

The Partnership With Patients: A Call to Action for Leaders

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On June 16, 2011, leaders of many of our greatest health care membership organizations were assembled in Washington, DC, for the Partnership for Patients kickoff meeting. What was different was that a pleasant woman at the back of the room was quietly brushing strokes onto a beautiful painting that evolved while speakers delivered their messages. No one realized she was a focal point of the meeting until she was called up to the podium. The following was a portion of her story:

“My name’s Regina Holliday and I’m a wife, an artist, and a mother; and I have a child with special needs; and I had a wonderful husband named Fred Holliday; and he was a professor at American University. He started having pain in January 2009, and it was in his ribs. Then he had pain in February 2009, and it was in his back. He kept going back to the doctor and they kept giving him pain meds. Then, finally, on March 25, he was hospitalized and he had tests. And two days later, he called me at work and he said, ‘Reggie, they were just in my room and they told me I have tumors and growths. Can you please come here as soon as you can because I don’t understand what’s going on.’ And I did; and I left; and by the time I got there, the oncologist had left town for a medical conference and was gone for 4 days where we couldn’t get information or access to his record. So I went around for weeks asking for information and no one gave us very much. And finally, I went down to medical records and asked for a copy of his medical record, just so we could understand what was going on. I was told it would be a 21-day wait and 73 cents per page. The very next day, the oncologist came into his room and said, ‘We’re going to send you home on a PCA pump.’ I knew what that meant, and so did my husband. So, we burst into tears, and the doctor left. I spent the next 5 days trying to get to another facility just so we could get a second opinion. When we were transferred, we were sent with an out-of-date and incomplete medical record and transfer summary, which meant the new facility could not provide care for six hours as they tried to recreate it using a phone and a fax machine. They couldn’t even feed him. I had to go down to the local pizzeria and get him a slice of pizza just so he could eat. The next day, the doctor sent me back to the first facility and asked me to get an entire copy. As the courier of my husband’s medical record, I got it and gave it to them. They read it for an hour, gave it back to me, and then I read it. It was full of actionable data that if I could only have seen it, he would have had better care. Then, we took that data, and my husband and I decided we would do everything we could to make life better for others. I began painting about it all throughout the streets of Washington, DC. And that is why I do what I do—for my husband and for everybody else, because nobody should have to suffer as we did. And I want everybody to remember, we are all patients in the end and we all deserve dignity and respect.”

(Regina Holliday, oral communication, June 16, 2011)¹

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When Dr Don Berwick, the leader of the Centers for Medicare & Medicaid Services (CMS), invited Regina Holliday up to the front of the room, no one anticipated what would happen. Few realized that they would become part of a world-class social entrepreneurship initiative that some later referred to as an “altar call” where they made public “commitments and requests” to mobilize their organizations.

Health care is often defined as an unsustainable proposition—one of infinite demand and finite resources. Many “experts” say that we can never catch up with the exponentially growing needs of an aging population, coupled with relentless innovation of costly new care methods. Given this hypothesis, many believe that we have only one option: cut benefits to cut costs.

Dr Berwick believes that we have an alternative—that is, improvement.

We have two options: to cut ... or improve.

“The bad news is that improvement is harder than making pure cuts; however, it is better for everyone and far cheaper in the long run.” (Donald Berwick, MD, oral communication, June 16, 2011).

The old-guard experts fail to recognize a vast untapped source of power: the human spirit. One of our country’s greatest industrialists, Bob Chapman, CEO of Barry-Wehmiller, says (Robert Chapman, oral communication, June 22, 2011) of our workforce,

“We have rented their hands forever when they will give us their hearts and minds for free...all we need to do is ask...and show them we REALLY care.”

This is a renewable natural resource. We have harnessed this source of energy in the past; however, it must be ignited by leaders.

Consumers also represent a huge untapped resource. Regina Holliday and an army of consumer champions, active in social media, have proven that patients and families in our communities are also willing to mobilize...and in their case, again, all we have to do is ask. This spells infinite impact!

A CALL TO ACTION—KEY QUESTIONS

This article is a call to action for leaders at all levels to “get into the game” of the Partnership for Patients. Our country depends on it. This means you—trustees, CEOs and officers, mid-level managers, and front-line caregivers. It means the CFOs in the community—the chief family officers who make the major health care decisions for their families.

The key questions about the Partnership for Patients are as follows:

- Who leads it?
- What is the Partnership?
- Why is it important to me?
- Where do I start?
- How do I succeed?

We address these questions below to help health care leaders get a running start at the partnership.

WHO LEADS IT?

If 27 years of entrepreneurial experience have taught me anything, it has been that the success of any venture is as much about the team as the product.

I would have never predicted, as a supporting cast member on Institute for Healthcare Improvement (IHI) performance improvement teams in the late 1990s, that those in the room would become central pillars of the global patient safety community. Who would have thought that the work of Dr David Classen would have become the Global Trigger Tool² and that our work with Dr Classen, Dr David Bates, and others would have evolved into the CPOE Flight Simulator which measures the performance of computerized prescriber order entry systems now being installed in US hospitals?³

Even more unimaginable was that some would become leaders of CMS and that the very financial security of our nation depends on the programs they lead. So what kind of people are they—bureaucrats, academics, or what?

Dr Berwick, described by a *Wall Street Journal* editor as a true quality evangelist and later to me as the north star of health care, needs no introduction. “He, as a single individual, has had more impact on global health care than anyone in the world” (Bernard Wysocki, oral communication, June 1, 2002).⁴

Growing up on military bases and then as the son of a National Aeronautics and Space Administration (NASA) rocket scientist during the moon race, I was taught that public service is a calling and that partisan politics was not a luxury that our family could afford. Having worked closely with the last 4 administrations, regardless of the party in control, this author has found the public attacks on Dr Berwick about as credible as the theatrics of wrestlers on television. The value of the content is about the same; and simply put, with health care and the country in serious jeopardy, risking global financial destabilization, Dr Berwick is a great leader and the ONLY choice for the CMS helm. Knowledgeable honest experts agree, regardless of political persuasion. After Dr Berwick’s appointment, Department of Health and Human Services Secretary Sebelius shared, (Kathleen Sebelius, oral communication, May 1, 2010) at a Washington, DC event,

“We needed a game-changer and Dr Berwick is a game-changer.”

Ever the humble and deferential leader, with more quality awards than anyone on the globe, Dr Berwick describes those to lead the Partnership as a “varsity team.” They are Joe McCannon, formerly of the IHI, Dennis Wagner, and Dr Paul McGann.⁵

Joe McCannon, the youthful and deceptively humble special assistant to Dr Berwick, is well known to many of us as the leader of the IHI 100,000 Lives Campaign that ultimately saved more than 122,000 lives in an 18-month period.⁶ He also led the IHI 5 Million Lives Campaign, which addressed some of the very same target areas as the Partnership for Patients, such as health care-associated infections,⁷ which have been found by the Centers for Disease Control and Prevention to cause almost 100,000 deaths per year.⁸ His background is in business and technology as a leader of a successful consulting firm in the Boston area, with experience in the software industry, and in publishing with organizations such as *Fast Company* and *The Atlantic Monthly*.⁹ Driving home the importance of action at

the meeting, he shared an expression he often uses to inspire his team to act:

*“Strategy is for amateurs,
logistics are for professionals.”^{10,11}*

The co-directors of the CMS Partnership for Patients Campaign, appointed by Secretary Sebelius, are Dennis Wagner, who has been the acting director and associate deputy director of the Office of the Center for Standards and Quality Measures at CMS, and Dr Paul McGann, who has been acting chief medical officer and assistant chief medical officer of CMS. They bring a wealth of know-how, tremendous energy, and dedication to this critical job.

Dennis Wagner, a seasoned leader, is acknowledged to be one of the greatest social entrepreneurs in the world. This author has worked with him for almost a decade and witnessed amazing results through just 4 of his leadership initiatives, including the 100% Access Zero Disparities Program,¹² organized during the Clinton administration, which has saved millions of dollars; as the director of the Organ Donation Breakthrough Collaborative,¹³ which led to more than 10,000 lives and likely billions of dollars saved during the Bush administration; as the Health Resources and Services Administration’s director of the Patient Safety and Clinical Pharmacy Services Collaborative,¹⁴ which is focused on medication safety; and most recently working with the nation’s Quality Improvement Organizations,¹⁵ aligning the forces of savings through safety with the Partnership for Patients.

Partnered with Dennis Wagner is Dr Paul McGann, a brilliant physician with deep data analytics competencies, who has practiced as a geriatrician; so he is ideally suited to co-lead the Partnership. His amazing grasp of data and the intricacies of government measures and performance during 11 years of service to CMS harnesses the core content areas critical to fuel the guided missile of improvement that is targeting the front-line quality gaps of the Partnership.

Finally, John O’Brien, PharmD, MPH, the field director for the Partnership for Patients, has a terrific background in clinical, commercial, and government sectors, which is complimented by a rare understanding of the potential for social media as a bridge to great care.

Hardly a gang of academics or slow-walking bureaucrats, this team of “game changers” intends to fulfill the vision articulated by Dr Berwick (oral communication, June 16, 2011)—that

“CMS will become a major force and a trustworthy partner for the continual improvement of health and healthcare for all Americans.”

If values were genes and behaviors were traits, the CMS values genes are “*boundarilessness, speed and agility, unconditional teamwork, valuing innovation, and customer focus.*”¹⁶ Watching these values genes expressed through the behavior traits of these leaders is more like watching a high-paced startup rather than what you would expect from typical executives running the world’s largest insurance company. Word to the wise: lead, follow, or get out of the way—they are now rolling.¹⁷

WHAT IS THE PARTNERSHIP?

Secretary Sebelius and Dr Berwick announced the Partnership for Patients, with stakeholders from all sectors, on April 12, 2011, by national webinar.¹⁸

The Partnership focuses on the same target areas as the *National Quality Forum Safe Practices for Better Healthcare*,¹⁹ which we have helped support and are the most vetted and evidence-based practices developed. Incidentally, they both found their origins through many of the IHI collaboratives that the national community helped develop.

The Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates, along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. At the date of the meeting, 9 weeks after the original announcement, the Partnership already had more than 3000 pledge signatures from physicians, nurse groups, consumer groups, and employers and included more than 1700 hospitals. The public and private partners will develop models to deliver better care for patients that can be shared widely. The Web site for Partnership for Patients can be found at: <http://www.healthcare.gov/center/programs/partnership/index.html>.

The overarching goals of this new partnership are to:

- Keep patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to those in 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved during 3 years.
- Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased, such that all hospital readmissions would be reduced by 20% compared to 2010 numbers. Achieving this goal would mean more than 1.6 million patients will recover from illness without having a preventable complication requiring rehospitalization within 30 days of discharge.

Partnership for Patients—Areas of Focus

The Partnership will pursue the reduction of all-cause harm. The high-priority areas will be the following:

- Adverse drug events
- Catheter-associated urinary tract infections
- Central line-associated bloodstream infections
- Injuries from falls and immobility
- Obstetrical adverse events
- Pressure ulcers
- Surgical site infections
- Venous thromboembolism
- Ventilator-associated pneumonia
- Other hospital-acquired conditions

The Partnership for Patients also focuses on care transitions, which link patients between acute care settings and long-term care, rehabilitation, or their homes. Efforts identified to reduce readmissions will focus on ensuring that patients get the right care as plans are made for their discharge and post-discharge period.

Cost and Funding for Partnership for Patients

Nearly 1 in 7 Medicare beneficiaries is harmed during the course of their care, which costs the government nearly \$4.4 billion in health care spending. The personal costs to patients of extended hospital stays and time away from work are untold. The status quo costs a lot—and it is unsustainable for Medicare, for employers, and for the budgets of patients and their families. To address

this very costly problem, the Department of Health and Human Services will use \$1 billion made available through the Affordable Care Act. Other members of the Partnership for Patients—private and public, present in the meeting on June 16, 2011—committed to devote additional resources to supporting care improvement, and this will be encouraged.

According to CMS, achieving these goals will save lives and prevent injuries to millions of Americans and has the potential to save up to \$35 billion across the health care system, including up to \$10 billion in Medicare savings during the next 3 years. During the next 10 years, it could reduce costs to Medicare by about \$50 billion and result in billions more in Medicaid savings. This will help put our nation on the path toward a more sustainable health care system.

WHY IS IT IMPORTANT TO ME?

Health care and hospital CEOs have led through the “no margin—no mission” era where cost containment was the best course for survival. Now that the “no outcome—no income tsunami” is striking their shores, they are entering a new era requiring new knowledge, skills, and engagement of their teams.⁷

The sweet spot of high performance is at the intersection of leadership, practices, and technologies: engaged leaders, safe practices that deliver predictable outcomes, and technologies that enable them.²⁰

The Intersection of Leadership, Practices and Technologies

In previous articles, we have stated that quality, cost, value, speed, and trust are intrinsically interlocked and tightly coupled and that we can only defy the business laws of gravity for a time. Time in health care has been measured in glacial minutes up until now. However, like a ball being thrown in the air, what goes up must come down. The zenith of blind health care spending has been reached and our ball—even our whole ball game—is on a crash course with reality.

Health care harm has easily become the third leading cause of death in America, behind heart disease and cancer, with hospital accidents becoming a major source of attention. In his introduction of the Partnership, Dr Berwick referred to the report by the Office of Inspector General of the Department of Health and Human Services, published in November 2010, that 1 in 7 Medicare beneficiaries was harmed.²¹ The result of this report has been a wakeup call to the nation's leaders. The bad news was compounded by the report in the *New England Journal of Medicine* that one of our more progressive states has not improved during a 5-year period despite aggressive safety efforts²² and that even exemplary hospitals have a much higher rate of health care harm than previously believed.²³

At the meeting, Debra Ness, president of the National Partnership for Woman and Families, gave an overview of the Campaign for Better Care,²⁴ which is a multiyear initiative to improve the way health care is delivered to older patients with multiple chronic conditions and their family caregivers. She provided well-documented evidence for the magnitude of health care harm to Americans and defined why hospitals are risky places for patients:²⁵

- About 1 in 20 patients gets an infection each year while receiving medical care.²⁶
- An estimated 1.7 million health care-associated infections occur each year in hospitals, leading to about 100,000 deaths.²⁷
- Patients who contract infections in hospitals are much more likely to be readmitted.²⁸
- Medicare patients acquiring infections are more likely to be readmitted than those without infections. In 2007, about 45%

of patients with hospital-acquired infections were 65 years or older.²⁹

- The mean length of stay among patients who acquired an infection during their hospital stay was 21.6 days. The mean length of stay for patients who did not acquire an infection was 4.9 days.²⁸
- When older patients move from one care setting to another, the lack of coordination among providers can place these patients at risk for losing needed services, duplication of services, conflicting treatments, and increased stress.³⁰
- Only 42% of older adults receive some postacute care services after discharge from the hospital.³¹
- Older patients, African American patients, lower-income patients, and patients with serious chronic conditions are more likely to have complicated transitions of care, which can lead to readmissions to hospitals.³²
- Driven largely by poor discharge procedures and inadequate follow-up care, nearly 1 in every 5 Medicare patients discharged from the hospital is readmitted within 30 days, and 34% are rehospitalized within 90 days.³³
- African American beneficiaries and those eligible for both Medicare and Medicaid (many of whom are African American) seem to be at higher risk for readmissions, particularly for stroke, diabetes, and asthma.³²
- Contributing to their increased risk³⁴ is the fact that African American and Hispanic patients have a higher prevalence and incidence of cognitive impairment, dementia, and Alzheimer disease than do white patients.³⁵ Dementia or other cognitive impairment makes caring for patients with chronic conditions more complicated.
- Preventable hospital readmissions cost the United States an estimated \$25 billion annually.³⁶ MedPAC estimated that in 2005, readmissions cost the Medicare program \$15 billion—\$12 billion of which could have been prevented.³⁷ More recent estimates suggest that unplanned readmissions cost Medicare more than \$17 billion a year.³³

Patient safety experts are no longer the only ones who know the numbers—media, consumers, and legislators feel the crisis brewing. It is becoming common knowledge that trustees governing our hospitals and health care systems have been behind the curve on performance shortfalls. Even the bottom 10% in quality believe they are average or even above average.³⁸

If you are a trustee, CEO, CFO, quality officer, midlevel manager, or front-line caregiver, this program is for you. The music has stopped, blind health care purchasing is over, and we are going to be accountable for quality. Financial leaders may indeed become the new heroes of survival if they learn to lead value-based decision making. Value-based purchasing is here, requiring value-based investment in safety.

The Greenlight Group, comprising leading hospitals such as the Mayo Clinic, Cleveland Clinic, Brigham and Women's Hospital, Ascension Healthcare, and Catholic Healthcare Partners, is tying down the important factors to the cost of harm and savings through safety.

The Cost of Harm and Savings Through Safety

They are defining the givens, assumptions, and variables that front-line hospital leaders need to make prudent investments in quality. The numbers are there.³⁹

We have reported the work of others who have documented the enormous cost of harm and savings through safety that can be generated:

- About 60% of hospitals' costs are generated by readmitted patients, yet readmissions occupy only 1 of 6 beds³⁹;
- Sixty seven percent of seniors admitted with a medical diagnosis are either readmitted or dead within 1 year of discharge³⁹;
- Modest expenditures of approximately \$50 of staff time at discharge of a patient generate more than \$412 in savings to the system.⁴⁸

We will soon document the details regarding the “cost of harm and savings of safety factors” as a work product of the Greenlight Group efforts.

For instance, Dr Stephen Grossbart, of Catholic Healthcare Partners, one of our nation's best quality leaders, reported, at a Greenlight meeting and webinar, held on October 28, 2011, at the National Press Club, that a 2009 analysis of more than 214,000 discharges in a multihospital system found that 50 to 60 patients must be treated without harming them to generate the excess funds to pay for one who is harmed. This has to be a wakeup call.⁴⁰

WHERE DO I START?

If you are a hospital or health care CEO or a trustee, you need to make sure you are signed on to the Partnership. The web link to sign up for the Partnership can be found at: <http://www.healthcare.gov/center/programs/partnership/join/index.html>.

If you have not already signed up, now is the time, because the no outcome–no income tsunami is here. In previous articles, we have used the tsunami and surfing metaphors to capture your attention and illustrate basic principles. There will be surfers who leverage the power of the wave and make things happen, swimmers who will capsize and watch what happened, and sinkers who do not survive and wonder what happened.⁷ Like politics, health care is dictated by local forces that vary. However, to most of us who have been paddling around our local ponds for years, the first waves of real value-based purchasing will really seem like a tsunami. To play out the surfing metaphor, you can apply basic fundamentals of surfing and the principles of greatness to hospital leadership and performance.

Surfing basics require the following:

- Understanding of the direction, force, and shape of the wave
- A steerable solid platform that will provide lift and forward direction
- Skills to smoothly propel the platform forward to match the speed and direction of the wave
- Ability to stand and balance the platform while controlling its trajectory

Great hospitals that have prioritized quality create unified safety platforms similar to surfboards that can achieve real lift out of the chaos. They clearly have an understanding of the waves coming and are well positioned to take advantage of the new forces. Most importantly, they have been practicing and improving at improving. Like the seasoned surfer, they have put in the thousands of hours and made many thousands of attempts at riding waves. Thus, they have been building reliable skills at propelling themselves forward and balancing the forces of gravity and the waves.

death by delegation, or allow participation in this initiative to be “slow-walked” to failure.

It is time for the C-Suite, the board of trustees, quality and safety leaders, and front-line representatives to get in the game. Most of all, bring patients into the loop. Trisha Torrey, one of our nation's foremost patient advocates, provided these words (Trisha Torrey, oral communication, June 18, 2011) of wisdom:

“Caregivers must build new bridges to their patients; and the invisible mortar of those structures will be trust that we earn through transparency.”

HOW DO I SUCCEED?

A universal finding is that great organizations have great leaders and that great leaders inspire and design organizations to behave consistently with a set of core values. The greatest organizations seem to unleash the talents within their people when they aspire to accomplish the most noble of objectives. When they close the 18-inch journey between the heart and the head, they move the hands to action and the lips to spread the word of celebration.^{41,42}

At the meeting, Dr David Pryor, chief medical officer of Ascension Healthcare, presented updates to their extraordinary results, previously reported by us,⁶ when they decided to set out a bold 5-year plan of “No needless death. No needless harm”; and they distributed countdown clocks to each leader that counted down days to the end of the 5-year period. Before the clocks ran out, Ascension had met its goal.⁴³ Dr Pryor attributes the success to living their core values, and that meeting their goals was a “mission imperative.”⁴⁰ The Ascension performance results and those for amazing state-wide successes reported by Rick Foster, senior vice president of quality and safety at the South Carolina Hospital Association, provided a perfect lead-in to Joe McCannon, who inspired the audience by describing the characteristics of successful high-performing organizations. McCannon addressed 10 things that organizations can do to make meaningful change. He listed these characteristics of successful organizations to help the audience understand what it will take to become a winner in the new era of value-based performance improvement:

1. They have shared, crisp, public aims, owned by leadership.
2. They welcome everyone.
3. They get to the field.
4. Their work is rooted in actions and transactions (value).
5. They are “brutally opportunistic.”
6. They play well with levers.
7. They operate a “recognition economy.”
8. They have a shared story and they use the language of creation (not avoidance).
9. They examine and revise their rules base.
10. The patient is in the room...always.

McCannon used Contra Costa Regional Medical Center in Northern California as an example of winning behaviors.

“When I walked into the lobby, I saw run charts and control charts for every adverse event that they're targeting, about 15

*Our recommendations are to START NOW.
Assemble a team; don't staff it out; don't create*

adverse events. I saw all-cause harm rates, risk-adjusted mortality, right there for anyone who comes into the hospital to see. That's leadership. That's holding ourselves to aims. That's about results. They welcome everyone. So these initiatives that really succeed don't say 'we're really only interested in working with certain people.' And they also don't hold the initiative by the throat. They don't say, 'These are the things we're going to do, here's the program, here's the set of activities.' They trust the field. They devolve control. They unleash, to use a term that our CTO at Health and Human Services often uses. They unleash all of the potential on the field. We get maybe 5% or 10% of the potential if we try to dictate what's going to happen. If we tap into what's out there and unleash it, we get much, much more. They get to the field. They understand that the change isn't happening in here. It's happening right now in an intensive care unit in Texas. It's happening right now in a step-down unit in Portland. Those are the places we need to go. That's where we'll do our learning. That's where we'll do our listening and that's where we'll drive our change. They understand that the work is rooted in actions and transactions." (Joe McCannon, oral communication, June 16, 2011)

On June 20, 2011, the Partnership for Patients' first webinar was broadcast worldwide and served as an introduction to the patient safety initiative. It was organized by Dr Gary Kaplan, the president and CEO of Virginia Mason Hospital and Medical Center in Seattle, which was recognized in 2010 as the Hospital of the Decade by the Leapfrog Group. He spoke of the lessons they had learned, which resonated with McCannon's message. He referred to a favorite quote:

*"In times of change, learners inherit the earth while the learned find themselves beautifully equipped to deal with a world that no longer exists."*⁴⁴

In the same webinar, Dr John Toussaint, MD, another national quality leader who formerly served as president and chief executive officer of ThedaCare, Inc, a community-owned, 4-hospital health system, founder and now president of the Center for Healthcare Value, a performance improvement organization, reinforced (John Toussaint, MD, oral communication, June 18, 2011) the characteristics of those who succeed:

"There are two words people have to remember on the improvement journey—they are humility and

perseverance. We trained and trained and trained some more ... in real-time improvement work."

A final thought (Thomas Zeltner, MD, oral communication, June 18, 2011) on characteristics of those who will win in the future comes from a colleague and cofounder of the Global Patient Safety Forum in Geneva, and the former Health Minister of Switzerland, Dr Thomas Zeltner, MD.

"Rather than keep the old world thinking alive, it will be important to adopt the new world thinking of the digital age."

He draws our attention to the recent report by the World Economic Forum entitled, *The Future of Government: Lessons From Around the World*, which proposes that leaders must stay relevant by being responsive to rapidly changing conditions and citizens' expectations and build capacity to operate effectively in complex, interdependent networks of organizations and systems that coproduce public value. This report states that organizations need to be

*FAST: Flatter, Agile, Streamlined and Tech-enabled.*⁴⁵

We agree with Dr Zeltner that these characteristics are precisely what our hospitals and health care organizations need to adopt to win in the new value-based environment. Social media will clearly be a tool of the future.

CONCLUSIONS

As the meeting progressed to a close, led by Dennis Wagner and Paul McGann, they inspired the process of "offers and requests" with audience members taking the microphone and committing their resources and will. These novel tools of social entrepreneurship that were so powerfully used in the organ donorship program and other initiatives appealed to the better angels in the hearts of the audience and defeated the devils of procrastination and skepticism lurking in the subconscious minds of these future Partnership for Patients.

As the commitments of organizations continued to build, many of the audience commented that they had not expected to come to an "altar call," humorously alluding to the evangelical nature of the day. They were surprised by their own "offerings" that were compelled and moved by the power of the messages.

The audience was struck all day by the deep humility expressed by the CMS leadership team that Jim Collins—author of *Good to Great*—would describe of "level 5 leaders" and the kind we only uncommonly see in politicians.^{46,47} For instance, they expressed their regret for not having invited more patient advocates and not having invited them earlier in the process. They challenged the audience not to make the same mistake.

At the end of the meeting, Regina Holliday was invited up to the front of the room to present her painting, which she entitled "Partnership WITH Patients" (Fig. 1). She expressed that



FIGURE 1. Partnership WITH Patients by Regina Holliday.

the Partnership For Patients logo depicted a caregiver doing something TO a patient rather than working WITH a patient. She redesigned the caregiver listening to the patient's heart while the patient was embracing the physician and providing emotional support. She made the faces real, rather than the faceless images so often depicted in electronic medical record avatar graphics that can feel cold and impersonal to many patients. Above the physician and patient, she painted the symbol for infinity as a cloud floating in the sky. This represented the infinite relationship between provider and patient and also the infinite possibilities of cloud technology, communicating her passion for how proper use of health information technology could have changed the end of her husband's life and could change the lives of so many patients.

Within the painting, she captured the dual goals of the Partnership for Patients: a 40% reduction in hospital-acquired conditions and a 20% decrease in readmissions by 2013. These are depicted as children's slides on a playground. A joyous physician is sliding down the 40% reduction slide. A patient is waving and looking over her shoulder at patients far off in the distance.

There is a smart phone in the hand of the patient. This patient is "live tweeting" through the social network, Twitter, during her appointment. She represents the spread of the power of the patient's voice and how she will communicate it through social media. There is a belt in the background of the painting, and people standing beyond the belt are not part of the conversation; however, they wish to join. They are depicted to be "outside the Beltway," referring to the community of Washington, DC. There is a feeling of hope within the painting meant to express

that social media will soon be part of the conversation and healing.

Regina Holliday closed with her 2 critical messages: First, that patients are a valuable resource to both their care team and national policy development. (They need to be invited into the loop); Second, social media can reach out to our nation's patient populations. She challenged the partners to meet patients where they are—at the intersection of hope and need.

She got a standing ovation from the leaders in the room who in this instance had just become the partnership WITH Patients.

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