient safety and effectiveness.

Margaret Flinter: That's right. Patient Safety saves lives and saves money, and today's guest is a national expert in that field. Dr. Lucian Leape is internationally recognizes for his efforts in advance in patient safety. He is known as the Father of the modern Patient Safety Movement and his body of work includes the landmark 1999 Institute of Medicine Study, To Err Is Human, which prompted the medical community and legislators to find ways to improve patient safety. We are so happy Dr. Leape can join us today.

Margaret Flinter: But no matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded or if you would like to hang onto our every word and read a transcript of one of our shows, come visit us at Chcradio.com. If you are social media aficionado, you can become a fan of Conservations on Health Care on Facebook, and follow us on Twitter.

Mark Masselli: And don't forget, if you have feedback, email us at Chcradio.com. We would love to hear from you. Now, before we speak with Dr. Leape, let's check in with our producer Loren Bonner for the Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. House Budget Committee Chair Paul Ryan's 10 year budget blueprint has been officially released. The proposal is designed to Reign in Medicare and Medicaid Spending while squeezing trillions of dollars from the nation's deficit. The plan makes fundamental changes to Medicare by converting the entitlement program for the elderly into a premium support program where the government would spend a specific amount for beneficiary's care. Congressman Tom Price from Georgia spoke at the unveiling and said "In addition to changing Medicare, the proposal would also repeal President Obama's healthcare overhaul."

Tom Price: This budget repeals and refunds the government takeover of healthcare so that we can advance patient-centered health reforms, and this budget reflects an honest assessment about the current unsustainable trajectory of Medicare and save the program for future generation.

Loren Bonner: The republicans' 2012 budget proposal stands little chance of becoming law since it would have to be approved by the democratic control

senate and signed by President Obama. The senate has voted to repeal the unpopular tax-reporting requirement in the Health Care Law widely referred to as the 1099 Provision. The measure had few backers from either party, yet a month's long battle ensued over how the repeal would be paid for. The measure now goes to the president who is expected to sign it. The much anticipated Accountable Care Organization or ACO rules for Medicare have been released by CMS. The Medicare shared savings program as it's officially known would allow providers to band together as ACO starting in January of 2012. The ACOs create an incentive for healthcare providers to band together and form a network to coordinate Medicare patients' care with the end result being improved quality of care and cost savings. The 429 page proposed rule is just a draft that now enters a 60-day comment period for the public and interested parties to way in.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Lucian Leape, one of the nations leading figures in patient safety, widely known as the father of modern patient safety movement in this country. Dr. Leape is currently Adjunct Professor of Health Policy in Harvard School of Public Health and Chair of the Lucian Leape Institute at The National Patient Safety Foundation. Welcome Dr. Leape, begin your career in pediatric surgery and came to health policy later in life. You credit Dr. Howard Hiatt, pioneer in patient safety must widely known for his work on the Harvard Medical Practice Study with guiding you in this direction. What were your early years like when you began in this field and what else has influenced your work?

Dr. Lucian Leape: I spent 25 years as an academic pediatric surgeon and decided going to health policy work and Dr. Hiatt invited me to join the just beginning medical practice study, so this is a very different experience for me. This was a big population based record review study, we looked at 30,000 patient records in hospitals in New York state and what really struck me after we had done all the work and got the data and analyzed it, were two things, one is the extent of the injury of patient harm from treatment was much greater than I had ever realized as a practitioner. You know you don't see these things very often in your everyday practice, but when we you know looked at overall a large sample patients it turned out at one in 25 or 4% had an injury, but what really struck me was that two thirds of those seem to be due to errors which we could tell just looking at the records, so I was certainly impressed with the fact this was a much bigger problem I had ever realized before.

Margaret Flinter: Dr. Leape in reading some of your work, I can see your real interest in passion for changing the culture for one of the shame and blame as it sometimes called to looking at the breaks and complex systems that really lead almost inevitably to the error happening. Could you tell us a little more about how systems theory works in healthcare when you apply it to this issue of patient safety?

Dr. Lucian Leape: Sure, this is really the driving concept behind the patient safety movement. I referred it was a transforming concept, the idea that people make mistakes was not because they are bad people, it is because they are in a bad system and this was brand new to us background of 15 years ago, because we had all been trained in medical school and same for nurses in nursing school that if you, you know learn your lessons, do your homework, and keep up and are careful you would not mistakes. When it turns out, you have to do all that but that doesn't keep you from making mistakes, and so there was a whole and immense body of knowledge regarding psychology, human factors engineering, and that sort of thing about the fact that errors are induced. They are caused by defects in the system and the corollary of that _____ 9:33 is the point is that you can change the system, you can change the processes of work to make them much less error prone to make is much less likely that you will make a mistake and that's the concept behind the systems change that is as Don Berwick like to say every system is precisely designed to produce exactly the result it gets, so if you don't like the results in this case harm the patients then change the system. I often think that's true, I mean you know people say that that's extreme and always still human factor and there certainly is, and we do have problems with people who have not kept up or have conferencing problems, but those are systems problems too, what's the system you have or making sure that people who are properly trained and are maintaining their skills and so forth so, this idea that if you want to improve an outcome, look to the process is very fundamental for safety and for all of quality improvement and has really proved to be very useful, I mean it works, we do it and it makes a difference.

Mark Masselli: Speaking with Dr. Berwick, you are a member of the Institute of Medicines Quality of Care in American Community, you helped write the famous, To Err Is Human in 1999 which stated that medical errors kill up to 99,000 patients per year and that prompted the medical community and law makers to find ways to improve patient care, and a few years later in 2001, the IOM published crossing the quality chasm which offered a set of performance expectations for the 21st century health care system, what some of the areas you have seen progress in patient safety since the called action became more widely adopted.

Dr. Lucian Leape: Well, in several areas that we have seen substantial strides, the first thing that comes to mind is medication use. We prescribe three and a half billion prescriptions a year in America and doctors make mistakes and pharmacist make mistakes and nurses make mistakes, patients make mistakes in using medicine and so there is tremendous amount of attention to go to some of our first studies, the first study we did to try to see if this systems theory work was on medication systems and so there has been a lot of work on improving medication systems Simple thing we did which now must be almost ten years ago was to remove hazard destructs from the unit as medicines that if you accidentally gave him would be fatal, and you have them done in the pharmacy where they can mix them and take care of them. So medication safety has been

one area, another has been we had in our interest but a lot of other people as well in computerizing patient records and computerizing the order system so that you order a medication on a computer instead of writing prescription by hand. This has immense potential to improve safety and it's just taking forever to get it implemented, I mean finally the Obama administration appropriated $30 billion to move electronic medical records into doctor's offices. I think the other areas where we have become much better at, patient identification making sure we have the right patient for the procedure, the medicine, or whatever. You went to hospital now and it seems everybody is asking you your name and your birth date, but that's good, that's a good thing and so it's a nuisance but it's a good thing. And then it has been a lot of attention in the last few years on preventing infections. Infections are one of the most common types of adverse events and infections are one of the big ones, and we have had a lot of improvement in that area as bloodstream infections, pneumonia, surgical infections, etc. So, I think it's been a lot of good work and a lot of improvement, not nearly enough though, I mean we still have a long way to go.

Margaret Flinter: Dr. Leape many institutions certainly like the Institute of Medicine and your own Institute, The Lucian Leape Institute at the National Patient Safety Foundation are hard at work on this issue of advancing patient safety, and there are also the very well known to those best in healthcare anyway, figures like Dr. Peter Pronovost, who has been a guest on our show, who created a really a breakthrough but very simple intervention using the checklist to reduce those central line catheters that you were speaking about a moment ago and I remember when we spoke with Dr. Pronovost, the good news was that hospitals that had rigorously adopted this had reduced their central line infections down to near zero and the bad news was that not every hospital had adopter, was seem to be so obviously, and effective interventions, so guess my question is has patient safety, at the hospital level or large healthcare organization level moved into the executive suite, the corporate suite, the board suite or is it off still on a sideline in quality. Would a board of directors expect your reports on errors in patient safety the same way they would on the financials of the institution these days.

Dr. Lucian Leape: That's a great question and I take it too hard because I happen to sit on the board of directors of hospital and I am sort of the local knowledge about this, but the short answer is not enough. And first problem is get back and say I think Peter Pronovost work has been absolutely path breaking. It was the first demonstration that you could completely eliminate a certain type of adverse event, but _____15:29 people always said well you can reduce them, and if you do a better job we will have few of them. And the whole idea and safety of course is to have none. Peter's work particularly in Michigan where he had got them to implement the protocol for preventing central line infections and also a protocol for preventing pneumonias and people who are on ventilators, and he had 68 hospitals that went six months without a single episode of central line infection and without a single episode of ventilator-

associated pneumonia, that alone with those hospitals saved over 1500 lives, and so I am just, you know I cannot speak too hardly about Peter's work. I am glad you had him on your show because it really changed the conversation about the improvement to eliminating adverse events. The problem is that most hospitals still are on board, and if you look at the healthcare systems that have really, really made great strides in safety, and I think of Virginia Mason Medical Center in Seattle and Cincinnati Children's, and I think Geisinger in Pennsylvania and some other hospitals that have made a big difference, all those would have the full support of the board as well as the leadership of the CEO, the question for those ways of working is how would every hospital do that and we haven't figured that out yet.

Mark Masselli: This is conversations in Healthcare today we are speaking with Dr. Lucian Leape one of the nations leading figures in patient safety. We will pull the thread a little more on the mandatory reporting, which is mostly bit in the purview of the state. Do you think there is a need for a federal system of regulation, talk to us a little bit about the role Medicare might play or should it be left up to the states and hospitals and along these same lines what can regulators do to learn from various states and encourage safety and quality and innovation.

Dr. Lucian Leape: Well I think that last question is the important one and that is one why report and what does it have to do with safety, but lets start with the fact and that is it's only half of the states require reporting. So if you say you think this is essential, it's quite evident that leaving it to the states doesn't do the job, and that's an argument some people have used for a national system. But the important questions what are we trying to accomplish when you look at the state reporting systems and some of them are very impressive, I think Pennsylvania has an outstanding system, for example. They get 10's of 1000's of report, and so if we were to have a national reporting system we would get, you know, over a million reports a year. And as soon as you say that you would then can immediately understand that the obvious question which is, how do you process that? The only reason to report is that you can learn from it and make changes to prevent something from happening again and _____ 18: 32 to be of value they have to do an investigation to try to understand what went wrong and try to figure out what might be done about it. Without that kind of investigation which, a term we use as root cause analysis really trying to understand where the system broke down. Remember it's not bad people it's bad systems, okay what were the bad systems? And so that takes time, money, expertise, etc. Without that, all you are doing is getting account. You can say at the end of year well we had, you know, 5,000 falls and well that's nice to know but now what. So meaningful reporting requires meaningful analysis that has to be done at the place where the injury occurs, has to be done in a sophisticated way, and then information that collected and put together. This is a huge job. What we really should do though is have a better way of sharing those learning.

Margaret Flinter: And I couldn't agree with you more about the value of those root cause analysis and primary care outside of the hospitals as well as in hospitals. Now your institute has identified six areas of focus that require system level attention if we are going to move this national patient safety agenda forward and for our listeners, I want to go through them for a moment. They include medical education reform and by that I assume to meet all health professionals educational reform, engaging consumers transparency, integrating care, the safety of the healthcare workforce itself and also the restoration of joy and meaning in work. And that last one the restoration of joy and meaning and work really stands out to us, it's so rarely discussed in healthcare. We certainly talk about it in primary care as fundamental to maintaining that vitality and energy and compassion over many, many years of caring for patients. But perhaps you could elucidate the relationship as you see it between patient safety and restoring joy and meaning in workforce.

Dr. Lucian Leape: We have been talking about burnout in nurses and doctors. We have been talking about doctors retiring or only nurses quitting, and etc. And in too many of our healthcare institutions we have a toxic environment and it's just has grown that way. We sort of haven't changed the way we practice in 50 years in the fundamental sense, but medicine has changed dramatically, and as a result puts tremendous strain on people, and so our hierarchy to nature of healthcare where, you know what the doctor says goes that doesn't fit anymore. The big lesson over the ast 10 years in patient safety is it's not enough to have good safe practices, it's not enough to have checklist, it's not the checklist that makes patient safe, it's the team work that it takes to put the checklist in place, it's the team work it takes to implement the safe practices, and team work is almost a foreign language in healthcare. We don't run at medical school. It's fair to say in many if not most hospitals we don't have the kind of collegial team collaborative working arrangement that's essential. And as a result the physicians and the nurses and everybody are under increasing strain and it has literally suck the joy and meaning from their work. We think it's an absolutely critical thing. We have already had one roundtable on this, we are going to have another and we will be publishing a whitepaper with some very specific recommendations, which I am hoping will address this.

Mark Masselli: Dr. Leape we would like all of our guests this question when you look around the country and world what do you see in terms of innovation and who should our listeners at conversations be keeping an eye on?

Dr. Lucian Leape: Well it's interesting because innovation is almost has to be the daily work in quality improvement and safety, that is healthcare workers need to address specific problems they surface in their work and then develop an innovative solution for it. Massachusetts has a mandatory reporting system for serious reportable events and they report the results once a year and you know at the number one adverse events in hospitals by far falls people falling out. Well we got to be able to prevent that and so there is a lot of work given to that and I

think there is some innovative thinking there. And of course when technology marches ahead, you know, full steam, I mean you know I was a surgeon for 25 years, but I made incisions on people and sew them up. They don't do that anymore, they operate through these little tiny scopes and with robots and so nobody can predict where that's going to take us except it does post new problems for safety that we have to address.

Margaret Flinter: Today we have been speaking with Dr. Dr. Lucian Leape one of the nation's leading figures in patient safety. Dr. Leape thank you so much for joining us today on conversations.

Dr. Lucian Leape: My pleasure thank you for having me.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

Margaret Flinter: This week's bright idea focuses on a program that improves the way asthma is managed in children. The Cambridge Health Alliance and Integrated Healthcare System in Massachusetts wanted to take a more proactive approach to reducing the number of children who use the hospital emergency department for asthma-related treatment as is the case around the country asthma is one of the leading causes of ER visits for children, particularly low income children, and one of the major reasons for miss days of school, and certainly the data shows that with better management, these consequences can be prevented. But at the most fundamental level, the Alliance's Childhood Asthma Program is a community based model of care, teams of community health workers with registered nurses make home visits to help parents reduce or eliminate some of the asthma triggers. They outline an individual asthma action plan with regular steps to prevent or treat asthma attacks and another key element is the patient registry so that the child's asthma information is available whenever he or she enters the healthcare system, be it the primacy care office, the school health center or the emergency room. The asthma program has dramatically reduced hospitalizations and ER visits for children in Cambridge, annual asthma related emergency visits fell 50% from 2002 to 2009 for children enrolled in the program. An approach to pediatric asthma management that's moving away from reactive treatment to aggressive daily management through an integrated system of care that includes every place, the home, the office, the school now that's a bright idea. This is Conversations on Health Care, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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