Mark Masselli: This is Conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, I hope you had a wonderful Thanksgiving.

Margaret Flinter: I did enjoy the football game.

Mark Masselli: Well, that's great. Hopefully whatever team you were rooting for won. I was just thinking back though we are about a year out from when we were right on the precipice of healthcare reform being passed in the United States senate and they got those 60 votes they need, but a year has passed and a lot has changed. It seems to be as much energy now looming on the horizon to repeal health reform which is never great news.

Margaret Flinter: Well, you know in terms of the football game I always root for the underdog and now I am a 100% sure who the underdog is in the push on Healthcare Reform. A year ago it was a high drama waiting to see it pass, now it's high drama to make sure it gets implemented and I think we will be just continuing to see how this unfolds.

Mark Masselli: Well, there are a lot of things to keep an eye on and one of the most important things to keep an eye on is your public radio station and right here at WESU we are out there asking all of our listeners to join us in this pledge drive. This is the sixth annual holiday WESU Pledge Drive and our goal is to reach $15,000 by December 12th and we are hopeful Conversation listeners all over the country are engaged in your own public radio station but recognize the benefits of the WESU provides us with hosting the show.

Margaret Flinter: And we know our listeners know this but we can't say it strongly enough. If you support and depend on non-commercial college and community radio then it is up to us, our listeners to sustain the unique variety of music and talk-shows that WESU brings you every week and to say thanks to the wonderful community members and Wesleyan University students who volunteer their time to bring us these shows.

Mark Masselli: And as you know WESU has hosted Conversations on Healthcare for over a year now, can't thank them enough for everything they have done. We said it last year and we will say it again helping out community radio stations is good for your health and it will make you feel good as well to pledge so do us a favor and make your pledge today to WESU. You can call us at (860) 685-7700 or reach us online www.wesufm.org.

Margaret Flinter: And supporting WESU sends a much bigger message to the world that I think also makes this feel better. With the pledge to WESU you are

saying I support free speech, I support the voice of the people and local radio, you know we want more than just the large companies dominating the airways.

Mark Masselli: You know WESU is an important service to the university and to Central Valley and beyond it's been big year for WESU with the completion of a three-year project for quadrupling. It's broadcasting power from 1500 watts to 6000 watts can you hear me now out there in Southern Mass, yes you can. 71 years of going strong, give us a call at (860) 685-7700.

Margaret Flinter: It goes a long way, so once again please make a donation online at www.wesufm.org or call at (860) 685-7700 and thanks to everybody who has already made an important gift to community radio.

Mark Masselli: Let's turn now today's show. Our guest is David Mayer, he is a leader in Patient Safety and he is Associated Dean for the University of Illinois at Chicago College of Medicine and Co-Executive Director for UIC's Institute for Patient Safety Excellence. He has integrated an innovative patient safety program into his curriculum at UIC's Medical School. His work is helping drive quality in healthcare around the country.

Margaret Flinter: And no matter what the story, you can hear all of our shows on our website chcradio.com. Subscribe to iTunes to get our show regularly downloaded or if you would like to hang on to our every word and read a transcript of our shows, come visit us at chcradio.com. Think about becoming a fan of Conversations on Healthcare on Facebook or follow us on Twitter.

Mark Masselli: And as always, if you have feedback, email us at chcradio.com, we would love to hear from you. Before we speak with David Mayer, let's check in with our producer Loren Bonner with Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. Congress reconvenes this week for the final leg of the "lame duck" session before the end of the year. One of the many items on the agenda concerns the Child Nutrition Reauthorization Bill, which promotes healthier school lunches and has gained support from First Lady Michelle Obama and her campaign to fight childhood obesity. The house still has to consider the senate passed bill. The Child Nutrition Act controls the programs that provide school lunches to the more than 32 million kids across the country who rely on Federal Nutrition Programs. But the bill goes further than simply reauthorizing existing programs as it did in the past. This time it would allocate an increase in the reimbursement rate for schools that agreed to serve healthier lunches. The center unanimously approved the bill this summer. It gave an additional $4.5 billion to child nutrition programs over the next 10 years, paid for with cuts to the nation's Food Stamp Program. That house hopes to find alternative funding in the "lame duck" session that would improve the program without cuts to food assistance. Employer provided healthcare benefits are in jeopardy as congress gets serious

about cutting the deficit. Leaders from both parties have considered shrinking or even eliminating tax breaks that help make employer health insurance a leading source of coverage in the nation. Economists predict this could turn Americans into frugal healthcare consumers by having them face the full cost of their medical decisions. Labor unions, however, strongly oppose such a move and are gearing up for another fight.

Mark Masselli: This is Conversations on Healthcare. Today we are speaking with Dr. David Mayer – Associate Dean for the University of Illinois at Chicago College of Medicine, Co-Executive Director of UIC's Institute for Patients Safety Excellence and a practicing anesthesiologist, welcome David.

David Mayer: It's a pleasure.

Mark Masselli: At University of Illinois at Chicago College of Medicine your students are schooled in patient's safety. You have integrated in innovative patient safety program into your curriculum which has become a model for medical schools across the country and around the world. Can you start out by giving us a snapshot of this curriculum and some of the hands-on exercises that students perform and what lessons are you trying to instill and why is teaching patient safety so important today?

David Mayer: To go about the first part of your question our goal many years ago was we are very aware of what was happening at clinical care and at the institute of medicine in 99 released to err is human, which really brought forth the critical medical error crisis we had in the country today. And having been someone who would study quality and safety for many years in my career it was refreshing to see what happened with that after the report was generated, and had spent a lot of time looking at different models of high reliability organizations for instance, aviation, nuclear energy type industries and particularly in aviation they faced a similar crisis in the late 70s and early 80s and put a lot of focus into starting training very early in their culture literally from day one. And some of the recommendations to us in healthcare was we should be doing similar with our health science students. And so we adopted their principle about 8 years ago. We were able to launch a lot of our curriculum using the aviation model. Some of the workshops we put into place based on that model included making students understand the importance of working together in teams very effectively. So we started teaching students very early, practice of teamwork, effective communication, conflict resolution, emotional intelligence and leadership skills specific to patient safety. Through the years we have worked very hard to see what worked, what didn't and kind of you know always worked to change and improve it and we have a really nice I believe for your curriculum in patient safety today.

Margaret Flinter: And Dr. Mayer I know anesthesiologists are often given credit for maybe having made the most improvement in the whole patient safety arena

so congratulations on that. And you know it seems that the courses in the workshops everything from teamwork to conflict resolution as you said we have seen that they should be essential and required as part of every health professional students education. And the public is focused on this, the joint commission is focused on it, Medicare is reporting an adverse events, but to the best of my knowledge, this still isn't required and there so many things are required as part of health professions training. What's the national debate among the various accrediting bodies in terms of this becoming required part of the curriculum for medicine for example?

David Mayer: You bring up excellent points and the great thing about it is we are seeing a lot of movement in this area today. The American Association of Medical Colleges has been doing a lot of wonderful things over the last 4 or 5-6 years trying to raise awareness, trying to demonstrate best in practice type curriculums at the recent AAMC meeting. I think you are aware of the Lucian Leape Institute report that just came out regarding medical education and some of the deficiencies in areas that can be improved. A lot of us have rallied around there report and have been moving patient safety deeper into the curriculum across the country. And finally at the resident level the ACGME which is our accreditation body for graduate medical education and under Tom Nasca's leadership is doing some again wonderful work in raising awareness and incorporating new rules and regulations and what residents need to be educated on during their residency training. There is a common set of educational elements and then specific elements within their disciplines that they are now going to be required to learn and demonstrate competencies and before they finish the residency.

Mark Masselli: Dr. Mayer I am sure you keep in touch with former UIC medical students and what kind of experiences are they having? You obviously making them aware and educating them about patient safety but trying to change the culture of the institutions they are working in requires a different skill set. So what does it take to get a resident to report on unsafe condition make note of a colleague who doesn't wash his or her hands or an adverse event for example and do you think anything in healthcare reform will break down some of these barriers?

David Mayer: Residents are at a very unique position in healthcare today. They make up a little over 11% of you know the practicing physicians out there in front of patients taking care of patients and David Leach, the former CEO of the ACGME had a wonderful statement many years ago. He says, "Residents can be the moral agents out there that can be their protection, can be those eyes and ears for our patients." However, residents are also in a very difficult position of being evaluated being accessed. They come into an organization where the culture may not be supportive of them to raise their hand when they see something for fear of you know blaming and whistle-blowing but also the repercussions that may occur. We need to change their culture. Tim McDonald

and myself and Nikki Centomani have been doing at the University of Illinois here, we are trying to change their culture in making reporting a key part of the resident educational process because we show them on a regular basis, on a monthly basis how those reports can turn into what we call gifts. Those are gifts that we are allowed to change our culture, change our processes before harm occurs. Just to give you some data when we started this program with our residents about three-four years ago out of the 1500 incident reports we would get an incident is anything from an adverse event where a patient may have had effect from our care. All the way in the near misses and unsafe conditions the things we see the work around everyday, out of those 1500 only 5 came from our residents and we knew that was clearly a gap and a deficiency in our system. Today after going in and educating the residents on the importance of reporting the values and then showing them what happens when they do report these things we are closing in on almost 7000 incident reports a year and about 20% of them come from our resident today and I will tell you that with the 7000 reports we see today we are safe for hospital today than we were three years ago.

Margaret Flinter: Dr. Mayer, in addition to the institute for patient safety excellence that you founded at the University of Illinois, you also co-founded Transparent Health an organization that delivers innovative education programs in patient safety and in disclosure of medical error to healthcare providers and patients, certainly for all medical students, for physicians, for nurses, for all healthcare providers the worse thing that can happen, the worse feeling is to make a mistake. What do you teach caregivers to do when confronted with the reality that they have made a mistake? What's the strategy and what's been your experience yourself and with your students with full disclosure after a medical error happens.

David Mayer: At first a little clarification, the institute of patient safety excellence which we created about 7 years ago here at the University of Illinois really wasn't my creation. It was the creation of many people across our medical center you know clinical care, education and research the scope of what we do in academia and everything we look at regards to safety and quality is focused through this multi-professional institute. And the Transparent Health side this was an organization Tim McDonald and I started in hopes of trying to share with people out there through series of educational films that tell true stories, real stories of patients and families who have been harmed from our care. Try to use them to create and educate on two important points. The first is no matter how good we get errors are still going to happen and we need to learn from every error we see and how we can improve our systems in patients and families, god bless them. Many of them just want to give back, want to share these stories even as difficult as it is so we can make healthcare safer so others don't suffer similar consequences, health consequences. And the second reason we made them is because even when errors occur, we need to do the right thing after the fact. For many years the profession has really tried to first deny and then defend the indefensible because we have been given advice or we have been told that to be

open and honest is the totally wrong thing to do because you will just get sued, you will lose your license and yet there is never been any hard data to support they are trying to defend the indefensible when we have been wrong is the right policy. And so many places across the country today said you know what when patients get harmed we need to be open and honest with them, we need to share with them everything that happened and answer their questions, if appropriate and we did cause that harm we need to apologize. And there is a difference between being empathetic when we say oh we are sorry this happened to you versus apologetic when we say this is our fault, how can we make this better. There is a big difference in those. We need to make it better it could just be waiving bills and letting the patient move on. Other times it requires some sort of settlement and finally and if patients tell us unless this is important is the first three if not more important is what are we doing as institutions, as learners to ensure that what happened to patient or family member doesn't happen again.

Mark Masselli: This is Conversations on healthcare. Today we are speaking with Dr David Mayer – Associate Dean for the University of Illinois at Chicago College of Medicine and Co-Executive Director of UIC's Institute for Patient Safety Excellence. Dr. Mayer, we understand you are awarded a federal grant to implement and evaluate your Patient Safety efforts on the larger scale. Can you tell us more about your goals and what metrics will you use to evaluate your success?

David Mayer: The grant which is based on the work I had been referring to done by Tim McDonald and Nikki Centomani and Bill Chamberlin at our medical center involves what we refer to in sort of you know passionate ways the Seven Pillars program, the seven elements of dealing with adverse events when they occur in an institution. And it's taking their policy of doing a rapid investigation, understanding the issues around the harm, addressing it, apologizing, providing rapid remedies and bringing those things to closure. We have got a strong care for the Caregiver Program because as caregivers we many times, we don't go into healthcare trying to harm somebody. We go into healthcare trying to cure and trying to help people and when those errors occur many times and finally it's the Quality Improvement Initiatives and capturing data to show that we have changed our systems. The Seven Pillars was recently awarded as you refer to a $3 million AHRQ Medical Liability, Patient Safety Demonstration grant. That money allows us to take the program that's been developed at UIC here and roll it out to ten hospitals in the Chicago area.

Margaret Flinter: Dr. Mayer, the Patient Safety movement I think we would all agree isn't really all that new certainly the Institute for Healthcare Improvement has been working on this going on two decades. Now the joint commission has had patient safety as one of their key indicators. But it seems I think to those of us practicing across the country, there is the area of the science and the area of the standards and what there is a need for almost is a sense that the science has evolved to the point where we train this is the way to do things to prevent medical

error, this is the standard you need to follow whether you are in a Tertiary Medical Center at Community Hospital or Ambulatory Care but it doesn't seem we have gotten there quite yet. There is not one universal set of standards, what's your sense about the direction we are on in terms of achieving that? Is that a realistic goal in terms of patient safety?

David Mayer: Yeah, I think it's a realistic goal and I think you might say turn the corner have we reach the tipping points yet, I don't believe so, but there are some you know amazingly wonderful things going on across the country whether you pick up any of the safety journals or you go to some of the major safety meetings you see these programs that have been implemented. Many of them at the grassroots type level literally from nursing units or departments in within those health institutes that have just started on their own doing a lot of this work and then to disseminate this work you hear about things like Pronovost's central-line infection rate data, you hear checklist data, you hear about this type of efforts that now are being disseminated across the country.

Mark Masselli: Dr. Mayer when you look around the country and the world what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

David Mayer: There are some amazing things. We do a fair amount of work with the government in New South Wales in Australia and you know one of the programs that I think is an amazing program that they have developed is what they call the Between the Flags program. It's similar to what we have in the states here but taking it a little bit further in regards to the Rapid Response Teams. And I am not sure how much you know about the Rapid Response Teams but the ability to bring in a second set of eyes, another group of caregivers to look at a patient when you are uncertain and we now have not patient activated rapid response teams where patients and family members can make that call to bring in a second set of eyes to look at their loved ones. Those will offer us an opportunity to correct what we have seen in regards to failure to rescue certain patients that end up going too far down and get too sick before we can really act on them. In Australia they have done this and it's based on their lifeguard model where they know as a lifeguard that if I keep all my swimmers between the flags so it's two flags, one put to the right to me, one put to the left to me, based on my physical ability if you get in trouble between the flags I can save you. I know that I could get to you and save you but if you are outside the flag I lose my ability to rescue you when, if needed. And the idea being that, keep everybody between the flags and what they have done is they have set the same thing in parameters with patients that if a heart rate goes above a certain level or goes below a certain level it automatically triggers the rapid response team. So it takes out of that human intervention so to speak of making that decision or picking up the phone and calling and it allows the patients' own vital signs and conditions to trigger that rapid response team and they call it Between

the Flags. I think that's very innovative in using technology in a way to interface with human action.

Margaret Flinter: That is a great analogy and we will remember that Between the Flags when we always learn something from our guests. Today we have been speaking with Dr. David Mayer – Associate Dean for the University of Illinois at Chicago College of Medicine, Co-executive Director for UIC's Institute for Patient Safety Excellence and a practicing anesthesiologist. Dr. Mayer, thank you so much for joining us today on Conversations.

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

Margaret Flinter: This week's bright idea focuses on the University of North Carolina at Chapel Hills Nutrition and Medicine Program providing nutrition education courses for medical students. The problem of inadequate nutrition education medical schools has been around since the 1980s when a National Academy of Sciences Study recommended that medical students receive at least 25 hours of nutrition instruction and noted that very few medical schools met the standard. Almost 30 years later only a quarter of medical schools hit that mark and doctors and their patients feel the consequences. Well the doctors have learned the ins and outs of diagnosing and treating all manners of injuries and diseases, many say they struggle when it comes to nutrition counseling. This is where the nutrition and medicine program comes in. Developed 15 years ago by the University of North Carolina, the program's online interactive courses teach medical students about a wide variety of nutritional issues, from nutrition during pregnancy to pediatric obesity to the proper use of supplements. UNC offers the program free to all of the country's medical schools. Many would see it as an easy way to integrate comprehensive nutrition instruction into students already packed course loads. Nutrition and medicines creators hope the program will help the next generation of doctors to better advise their patients on nutrition at a time when obesity rates are record high and proper nutrition counseling has never been more important. And perhaps it will encourage them as well to refer their patients on to other members of the healthcare team who have the expertise to really help patients with fundamental diet and nutrition issues. Now that's a bright idea. This is Conversations on Healthcare I am Margaret Flinter.

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

Conversations on Healthcare broadcast from the campus on Wesleyan University at WESU, streaming live at www.wesufm.org and brought to you by the Community Health Center.