Patient Safety and High Performance Leadership Summit
Issues in Governance, National Collaboratives, and H.I.T.:
National Safety Programs

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Webinar Transcript

Charles Denham: Can we have everybody sit down? Very good. So for our screening audience, we'll be showing a video, and we'll get started right away to introduce this panel. Can we have everybody sit down? Thank you. So we're going to introduce this panel with a video, and we'll kick it off. Partnership for Patients.

Male Voices in Video: We have a problem in American healthcare. A lot of people don't realize it, but healthcare in American hospitals is not safe. Partnership for Patients is a unique, public/private partnership that's never been done before.

Since this initiative was launched in April 2011, by Secretary Sebelius, we've already racked up some impressive results. More than 6,500 organizations have enrolled into the Partnership for Patients, including more than 3,000 hospitals. It establishes two bold national aims: a 40% reduction in hospital-acquired conditions, and a 20% reduction in thirty-day readmissions.

Female Voice in Video: We're working very closely with those State associations to reach all of the hospitals we possibly can across the nation so that we can help deliver the best information about what effectively works to drive down hospital-acquired conditions and to improve our readmission rate.

Second Male Voice in Video: South Carolina Hospital Association, along with over 30 other public and private sector healthcare partners in South Carolina, have been working for the last five years through the Every Patient Counts Partnership to improve the quality and safety of care of every patient in our state. More recently, we've aligned that work under the National Partnership for Patients, specifically focused on reducing preventable harm to patients across our state, reducing readmissions, and improving care coordination and transition for patients statewide.

Second Female Voice in Video: There has to be a culture of safety, so we developed this toolkit that has everything in it. Lots of information about what the problems are in terms of patient safety, and what you can do about them. And then what the [boards] can expect from the institutions that they are fiduciaries for, and how they can drive change to a culture of safety.

Third Female Voice in Video: We work with a partnership of hospitals and long-term care centers. We're matching up providers in the acute and the long-term care realm, and we're working very specifically with patients and identified family care partners. We are equipping them with the training to use and create their own health record – their own electronic health management record that they then take with them to different sites – to build their confidence, their health confidence, or their self-confidence in their ability to manage their own chronic condition. And that's been one of the pieces that's been missing.

Third Male Voice in Video: With reducing central line-associated bloodstream infections, we have seen a sixty-nine percent reduction. We are really changing the culture in the operating rooms across the state, and we've seen some early reductions, about twenty-five percent, in surgical-site infections. Looking at the cost impact – we have done some measurements as far as it relates to central-line infections, and we've seen probably about, just in that one initiative, about a $10,000,000.00 reduction in costs statewide.

Fourth Male Voice in Video: Through this collaboration, we've given hospitals tools to do root cause analysis, and for central-line infections, catheter-associated infections, we've seen significant – and by significant – twenty-, thirty-, forty-percent drops in rates over a very short period of time.

Fourth Female Voice in Video: It's a matter of how do we take the really great programs and processes that have already demonstrated their success, and bring those to scale and spread them in all settings. And that's helpful, and that's the difference.

Fifth Male Voice in Video: We eventually ought to be able to share a bit of practice and create a learning network so that the participants who are signed up, and are attempting to improve, [so] that they can share their learning experiences. Therefore, we can then move the dial on improving care and defending the cost of it.

Sixth Male Voice in Video: We're going to move from that provider-centered, volume-driven environment to a patient-centered, value-driven environment. What I mean is that, value is quality divided by cost. And as we start to really improve safety, quality will improve, costs will drop, value will go up, and as a by-product it will be more patient-centered.

Fifth Female Voice in Video: You want to make your care safer. Why not take advantage of this important opportunity to really link with others who have the same goal, and who have different perspectives, different tools or strategies at their beck, and who are ready to move with you to improving safety?

Sixth Female Voice in Video: I believe that the people [who] run hospitals or run nursing homes are in that business because they want to help people. People pride themselves on that, and I think that the Partnership for Patients and that the goals that have been set out are goals that these organizations will embrace and will support.

Seventh Male Voice in Video: If you want a system, you set an aim. Aims create systems, and that's what's different.

Eighth Male Voice in Video: So this is like when John F. Kennedy said, "We're going to put a man on the moon;" that created systems. That caused NASA to organize a moon shot.

Ninth Male Voice in Video: And the same thing is going to happen here, except now we're going to eliminate patient harm in America's hospitals all across the country.

Charles Denham: Terrific. And I think so many of us out at the front lines [who] are trying to help communicate this program out to folks in the front line find that they're overwhelmed. I mean I think that, Mike Henderson, you and I are working out in the field helping people understand, even though the message is really clear, how we get down to the granular sort of piece. The Partnership has got great aims that's based on great evidence. And the fun thing for us is that having been – and Dave Classen is a wonderful contributor, and Jim Bagian through the Safe Practices for Better Healthcare, Arjun and the infections we have worked for the last three or four years that tie that evidence to the papers. But the challenge is those barriers – those chains of habit are too light to be felt until they are too heavy to break. Those chains of habit are tough.

David, as we look at this – if we said five years ago, "Wouldn't it be awesome that there was a government program that targeted the stuff we knew worked?" And there is now, but five years ago, or six years ago, there wasn't. Now where are we out at the front lines, because you're out there helping hospitals giving consultative support to do just these things that are described by the program? Give us a reality check so that this can be a learning moment for all of us.

David Classen: I have a mother who is 85, and she has congestive heart failure, and has atrial fibrillation, and she's on Coumadin. She goes in and out of the hospital. Unfortunately, even in today's

world, virtually, reliably, one hundred percent of the time, her medication gets screwed up when she leaves the hospital. So we still, I think …

Charles Denham: And you are one of the top guys in the world of medication management and your mom …

David Classen: It still happens.

Charles Denham: It still happens.

David Classen: It still happens. So I think the point here, and the reason this program is so important is, despite all of our programs on safety since 1999, and the IOM report, "to err is human," we still have a long way to go. Clearly, where those vulnerabilities are, transition to care, I think which we all recognize, and are a major part of this program, and I think deliberately so. So I think that's sort of the test for me, when my mom can go in and out of the hospital, get her medications handled correctly, I'll feel much safer about the system. But still today, I think it's a challenge.

Charles Denham: We need a system, big barriers, the beginning of the beginning. Bill … I love the way Bill helps put it into perspective that pilots – we talked about aviation a lot today. We talked about the term "helmet fire." "Helmet fire" is when the oxygen inside a pilot's helmet in the military catches on fire, and it's really painful before you die. And so most of our caregivers out there are in a "helmet fire" over measures. There are so many measures. I mean, even five years ago, it was a thousand measures in a thousand days. How can you guys bring us these NQF Safe Practices? Bill, you do a great job of helping us understand how to go from national reporting, regional reporting, local reporting, and then over here with performance improvement measures. Can you give us the context of where we are today? You and David worked on the common formats of data. A lot of wonderful work people don't even know about. Give us a perspective. Where are we today on measures because one of the – docs will watch this video and then go, "Yeah, but they haven't fixed the measures." And they really have, and they're getting fixed, and they're getting – they're not perfect yet. But give us the – where are we?

Bill Munier: Well, we're making progress. I think that's the place to start. One of the things … sometimes when people talk about measurements, they focus on … the measurement isn't everything, because you can measure things and then nothing happens. And that's true. Measurement isn't enough. But why measurement is important is that in quality and safety, you can't tell if you have made any progress if you don't measure. So measurement is absolutely integral so that you can say, "Here's where we are today, and here's where we were yesterday, and we've made some progress." Everybody is mentioning central-line infections because we've made a lot of progress there, but why do we know that? We know that because CDC has a measurement system, and others have adapted measurements systems so we can track where we go.

The problem is then that everybody is measure things the wrong way. Everybody has a different measurement system, and IP is very exciting in the fact that it makes measurements, more powerful measurement, possible. But everybody else who builds their system and they write code, and then they have an investment in doing it the way they do it, so we can't all learn together. There is a collective learning. So we need to count apples to apples together.

So that's basically all of the different measurement systems that are out there today helps the individual people where they are, but we don't learn very fast either about the care we're giving, or how to make the measures better themselves. So our agency has been actually working in conjunction with CDC, FDA, and the other federal systems to develop a uniform set of measures. We also work with the private sector, I might add, and we get public comment. We've developed a common set of measures starting with patient safety in hospitals, and then expanding to nursing homes, which are called the common format. I referred to those before the common format, whereas the unified way of measuring things that is scientifically supportable and can get better over time. And once everybody begins measuring certain simple things like central-line infections, which they're now doing and we see the progress there. But falls,

pressure ulcers, all those medication errors, and all those other things that are plagued on patient error and hospitals, then we can begin to make much more rapid advances.

Charles Denham: There's a lot of inertia because of just ignorance, but there is progress, and I think that's where all of us in this room could be message bearers. That collaborating and joining The Partnership gives you the opportunity to see where the measures, and to have partici- … is that a fair statement, that being involved in these collaboratives is not only good to help you do better, but to understand how to measure doing better? And I know, Farzad, you were going to say something, but I wanted to go to Arjun first who flew in from Atlanta just specifically for this panel. We are so grateful for your leadership and participation in our Greenlight Program in the infections area. We've talked a lot about the measurement of infection, and we've had you speak at our national webinars as well. But what you're hearing today, what's the best message you can give us that we can put to action? Where are we today on these infections that we can really ask since you came in specifically for these …

Farzad Mostashari: Right. Absolutely. I was thrilled to be able to join you for this, Chuck. I appreciate the invitation. I think what Bill said is key. That measurement is so critical to improving performance. It's not an end of itself, but its measurement is an absolutely critical means to the end that we are trying to achieve, which is the elimination of these infections. We've made huge progress. I think that we have seen a real transformation in how we view the measurements of these infections. We are seeing an increasing number of these infections now be publicly reported with states initially leading the way requiring that hospitals report information on some of these infections to the public. The federal government has followed suit, and [an] increasing number of these infections now have to be reported nationally. And it is. There is no question that this awareness of the problem, the transparency – the culture of transparency that's created when you publicly report, and you say, "This is how we're doing." We may not be where we want to be, but we're going to show you where we are, and we're going to tell you as our patient advocates have told us. Tell us what you're doing to get to where we want to be. It's okay if you're not there yet, but tell us how we're going to get there. And what we're seeing is people increasingly using measurement, and I think the point that people are making is just so vital.

The measurement that we want to state is for action. So what we want are not measures that at the end of the year tell us, "Well, how did we do this year?" We want measures that, as we're moving forward, can tell us – the facilities can look at their own information, month to month, week to week, and say, "Well, how are we doing, what are we going to do better?" And that's one of the reasons [that] we're excited [about] our measurement system that we use to measure these infections that Bill has mentioned. The National Healthcare Safety Network is that type of system that allows local data for local actions. Facilities have access to the data. They know how they're doing, and they can share that information with us so that nationally we have a sense to that it's the same system. And that's exactly what we measure. We don't need two, three, four, five different systems to measure the same thing. We want one system that has multiple purposes.

Charles Denham: Fantastic. Farzad, you had a …

Farzad Mostashari: I was going to say, we measure those to monitor progress, but also to signal what's important. And what you're seeing from the federal government on this panel, and I think more broadly from the Department of Health and Human Services, is something that is unusual for government, which is focus. It's focus. It's saying, let's focus on a few key things, and let's get all hands on deck to solve those. And quality measurement. The problem isn't that we don't have enough measures. Right? We have as you say, providers are saying, "there's thousands of measures. What do I focus on?" Right? And, what we've done is to say, "Let's focus on a few key things." Patient safety, Million Hearts Program around cardiovascular deaths. Let's focus on a few things for the national heart [inaudible], and then look at – do we have the right measure for that? David mentioned his mom has a-fib and is on Coumadin. Right? Half the people on Coumadin in this country are on it because of a-fib. Do we have a measure that is nationally endorsed that looks at the safety of Coumadin? All people on Coumadin, whether their INR is therapeutic. Not too high, not too low. Do we have a nationally endorsed measure for that? No. We took our eye off the ball. And we are making great progress on getting to those measures that matter that focus on what really is at hand.

Charles Denham: And the disappointing thing, my mom's on Coumadin. We wrote a meta-paper on that, and found that routine care, systematic care by pharmacists exceeded what doctors were doing in their office because they were giving homeopathic doses of Coumadin. And it's crazy.

Farzad Mostashari: And without having a measure you'd never know.

Charles Denham: We really need to focus. I want to make sure that we cover everybody, because we've got the Partnership yet, and I just want to make sure everybody's covered. The QIOs are a terrific resource for tying into the Partnership, and many organizations, even in this room, didn't know what the QIOs were. Even safety-net hospitals that can tap into them who desperately need help. But I wanted, Jean, to just give you a chance to make the pitch for what they do. Again, because we have a different audience that logs on at different hours, on what the QIOs could do, and then come back to you, Paul.

Jean Moody-Williams: Thanks. One of the important things is that we use the measures that my colleagues here are referencing. We use them in a number of ways so that the QIOs, which exist all throughout the country, every state and three of the territories, they exist in those areas. And we consider them the infrastructure that's out there to help us carry out these national goals at the local level where care really occurs. They provide support to hospitals, nursing homes, home health agencies. Most of the providers can tap into the resources of the Quality Improvement Organization and learn how working in the communities that they serve, to utilize measures to monitor improvement, to implement some of the great evidence based materials that are becoming more and more available, and then monitoring how they're improvement goes. One other thing I want to mention – because I happen to come from an agency that does payment, which is a sister for Medicare & Medicaid Services – is that we're also using these measures to make sure that we are aligning payment with the kinds of outcomes that we would like to see. So often in the past, we've been paid and paid for the services and the volume, but no more. We want to make sure that we are aligning payment with better outcome. That is happening at this very moment that we speak.

Charles Denham: So if we have safety-net hospitals [that] are – I know Dr. Williams is here, and I congratulate you all for being [among] the top 100 hospitals in America, a small rural hospital. But there are many that are not as wonderfully led as yours is and are really, really struggling right now. Can rural hospitals and safety-net hospitals contact the QIO for help? Because I know even in this room, there are some [who] are representing them. Is that something they can do to get help, and maybe want to participate with these?

Jean Moody-Williams: Yes. Not only would we love for them to contact us to get help, but also to share the things that they're doing which could service best practices for others. So it's a give-and-take. Actually, we encourage you to contact your Quality Improvement Organization, Partnership for Patients, Million Hearts, and many other projects are part or the work that they do.

Charles Denham: Bill, PSOs. So we've got great PSOs. We've got lots of PSOs. Patient safety organizations that protect information that would allow us to really cross-collaborate. There are great ones like ISMP's that are just doing terrific work, and have always have even before they were a PSO in helping us understand medications errors and harm, and Mike, who is on our panel, our committee on The National Quality Forum Safe Practices and that. Can you give us the latest on – how you know – it's almost like Disneyland. I think David Hutton and I talked about it. All of these federal programs, you're not sure what is a ride or what's under the grounds that the tunnel between the rides at Disneyland. There [are] so many of these things, it's hard to understand how all the structures fit together. Where are we with the PSOs, and how can we take advantage of our PSOs, or that framework, and tie back to the common framework?

Bill Munier: Well, just for numbers' sake, there are 77 PSOs, 31 states in the District of Columbia. Many people may say, "What's a PSO?" I guess the easiest way to explain them is that professionals have been reluctant to do peer review if they thought they would be sued the next day for their deliberations about the mistakes that they've made themselves. So many states have passed peer review laws to

protect professionals when they deliberate on behalf of the public welfare, and those protections, by and large, don't exist outside hospital walls or beyond state boundaries. So a hospital chain, for instance, wouldn't aggregate information and necessarily analyze it because that information would be unprotected. With the Patient Safety Act, it did, which created PSOs. It essentially set up uniform standards across the country to protect peer review. So Patient Safety Organizations, which are voluntary, nobody has to be one. But Patient Safety Organizations get together and they provide these uniform protections, and then any licensed provider and any of the states in the country can get together and deliberate about quality. What it's supposed to do is to encourage increased level or forwarding increased analysis about how to make care safer and of better quality. The program is off to a fairly rapid start. It's only a couple [of] years old, two years old, and we have 77 of them across the country. They're just beginning to collect information. Obviously, we can't add – if somebody counts things one way and somebody counts them another way, we can't add that information up. So they are using common formats, and we're about to begin this year to get the first information aggregated nationally where we will begin to learn. So Patient Safety Organizations should be a stimulus, or more review, more honest reporting about what's right and what's wrong with the delivery of healthcare in this country.

Charles Denham: Fantastic.

Bill Munier: More analysis and more alarms.

Charles Denham: So I want to go to Jim …

Bill Munier: At the local level.

Charles Denham: … to Jim Bagian and then back to you all regarding the Partnership, since that's where we started. Jim, you led the Patient Safety Center at the VA, and had both the benefits and probably different barriers we wouldn't know about. But you did have the opportunity to really take a very standardized approach. You were a great leader of that. It showed great results. Now you're out with the rest of us, and you're in an academic environment, and you have all of the chains of habit that I described earlier and that kind of thing. Now that you can see back through a different lens at programs like this, what advice do you have to those of us out at the front lines to take advantage of these programs? What's the best practice to take advantage of these great programs now that you can look back, but you've done it the other way when you had a little more control, but maybe other barriers?

Jim Bagian: I think that there [are] some differences, but there [are] many similarities. I think, one, as we said before, you need to have a crisp goal, "Why are you doing this?" And that has to go down to the people you want to get reports from. If people are reporting whatever it is, whether it's outcome data, whether it's process data, if they think that they are just doing it because you told them to do it, you are going to get inconsistent, inaccurate results. I think you have to also show that it's a benefit to them in some ways. That means most people, as said earlier, want to see the patient do better. They want to see, that's why they're in healthcare. So if they report something that's about outcomes, they understand how that outcome report will add to [our] controlling the system better, understanding it better, having better inventions, being more proactive. If it's in the case of process, the same way.

Another thing that hasn't been talked about, or maybe directly, is that there's also reporting to identify vulnerability. These aren't measures of incidence or prevalence. If you look at those type of, I'll call surveillance, and if Arjun will permit me, it's not surveillance in the same rigorous way that CDC might do it. But I don't need to have a statistically significant sample if I'm looking at devices. For example, if there's a device – that I find this device has a programming issue, a performance issue – if I see that's it's a property of this device, this class of device, not just this individual one in my hand, I don't need 15 other reports. One suffices; and then I can forward as Dave was saying, to investigate, understand what's behind it, and then what we do. So I think there has to be feedback. When you get a report, there has to be feedback. When you get a report, there has to be feedback so the reporters understand why it's worthwhile. Well, this one took action, its demonstrated improved patient care, or we've eliminated vulnerabilities or hazards. That needs to be done. So I think there's, for quality control, like run chart …

Are we where we wanna be? There's outcomes, do we get to an outcome? So, surveillance or identified vulnerability. And they need to be different.

Charles Denham: And what you just said is a mouthful, sophisticated. It is going to require more. Those of us [who] are representing trustees, if we get into after the election and go into massive cuts in Medicare, it is going to be very tempting to cut your quality and safety program. What do we always do? We cut housekeeping, nursing, safety, and education. And…

Jim Bagian: Could I interject on that?

Charles Denham: Yeah.

Jim Bagian: A really important point: if there were cuts, if I had a choice, and I don't really think that I would want to make them. Which one would I want to have first? I probably would say I would always want to have a report that gives me where the vulnerabilities are. Because if you make the vulnerabilities well known there are plenty of people who will, you know, even if we can't orchestrate as we optimally would like to do it, they will say, oh here's a problem, I'll fix it. You can't fix problems you don't know exist. If we strictly look at outcomes without any of the others that doesn't give us the ability to look beyond this focus problem to others. If you are identifying a vulnerability there are a host of vulnerabilities different people will look at solving. There are medication problems, IT problems, there's a whole host of things. So, I mean, you would never want to make that choice, but I think the vulnerability one is more nebulous, but I think it is the one that allows people to really identify the focus.

Charles Denham: Act right way, absolutely. So coming back, just for time, I want to come to these guys and then we will come back to everybody, but one of the things that I see out where I live on the West coast is hospitals are in collaborative fatigue. Everyone is having a hard time recruiting hospitals to submit data because they are just overwhelmed. I mean they just do not have any more staff to report one more thing and it is like they just go, get into the helmet fire that I described, because we are doing our imaging collaborative effort, which can deliver immediate results. Our overuse of CT is 20% to 30%. You know our inappropriate of imaging orders are 40% to 60%. I could show you Mike and his hospital. In two weeks after a 45-minute briefing of the 5 Rights, [they] cut 17 scans and two of them were kids. That was ionizing radiation. I'm a radiation oncologist, that carcinogenic, that is pretty cool, a small rural hospital. So we can give them immediate feedback on things; but when we talk broadly, they are so overwhelmed that all of these collaboratives. Give us some advice on how we can get trustees to put dollars on these collaboratives and how we can hit this collaborative fatigue issues, because I am sure we are running into it, and I know in California as I talk to them about, "Hey, are you with the Partnership?" and I'm cheerleading for your program guys, and they are going, "Oh my gosh, do you know, one more collaborative and I am going to blow my head off." And that is what they say off the record. How can we … are you all experiencing that, are we experiencing collaborative fatigue, everybody is wanting to collect data? So help us with that to help you. Because that is a barrier that I am having, trying to help get folks in your program. They can join, sign up; but are they going to be actively submitting data and how do I make the case to the trustees to say, "Put some more bucks on this horse"?

Dennis Wagner: I think, Chuck, what I would like to do in responding to your question on this is to circle back to what Farzad said earlier, because I think it is part of the matter that the Department of Health and Human Services and the Partnership for Patients [have] done something extraordinary that I think we have never done before. We've said, "Focus like a laser on these two aims, a 40% reduction in preventable hospital-acquired conditions by the end of 2013 and a 20% reduction in 30-day readmissions." We've never done anything like that before. We usually have big volumes of reports with all sorts of aims. This is a different day and those two powerful aims create an extraordinary strategic asset for the department, but most importantly for the patients we serve and the front-line providers. Because what those aims say is, "Whatever it is that you have got coming your way, whatever collaborative it is, whatever agency of the state or a non-profit sector or the federal government is coming to you with this, focus your efforts around these two aims. Align your programs, your platforms, your assets, whatever they are to these aims," and together nationally, they create the opportunity for us, I think the first time, to begin to perform as a system. Aims create systems and that is a huge asset and I

think that really is at the heart of cutting through collaborative fatigue, as you describe it. Zero in on these things that matter. We didn't choose those things by accident. Secretary Sebelius and Don Berwick have said and have focused us on getting better care, better health, and lower costs simultaneously. And if you want to get better care, better health, and lower costs, focus on these aims, because they are the low-hanging fruit for doing that. We know how to do this. Organizations all across the country, many of which are profiled on the movie earlier today, like Ascension Health, have shown us what is possible. So the problem is not whether it is possible—the problem is spreading throughout the entire nation. And I think that is the opportunity that this partnership creates.

I want to say one more thing and I am sure my co-director, Dr. McGann, would want to jump in here, but the one other thing I would say is that I'm a twenty-six-year veteran of federal service. I've worked in the federal government for 26 years. I never dreamt when I joined this organization, that that would be the case. But it's been extremely rewarding. Something has happened that has never happened in my career. We have a departmental team; Farzad's staff, Arjun's on it, Jean Moody-Williams and her staff are on it, Bill Munier and his staff, Noel Eldridge, Paul Moore, a lot of the people in this room, Dr. McGann and myself, and 30 others. And we get together three times a week, and we are coordinating, for real, the activities and the platforms of the Department of Health & Human Services, to bring about national change on these aims. That has never happened in my experience. We've had task forces, we've had things – this is different. It's a very different thing.

Charles Denham: The thing I want to remind ourselves is that they also listen. Because it was in October of 2010 when you were here as a visitor, because you weren't in the program, and we had 30 CEOs from around the country, and we had Mike Henderson and his Chief of Medical Staff, and we had Steve Swensen and a lot of people in this room. They listened because they just didn't decide on these aims out of the blue. They asked Mike, and they asked a number of these organizations and Mike Murphy from San Diego, the Baldrige winner, and said 40% was exactly what you guys are targeting. They ask our CEOs from our test bed, and you know what they said? "Yes." So, although we have the fatigue, we have CEOs [who] say, "Yes." And I think that's what we have keep affirming for you even though – and I don't want to throw you the barrier of "they've got the 'helmet fire' so they won't do it," but we have the C-suite that said "Yes," and they listened. The government listened and they became exactly what was proposed in a closed-door session when, Bill, you spoke in October '10, and then here at the Press Club where we had the meeting down the hall. So it's exciting to see the aims, and it's exciting to see the focus. We would want you all to understand, though, the "helmet fire" is going on, and the fatigue is really big. What I – go to Paul because he was going to say something, and then Arjun. Paul?

Paul McGann: There are two things necessary for a successful project at any level in government, or industry, or anywhere else: will and execution. What we're seeing is not the "helmet fire" and not the fatigue. We encourage anyone who's feeling that to listen to what we're saying. You just said it yourself. Farzad said it. Will is associated with focus and with the desire for execution. We have 4,000 hospitals actively participating in our 26-hospital engagement network. We've got hundreds and hundreds and hundreds of run charts of results coming in, and we've got a building momentum and a desire to do this right. And Sully Sullenberger said it this morning when he was talking about it. They asked him, "Well, how did you do this? How did you do this remarkable thing?" Was it 208 seconds? He said, "I focused on what was important, and I let the other stuff go behind." And it's hard to do that in an emergency, and it's also hard to do it in big government.

Charles Denham: I think you're picking up on that in the movie as well. We ask him the three things. He imposed a calm when he was in terror. "Well, they're kind of in terror right now." And the second thing that he did was that he put a structure on chaos. You're doing that; helping us with that. And then it was prioritization.

Paul McGann: There's a great calm, Chuck, that comes from coming together as this Partnership is with its alignment. So the people that are feeling that in the healthcare is in a creative destructive phase right now. The way to deal with that is to come together and talk about it, and work toward a common aim. That is the answer to this fatigue that you're talking about. So what we say to people [who] are feeling the

fatigue is come forward and talk to some of the leaders in our network; The Ascension Healths, and our Mountain Healths, even The Joint Commission.

Charles Denham: See, that is very helpful, I think that to the fatigue (I almost said “alarm”). Fatigue, I’m so used to talking about it in ICUs, but the collaborative fatigue. Arjun?

Arjun Srinivasan: I think, building on that point, one of the other things we see that’s incredibly important with this issue of collaborative fatigue, and we have seen that clearly. We see it a lot in healthcare-associated infections because we’ve been doing this for a little longer with a lot of these collaboratives.

One of the things that is critically important is also communication. It’s bringing folks together so that everybody knows the collaboratives that are going on. When we began working, the implementation arm for a lot of – we used through the state health departments. And what we told the states is, “Don’t go off in the directions by yourself. Bring everybody together.” So what the states did is that they formed these multi-disciplinary advisory committees. So they brought in the CEOs of the healthcare networks. They brought in the QIOs. They brought in the other agencies, the insurers, and they talked as a group. And they said, “What are our priorities? What do we need to focus on? Let’s all be aware of all the things we are doing so that I don’t start a collaborative in my hospital, and then you start one, and then you start one. Let’s all start them together. Let’s hate what’s going on now. Let’s build on those successes, and that kind of communication. ” That coordination that we’re seeing increasingly at the state level, and now with the Partnership for Patients where a lot of that focus; the hospital engagement networks are working with health departments. So I think that that level of communication will also enhance. You know, building on collaboratives rather than creating additional work.

Charles Denham: We have to get back on time, so we’ll have to stop. The one thing I was going to say is that we would be remiss if we didn’t thank Don Berwick for pulling us all together in the mid ‘90s. I can trace back almost every one of these safety initiatives, David, to when we were sitting around tables having wine and eating dinner, and when it wasn’t cool to be in safety and quality, and when it was Don’s courage to pull everybody together. I can still track back so much of all of this to eight or ten people [who] would be getting together. You’re one of those unsung heroes, David. So we’re going to thank you, and we’ll move to the next block.