Pittsburgh Regional Healthcare Initiative

PRHI Executive Summary

June 2001

This special edition features coverage of the Cabinet/Senate Visit May 31, 2001

Policymakers come to learn

On May 31st, some of Washington's most influential health policymakers paid a site visit to PRHI. On short notice, PRHI hosted Treasury Secretary **Paul O'Neill**, HHS Secretary **Tommy Thompson**, Senator **Edward M. Kennedy**, Senator **Bill Frist**, White House advisor **Mark McClellan** and many of the Capital's most influential health policy aides. Accompanying them was *Washington Post* political columnist **David Broder.**

One participant said: "After years of debate on frankly marginal health issues, it's so refreshing to come to a place where people are talking about patients and patient outcomes as the organizing principle of the system."

Despite severe time and logistical constraints, our goals were to convey the core principles of our community and systems approach to improving healthcare delivery and to show how the federal government could best support PRHI and efforts like it.

Please see page 8 for columns on the "5 P's" and "A Federal / Community Contract" for details on what we asked for. We plan to follow up on these items aggressively. Pages 4-9 give a rundown of the day.

L-R: Secretary Thompson (HHS); Dr. McClellan (White House); Senator Frist (R-TN); Senator Kennedy (D-MA); Secretary O'Neill (Treasury)

The PRHI co-chairs and staff want to express thanks to our hosts at Mercy Hospital and UPMC Presbyterian, our two venues, and all of the PRHI partners who were called on to participate in the presentations. Enormous effort went into the day from many, many people.

Though we were able to feature the diversity of PRHI partners, the logistical and content requests of our visitors left us unable to include all of the leaders who help drive our partnership. At the urging of our co-chairs, we focused on getting our message across to our visitors, in a way that could lead to lasting benefits for all of our partners, and believe we did that. We consider this visit only the beginning.

Thank you all for your ongoing support. Increasingly, it seems possible that we can influence the powerful forces that influence our operating environment, by showing our own power to shape how health care is delivered in this community.

> *"[The Pittsburgh Regional Healthcare Initiative] is a different and hopeful way of thinking about one of the major challenges this nation faces."*
>
> —David Broder, "Reason to Hope on Health Care," *Washington Post*, June 10, 2001

In that respect, it is worth noting how well our work has progressed over the last month. In our patient safety efforts, data collection has begun for our nosocomial infection work with the CDC across PRHI's hospitals. Major steps have also been taken toward implementing the MedMARx med error reporting platform at our major systems. In our clinical work, progress continues toward a process and outcomes registry shared by the cardiac surgery groups in the community. Look for our report on inpatient depression treatment. We have also strengthened our ties with other patient-focused outcomes initiatives across the country.

Please continue to let us know how we can better support your work.

Partner Spotlight Correction

In this space last month we included the names of those on PRHI's Leadership Obligation Group. To our dismay and regret, there were a couple of significant omissions! Two of PRHI's most active champions were not listed. Please note:

Renee Frazier, Executive Officer, VHA Pennsylvania
Charles O'Hanlon, Sr. Vice President, National City Bank of Pennsylvania

We are always trying to update our lists. If you have been omitted, please notify us. We'll be happy to make your name "front page news" as well.

Center for Shared Learning

Vickie Pisowicz
Director, CSL
412.594.2589
pisowicz@jhf.org

Dave Sharbaugh
Associate Director, CSL
412.594.2574
sharbaugh@jhf.org

The mission of PRHI's Center for Shared Learning (CSL) is to support the testing and implementation of a system-based approach to healthcare management, drawn from the Toyota Production System (TPS) and Alcoa Business System.

In a demonstration of the TPS concept of *jidoka*, people on the learning line at UPMC Presbyterian have been working hard to design systems that will assure no missing first-dose medications for its patients on Unit 10D. Folks on the learning line have redesigned work in the pharmacy to ensure a defect-free order entry process. In addition, the Accudose—an on-floor dispensing cabinet—on unit 10D has been redesigned using TPS principles to achieve zero stock-outs.

Jidoka *– A concept within the Toyota Production System, the Japanese term means investing machines with humanlike intelligence. In TPS, while jidoka does pertain to equipment with features that indicate defects, Toyota adds a "human element" to the meaning. At Toyota, defective items cannot be passed on to the next station, thus reducing waste, and enabling operations to build quality into the production process itself.*

The learning line at UPMC South Side is also working on the medication distribution process and meeting the needs of the patient at the point of care. Their efforts have focused initially on the design of work associated with the delivery of 9:00 am medications for patients on the 3 Med/Surg. Unit. They designed the activities, connections and pathways of the learning line so that medications can be delivered on time consistently. In addition, the learning line is experimenting with medication inventory levels and the use of stores and *kanban* cards, which are TPS tools.

Learning lines have two primary goals. They are the place where: 1) people learn how to design, operate and improve their work using the Rules-In-Use, and 2) the organization learns how to teach the principles of TPS throughout the organization. The Center for Shared Learning (CSL) is committed to providing the support necessary to make these and other learning lines in the region successful.

Would you like to learn more about what it takes to start a learning line? Would your organization like to send a "lend forward" to a learning for six months to learn these principles? If so, please call Vickie Pisowicz.

Clinical Initiatives

Jon Lloyd, M.D.
PRHI Medical Advisor
412.594.2566
lloyd@jhf.org

Geoff Webster
PRHI Co-Director
412.456.0973
websterchc@stargate.net

Southwestern Pennsylvania seeks to achieve the best patient outcomes of any community in the world. PRHI has established a partnership among clinicians, businesses, hospitals and insurers to achieve those goals in five pilot areas by (1) constructing outcome data sets trusted by those who provide care and (2) supporting collaborative efforts to improve care.

Cardiovascular Working Group

The Cardiovascular Working Group has almost completed developing its region-wide Cardiac Registry. Recognizing the variable outcomes highlighted in the 2000 report, physicians have decided to develop more detailed process measures that will help identify the things done differently that may lead to variable outcomes. The surgeons, cardiologists, nurses, and data analysts from eight pilot institutions are almost done defining the variables to be measured to address risk-adjusted mortality and atrial fibrillation. The next steps will be selecting a data registrar, collecting a quarter's data, and holding the first forum in the fall to compare key processes of care.

Clinical Advisory Committee to Release Depression Report

The Clinical Advisory Committee will complete the Depression Report in June and release it shortly thereafter. The release will be followed by a July or August forum that convenes professionals from across the region to review the system barriers to perfect care and to develop an agenda for improvement.

Clinical Initiatives, continued

Diabetes Working Group

The Diabetes Working Group is collaborating with HC4 to develop its regional report on diabetes, which has a target release date of August 2001. Recognizing the importance of outpatient treatment of this disease, the group is working with *national* partners—the American Medical Association (AMA), Health Care Financing Administration (HCFA)—as well as *regional* health plans to develop outpatient measures and means of improving preventive patient care.

PHC4 Cites Dramatic Reporting Increase

In May, for the first time ever, every hospital in the state reported all required information accurately and on time to Pennsylvania Health Care Cost Containment Council (PHC4). Through its emphasis on quality and cooperative relationships with physicians and hospitals, PRHI has made PHC4 information more relevant to clinical leaders in the region.

PHC4's increased reporting is due in part to our work, as well as PHC4's own diligent efforts. The increase in reporting will make future PRHI reports even more valuable and more strongly link the potential of the HC4 information to clinicians – the people who do the work.

Patient Safety Programs

Ed Harrison
Director, Patient Safety
412.594.2584
harrison@jhf.org

PRHI partners are working collaboratively to eliminate two major patient safety concerns: healthcare-acquired infections and medication errors.

Western PA to Begin First Regional Tracking System in the Country

Within the last month, the first phase of PRHI's reporting system for medication errors and hospital-acquired infections got ready to roll! Over the coming months, PRHI partners will be able to use region-wide data to inform their efforts to eliminate those problems. Due largely to PRHI's efforts, Western Pennsylvania is now the first region in the country with robust data collection capability for medication errors, hospital-acquired bloodstream infections, and clinical information.

Western Pennsylvania is now the first region in the country with robust data collection capability for medication errors, hospital-acquired bloodstream infections, and clinical information.

Still there is much to do. PRHI will continue working with U.S. Pharmacopeia to establish a "multifacility module" that will automate regional and organization-specific medication error data reporting. We will continue to aggressively pursue the development of a data exchange between MedMARx and other data collection systems—eliminating the need for duplicate data entry by PRHI partners.

Our Centers for Disease Control and Prevention (CDC) supported hospital-acquired infection reporting system currently collects data on bloodstream infections. We must continue to expand our data collection capabilities to include other categories of infection. Likely next candidates include methicillin-resistant *staphylococcus aureus* (MRSA) and surgical wound-site infections.

Finally, it is clear that PRHI's patient safety and clinical efforts are naturally beginning to converge. We will explore a number of areas for initial collaboration.

APIC Conference

Karen Wolk Feinstein, PhD, served as the keynote speaker for the Association for Professionals in Infection Control and Epidemiology's (APIC's) Annual Educational Conference and International Meeting on June 11, 2001. Dr. Feinstein's address to more than 2300 infection control professionals and epidemiologists provided an overview of PRHI, and discussed the role that infection control can and should play in reinventing healthcare delivery. **Sharon Jacobs**, MS, CIC, Infection Control Practitioner at St. Clair Hospital, and **Edward I. Harrison**, MBA, Director of Patient Safety for PRHI, presented a poster at the conference.

SPECIAL SECTION:

Morning Session

Mercy Hospital's morning sessions featured presenters from various PRHI member hospitals.

Perfect Patient Care Requires Consistent Reliable Data

Our colleagues **Joanne Narduzzi**, MD from Mercy Hospital and **Donna Ramusivich**, CHE, CPHQ and **Diane Cooper**, RN, BSN from Mon Valley Hospital used a concrete example to show the benefits of using the same platform for counting medication errors and sharing information about patient safety programs.

West Penn's **Marlene Garone**, MD and PAHC4's **Marc Volavka**, joined by **Michael Miller**, MD, underlined the critical importance of access to Pennsylvania's risk-adjusted data set, (maintained by the Pennsylvania Healthcare Cost Containment Council [PHC4]), and broad physician involvement in constructing our data sets.

Both presentations were honest about the limitations and costs of working with retrospective data sets. They also underscored the need for voluntary, non-punitive error reporting systems as indispensable "first steps" to improve patient safety.

The discussion led into the presentation on the importance of the electronic medical records (EMR), and the region's potential to be a national test site for a common clinical EMR backbone. UPMC's **Dan Drawbaugh** and **Fran Solano**, MD led the discussion, with comments from Mercy and others.

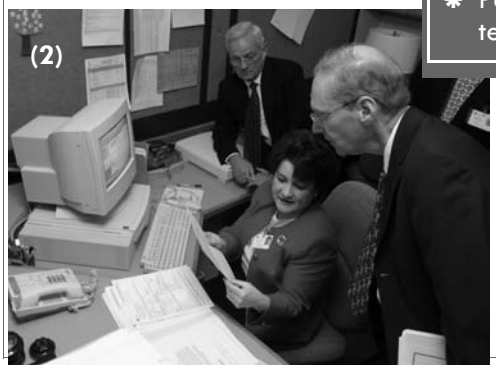
Morning Session Summary

Patient Safety
- Example: How two hospitals use MedMAR$_x$™ data, leveraged with PRHI partnership, to improve patient safety
- Importance of non-punitive data reporting to promote change

Clinical Outcomes
- How risk-adjusted data sparked crucial collaboration among physicians and "ownership" of process improvement
- Cost areas: data collection by hospitals, analysis and group facilitation by PRHI, and operation of PHC4

Electronic Medical Records (EMR)
- Enormous potential of uniform EMR standards to drive quality, safety and cost gains
- EMR makes Activity-Based Costing (ABC) possible
- Federal leadership in partnership with community required to standardize elements
- Potential of Pittsburgh region to be community test site for regional EMR development

Photos, this page:
(1) Dr. JoAnne Narduzzi kicks off the day, as Secretary O'Neill and Dr. Carl Sirio listen.
(2) Francine Spalla of Mercy's pharmacy department demonstrates MedMARx system entry for Secretary O'Neill and Kennedy staffer, David Nexon.
(3) PRHI Director Ken Segel answers questions for congressional aides in shuttle from Mercy to Presbyterian.
(4) Mon Valley's Donna Ramusivich discusses data sharing.



Photos by Cal Landau Photography, reprinted with permission

CABINET/SENATE VISIT, MAY 31, 2001

Below: (5), PRHI partner Renee Frazier speaks with County Council chief, Jim Roddey; (6) Attorney General Mike Fisher discusses TPS with Harvard's Dr. Kent Bowen; and (7) Senator Edward Kennedy engages presenters with questions.

Luncheon Summary

(1) Paul H. O'Neill, Secretary of the Treasury
- The framework for sustainable, system-based change

(2) H. Kent Bowen, Ph.D., Professor, Graduate School Business Admin., Harvard University
- PRHI's unique structure: patient focus at the point of care using a team learning approach

(3) C. J. Queenan, Jr., Esquire, Senior Counsel, Kirkpatrick and Lockhart
- Why key leaders support PRHI; why our region is an ideal site for demonstration projects in healthcare improvement

(4) John G. Craig, Jr., Editor and Vice President, Pittsburgh Post-Gazette
- How media's approach to PRHI helps protect "problem solvers"

SPECIAL SECTION:

Afternoon Session Highlights

At UPMC Presbyterian, afternoon sessions featured presenters from various PRHI member hospitals.

Clinical Initiatives: Date Ignite Collaborative Work

No progress toward perfect patient care is possible without the support of the physician community. PRHI's first success came when its Clinical Advisory Committee used a risk-adjusted outcomes data set to gain physician collaboration to improve care for critical procedures. During this session, physicians **Carl Sirio** and **Tom Smitherman** of UPMC; and **Richard Shannon** and **George Magovern** of Allegheny General examined:

- Cardiac bypass surgery outcomes to illustrate how physician leadership can be ignited using outcomes data.

- The importance of PRHI's safe, confidential environment for review of comparative outcomes data. This setting is crucial in overcoming clinician reluctance to accept the data, accept that variation in the processes of care cause those variations, and make changes based upon those data.

- The challenge of working with retrospective outcomes data.

- How government can support communities committed to this approach.

Session presenters were joined by PRHI co-chairs, physicians **Jon Lloyd** and **Marlene Garone.**

Afternoon Summary

Clinical Outcomes

✱Clinicians must own the process. Prerequisite: collaboration and trust, based on reliable data and protection
✱*Clinical Evaluative Sciences*, new discipline for linking outcome data to process of care
✱Outcome data important starting point, not benchmark
✱Cost areas: data collection and analysis; research into clinical evaluative science; training professionals in systems improvement

Patient Safety

✱How PRHI chose patient safety as a springboard for broader institutional change
✱Human and financial cost of hospital-acquired infection
✱Knowledge vs. action: the system as a stumbling block
✱Shared data: first step in system improvement.
✱CDC partnership with PRHI—power of the NNIS system, and its potential national applications
✱The continuing challenge: converting data to action

Toyota Production System (TPS) Demonstration

✱How TPS creates capacity to solve problems at the point of patient care
✱Potential for sustainable improvements in patient outcomes, worker retention, and costs
✱Demand for TPS education creates demand for teachers
✱Invitation for federal partnership with Learning Line experiments

Dr. Solomon (l) and Dr. Muto led the guests on a tour of the ICU, for a first-hand look at the extremely complex environment in which today's healthcare is provided. They highlighted infection control as a key point for broader institutional change.

Senator Frist, a heart-lung transplant surgeon, contributed astutely to the day's discussions.

Below: Guests on ICU tour

CABINET/SENATE VISIT, MAY 31, 2001

Patient Safety: How Hospital-Acquired Infections are Embedded in the System and How We Get Them Out

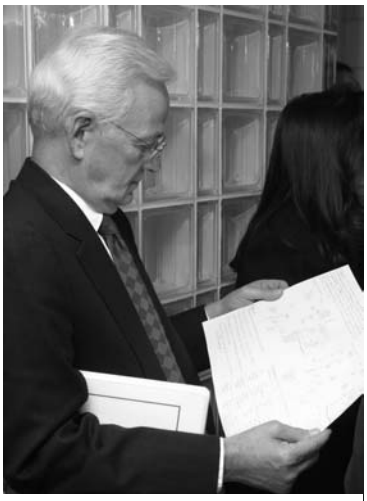
PRHI partners made a commitment to eliminate medication errors and hospital-acquired infections – problems that would engage the entire healthcare community. Using PRHI's partnership with the Centers for Disease Control as a case study, this session illustrated the scope of the infection problem, why it makes an ideal target for systems change, and the measurement groundwork for improvement.

Joining Greycourt CEO **Mark Laskow** and PRHI infection work group chair, **Carlene Muto**, MD, were CDC physicians **Steve Solomon** and **John Jernigan**. **Sharon Jacobs**, RN, MS, CIC from St. Clair Hospital and UPMC's **Mark Schmidhofer**, MD, also contributed. The session further highlighted the continuing challenges of reliably executing known "best practices" in the healthcare environment.

Changing the System at the Point of Care – One Patient at a Time

The afternoon session also provided an initial "glimpse" of TPS at two demonstration sites, or Learning Lines. Our guests saw first-hand how TPS is being applied in the workplace to help workers perfect medication delivery. They learned how TPS principles provide a framework to harness workers' collective efforts toward a common purpose– delivering customer (patient) needs on demand, defect free, one by one, immediately, with no waste, in a physically, emotionally, and professionally safe environment.

Duly noted: Senator Frist takes notes during Gail Wolf's presentation.



Secretary O'Neill examines the Pharmacy A-3

The session showed first-hand how efficient delivery can be achieved by the people who do the work, solving problems in the course of their work, one at time, immediately when they occur, from the root cause. In this system, everyone knows what to do, how to do it, when to do it, whether they are doing it right, whether they are ahead or behind, how to get help, and how to improve. Where organizations are prepared to work with this powerful but challenging model, PRHI believes TPS will produce constant, sustainable gains in the quality of patient care as well as safety improvement, waste and cost reduction, and worker retention.

Lisa Beckwith shows the first-dose process, which has been updated using TPS.

Presenters included PRHI's **Vickie Pisowicz,** UPMC's **Gail Wolf**, RN, DNS, Mark Schmidhofer, MD, **Lisa Beckwith**, RPH, **Renee Christopher,** RPH, **Doug Widener,** PharmD, and Harvard Business School professor, **Kent Bowen,** Ph.D.

While the dignitaries toured the pharmacy, their aides were briefed in a separate conference room about the learning line at UPMC Southside. Those presenters included Southside's **Deb Thompson**, RN, MSN**, Kelly Wasziek**, RPH**, Sue White**, RN, **Karen Ferrari**, RN, PRHI's **David Sharbaugh**, and Harvard Business School professor, **Steve Spear, Ph.D.**

Bowen and Spear, whose work, "The DNA of TPS," has inspired PRHI's approach, are working closely with us on this part of the initiative.

SPECIAL SECTION:

What Federal Support Would Help PRHI Most?

PRHI is driven by commitments of mutual obligation by its broad regional coalition. Corporate purchasers, for example, expect PRHI hospitals to make serious progress in patient care processes, and in return, have promised their political and financial support.

We have asked the federal government's leading health policy makers to consider a similar commitment of mutual obligation with PRHI and similar efforts across the country. In exchange for PRHI partners' redoubling of efforts to perfect patient safety and clinical care—and functioning as a learning lab for the country in doing so—federal leaders would invest as partners in PRHI's learning infrastructure to help accelerate progress and share results.

We suggested establishing a *federal/community "point of care" working group* through *federal demonstration projects* financed in part by the Health Care Financing Agency (HCFA) and Agency for Healthcare Research and Quality (AHRQ), among others.

Matching Commitments

Local coalitions like ours provide many critical ingredients for patient-focused system change, including: leadership; professional engagement; organization; data analysis and dissemination; learning networks; innovation; and matching funding. However, progress of initiatives like PRHI could be greatly accelerated with certain federal involvement. PRHI has recommended that a Working Group composed of leaders from national departments, agencies and legislators connect formally each quarter with select local healthcare performance initiatives to observe, learn, and help solve problems—first-hand—at the point of patient care. Participation in this Working Group would help ground national policy in patient experience.

What We've Asked for: the Five "Ps"

1. Data *Platforms*, analysis, and coordination costs

- Provide incentives for healthcare institutions to install and use outcome measurement and error reporting systems.
- Invest in outcome analysis initiatives at the institution and community level, to help professionals understand and use outcome data to improve care.
- Support the coordination costs of organizing and sustaining community-wide performance projects.

***2. Professional* training / management system innovations**

- Invest in demonstrations testing management models that have been proven in other complex industries, such as the Toyota Production System.
- Invest in demonstrations attempting to lay key "building blocks" for high-performance management in health care, such as activity-based costing.
- Make training in systems improvement a core component of medical education.

3. Legal *Protection* for sharing information about errors and outcomes

- Provide federal protection for information about errors and poor outcomes generated for the purposes of improvement. Punishment, ridicule and legal exposure drive reporting underground so learning does not occur.

4. Performance Research

- Increase medical research funding, including NIH funds, devoted to performance research topics. This is critical not only for learning, but to involve academic physicians and institutions more deeply in systems improvement.

***5. Payment* and Regulatory Incentives**

- Accelerate payment experiments to reward "the right care at the right time."
- Provide regulatory relief where federal/community demonstration partnerships suggest specific regulations impair patient outcome or efficient care delivery.

Federal Partnerships

Federal constituents for the Working Group might include HHS, HCFA, AHRQ, NIH, CDC, Treasury, Senators, Representatives, and perhaps outside partners such as RAND and the Robert Wood Johnson Foundation. Patient-focused efforts in other cities include Dartmouth's Center for the Evaluative Clinical Sciences, the Northern New England Cardiovascular Disease Study Group, the Maine Medical Assessment Foundation, and Utah's Intermountain Health Care.

Demonstration Projects

We asked, as part of this national shared learning network, to be considered for federal demonstration investments for data coordination and training costs. We also asked for federal consideration of adjustments to regulations or payment incentives as demonstration work progresses.

We will keep you apprised of the responses to our requests.

CABINET/SENATE VISIT, MAY 31, 2001

Visiting Dignitaries

Secretary Paul H. O'Neill
United States Department of Treasury

Secretary Tommy Thompson
United States Department of Health and Human Services

The Honorable Edward M. Kennedy
Member
United States Senate

The Honorable William Frist, MD
Member
United States Senate

Office of the White House

Mark McClellan, MD
Consultant
Council of Economic Advisors

Staff Members

Department of the Treasury

Tim Adams
Chief of Staff

Phil Ellis
Economist

Anthony Fratto
Public Affairs Specialist

Jeffrey Kupfer
Executive Secretary

Chris Smith
Senior Advisor to the Secretary

Department of Health and Human Services

Terrell Halaska
Deputy Chief of Staff

Office of Senator Frist

Shana Christrup
Detailee, AHRQ

Dean Rosen
Staff Director

Office of Senator Kennedy

William Abely
Personal Assistant to the Senator

David Bowen, Ph.D.
Health Policy Fellow

Edward Dunn, MD
Robert Wood Johnson Health Policy Fellow

David Nexon
Staff Director,
Legislative Assistant for Health Care

June/July 2001 at a glance

Tony Kelly, PRHI Administrative Coordinator
412-594-2567 kelly@jhf.org

June	Thursday, 21	Buying Healthcare Value* 2:30 p.m.	
		Clinical Advisory Committee, Mercy Hospital	4-6:30 p.m.
	Tuesday, 26	Trustee and CEO Forum	4:30-7:30 p.m.
		Duquesne Club, 325 Sixth Avenue	
July	Monday, 2	PRHI Co-Chairs*12-1:30 p.m.	
		Leadership Obligation Group	2 –4 p.m.
		Regional Enterprise Tower, A. E. Hunt room	
	Tuesday, 3	Nosocomial Infections Work Group*	8 a.m.-noon
	Tuesday, 10	ADEAC (med errors) Work Group*	3-4:30 p.m.
		TPS Information Session*	6-9 p.m.
	Tuesday, 24	TPS Information Session*	6-9 p.m.

* Meeting location: PRHI offices
Note: Call Tony Kelly to reserve space in TPS Information Sessions or request information about other meetings

Contact Information

Karen Wolk Feinstein, PhD, Chair
412-594-2555 *feinstein@jhf.org*
Ken Segel, Director 412-594-2558 *segel@jhf.org*

PRHI Executive Summary is a monthly bulletin highlighting the Initiative's most recent activities. Direct inquiries to: Naida Grunden, PRHI Communications Director, 412.594-2572, *grunden@jhf.org*.

The Washington Post

OUTLOOK

SUNDAY, JUNE 10, 2001

David S. Broder

Reason to Hope on Health Care

PITTSBURGH—It was a gathering of lions, a meeting any health care lobbyist would have paid big money to crash. Seated around the table at a local hospital the other day were Tommy Thompson, the secretary of health and human services; the most influential senators in their parties on health issues, Democrat Ted Kennedy and Republican Bill Frist; Dr. Mark McClellan, a health policy adviser to President Bush; assorted senior staffers from Washington and health experts from around the nation.

The most remarkable thing about the meeting was not the participants but what was said—and not said. For six hours of intensive discussion, what political Washington considers the most important health care issues—the patients' bill of rights and Medicare drug benefits—went unmentioned.

Instead, the visitors listened and learned from the team of briefers about error rates in dispensing pharmaceuticals, the number of infections contracted in hospitals and even about what Toyota Motor Corp. might have to teach Americans on the practice of medicine.

The host of the gathering—and the man as passionate about health care reform as anyone at the table—was Treasury Secretary Paul O'Neill, who in his earlier life as the CEO of Pittsburgh-based Alcoa had been instrumental in forming the Pittsburgh Regional Healthcare Initiative, a cutting-edge consortium of providers, consumers, insurers and employers whose goal is to demonstrate that sense can be made of the hodgepodge that is the American health care system.

Ever since he came to Washington, O'Neill has been telling the president, his Cabinet colleagues and lawmakers of both parties that they need to see what is happening in health care in southwestern Pennsylvania.

The consortium was formed three years ago, with O'Neill and Karen Wolk Feinstein, president of the Jewish Healthcare Foundation, as its heads. It now includes 32 hospitals, four major insurers, more than 30 business executives, the Pennsylvania attorney general and hundreds of physicians. Its work is supported by the Centers for Disease Control and a $1 million grant from the Robert Wood Johnson Foundation.

While most of its projects are incomplete, O'Neill told the visitors that enough has been learned to convince him that "with the money we are spending in this country, we have the resources to provide top-quality medical care for every American."

That can happen, the conferees were told, only if the health care system is turned on its head—not by changing its financing, as the Clinton administration proposed—but by focusing all its parts "on the patient at the point of care."

That sounds like a cliche, but it is not. As the head of nursing at one of the participating hospitals said, "Nurses now serve the hospital, not their patients," distracted by other duties from being the front-line caregivers.

Another example: Medical records now are kept in the offices of doctors and hospitals, often unavailable to others. The consortium is working with electronics firms to develop a "smart card" with an individual's entire medical history and background on it, including not only allergies but whether he or she uses a seat belt and has a smoke alarm. Each person would decide what information to share, but an attending physician could be alerted not to order tests already performed elsewhere and not to give a drug that wars with one already being taken.

The effort to improve quality and reduce costs involves collecting and sharing data on medical outcomes. Initially reluctant, the participating, highly competitive doctors and hospitals agreed to report to each other the outcomes of their hip and knee replacements and their cardiac surgeries. Come to find out, one out of six heart patients has to be readmitted, half of them within a week of being discharged. Now the physicians are trying to identify, as a group, which patients should be hospitalized longer to avoid the trauma and expense of the return hospitalization.

Similar quality and cost controls are being applied to eliminate errors and delays in dispensing drugs and avoiding the all-too-prevalent hospital infections.

The model for much of this is Toyota, which has the knack of competing on both quality and cost by inculcating a doctrine of "error-free" auto production. Toyota makes each employee feel responsible for meeting that standard and for signaling loudly to superiors when something in the system is preventing the worker from doing a good job.

Frist and Kennedy left Pittsburgh talking about federal legislation that would create a center in Thompson's department for "quality improvement and patient safety," expand the database needed to identify and eliminate frequent medical errors, and provide legal protection for people in the health care system who voluntarily disclose where the problems are.

It's a different and hopeful way of thinking about one of the major challenges this nation faces.

Progress Report

This month has marked more progress in patient safety reporting. Most PRHI partner institutions have now initiated bloodstream infection reporting based on the National Nosocomial Infection Surveillance System (NNIS), and medication error reporting using MedMARx.

PATIENT SAFETY REPORTING PLATFORMS IMPLEMENTATION PROFILE

PATIENT SAFETY REPORTING PLATFORMS IMPLEMENTATION PROFILE	NNIS-based Blood Stream Infection Reporting System			MedMARx Medication Error Reporting System	
	Data Release Executed	Facility Profile Submitted	4/01 Data Provided to CDC	Contract Executed or In-Process	System In Use
PRHI Partners:					
Butler Memorial Hospital*					
Children's Hospital of Pittsburgh				X	
HealthSouth Rehabilitation Hospitals	n/a	n/a	n/a		
Heritage Valley Health System, Inc.*					
Sewickley Valley Hospital	X			X	X
Medical Center - Beaver	X	X	X	X	X
Latrobe Area Hospital*	X	X	X	X	X
Lifecare Hospitals of Pittsburgh, Inc.	n/a	n/a	n/a		
Monongahela Valley Hospital, Inc.	X	X	X	X	X
Ohio Valley General Hospital					
Pittsburgh Mercy Health System					
Mercy Hospital of Pittsburgh	X	X	X	X	X
Mercy Providence Hospital	X	X	X	X	
South Hills Health System					
Jefferson Hospital	X	X	X	X	X
St. Clair Memorial Hospital*	X	X	X		
St. Francis Health System	X				
UPMC Health System					
Bedford Memorial	X	X		√	
Braddock	X	X		√	
Horizon – Greenville	n/a	n/a	n/a	√	
Horizon-Shenango	n/a	n/a	n/a	√	
Lee Regional	X			√	
Magee-Women's Hospital	X	X	X	√	
McKeesport	X	X		√	
Passavant	X	X		√	
Presbyterian	X	X	X	√	
Rehabilitation Hospital	n/a	n/a	n/a	√	
Shadyside	X	X	X	√	
South Side	X	X		√	
St. Margaret	X	X	X	√	
Western Psychiatric Institute	n/a	n/a	n/a	√	
West Penn Allegheny Health System					
Allegheny General Hospital	X	X		√	
Allegheny Valley Hospital	X	X		√	
Canonsburg General Hospital	X	X		√	X
Forbes Regional Hospital	X			√	
Suburban General Hospital	X				
West Penn Hospital	X	X		√	
Westmoreland Health System					
Frick Hospital	X			X	X
Westmoreland Regional Hospital	X	X		X	X