PRHI Executive Summary

Antibiotic-resistant infection

Wiping out MRSA in Southwestern PA

Methicillin resistant *Staphylococcus aureus* (MRSA)—an imposing name for an imposing, antibiotic-resistant organism. The facts are these:

- Healthcare-acquired infections are the fourth leading cause of death in the nation, causing an estimated100,000 deaths. They affect 2.2 million people each year and add about $1 billion in costs.
- In the United States, more than 50% of *Staph* infections are now methicillin resistant. The U.S. holds the dubious distinction of having the world's second highest MRSA rate. (Only Japan has more.)

Knowing that the problem exists is only the first step in eradicating it. On the inpatient surgical unit at the Veterans Administration Pittsburgh Healthcare System, an 18-month partnership between the VA, PRHI and the CDC has yielded promising advances against MRSA.

While scientific, statistically validated studies are years off, preliminary data show that on the learning unit at the VAPHS, MRSA infections have declined.

On October 2, PRHI convened nearly 100 infection control practitioners to pose an important challenge: ***if Scandinavia can eradicate MRSA, why can't Southwestern Pennsylvania?***

Continued, page 2

OCTOBER-NOVEMBER
2003

Inside:

O'Neill named CEO of PRHI

On October 28, former Treasury Secretary Paul O'Neill was named CEO of the Pittsburgh Regional Healthcare Initiative by Karen Wolk Feinstein, Chair of the PRHI board of directors.

"Paul O'Neill gave us our framework for coming together as a community to solve the interrelated problems of quality, safety, and cost in health care," said Feinstein. "Secretary O'Neill's work at Alcoa created the inspiration and guide for PRHI from its origins. We are very fortunate that he will take the reins directly."

Ken Segel, who directed the Initiative since 1999, commented, "The PRHI partnership can be proud of many accomplishments. But progress must accelerate substantially if we are to fundamentally reshape American health care. There could not be a more ideal leader for that task than Paul O'Neill."

Segel will remain with the Initiative to lead public policy operations and as a special assistant to O'Neill.

O'Neill served as CEO of Alcoa from 1987-2000. He served as United States Secretary of the Treasury from 2000-2002. O'Neill and Feinstein were the Initiative's founding co-chairs in December 1997. O'Neill currently is a member of the PRHI board of directors and chairs its Leadership Obligation Group.

From page 1

Wiping out MRSA in Southwestern PA

Armed with the knowledge gained at the VA and other partner hospitals, Southwestern Pennsylvania is poised to make great strides against this growing threat.

We don't seem to be freaked out about MRSA. Maybe we should be.

—Ronda Cochran, MPH
Behavioral Epidemiologist
Centers for Disease Control and Prevention
PRHI MRSA Conference
October 2, 2003

Karen Wolk Feinstein, Chairman of PRHI's Board of Directors and President of the Jewish Healthcare Foundation, challenged the group to think about MRSA not only as a way to combat all hospital-acquired infection, but as an opportunity to learn how to combat potential bioterrorism.

"Think about our country's preparations for bioterrorism," she said. "With MRSA we have a deadly organism that's transmitted the same way as SARS and other microorganisms that could be used as weapons. If we can wipe out MRSA, we are ready for bioterrorism."

"We are very encouraged by the work being done here in Pittsburgh," said John Jernigan, MD, Medical Epidemiologist from the CDC, and guest speaker at the conference. "The work at the VA is showing us that the community approach can work, and the Perfecting Patient Care approach can work."

"I don't want to come back in 10 years and say we need to mobilize to eradicate vancomycin-resistant infections. Let's draw the line with MRSA," said Ronda Cochran, MPH, CDC Behavioral Epidemiologist. "We don't seem to be freaked out about MRSA. Maybe we should be."

In the coming months, PRHI's Infection Control Advisory Committee, a coalition of the region's infection control practitioners and others with an interest in infection control, will hold focus groups to fine-tune the approaches to MRSA eradication in Southwestern Pennsylvania.

Did you know?
JCAHO National Patient Safety Goal #7 on hospital-acquired infections goes into effect January 1, 2004. More information at *www.jcaho.org.*

Join the regional attack on MRSA!

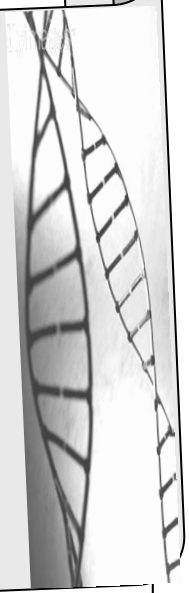
Infection Control Advisory Committee

The ICAC comprises infectious disease physicians, infection control practitioners and others from institutions interested in eradicating hospital-acquired infections. Partners include the Centers for Disease Control and Prevention (CDC), developers of the National Nosocomial Infection Surveillance (NNIS) system. In coming weeks, the ICAC will host focus groups aimed at eradicating MRSA from Southwestern Pennsylvania.

ICAC co-chairs:

- ***Carlene Muto, M.D.**, Hospital Epidemiologist/Director, Assistant Professor of Medicine, University of Pittsburgh School of Medicine*
- ***Cheryl Herbert, RN, CIC**, Director of Infection Control for Allegheny General Hospital*

PRHI Contact: Patricia Zurawski, RN, MSEd, Administrative Manager, Infection Control
412-535-0292, ext 119 pzurawski@prhi.org



Rolling up our sleeves

10 steps we could take *today* to halt the spread of MRSA

PRHI's Infection Control Advisory Committee is planning follow-up focus groups and further action. In the meanwhile . . . here are some steps everyone can take today to halt the spread of MRSA.

1. **Use hand hygiene** precautions for all patient contacts. By itself, adequate hand hygiene may reduce healthcare-acquired infection by 25%.

2. Institute procedures to ensure that **hand soap and alcohol sanitizer** are present when and where needed.

3. **Use antimicrobial soap or alcohol sanitizer in ICUs**.

4. **Identify colonized and infected patients** with active surveillance cultures (ASC).

5. **Isolate** patients known or suspected to be colonized or infected with antibiotic-resistant microorganisms. In countries where MRSA has been all but extinguished, presumptive isolation is practiced.

Check out these CDC sites:

Hand Hygiene in Healthcare Settings
www.cdc.gov/handhygiene/

Antimicrobial Resistance Prevention
www.cdc.gov/drugresistance/

6. **Use barrier precautions** (gowns, gloves, masks) when caring for patients in isolation. Masks have been shown to protect healthcare workers from nasal colonization. Consider disposable gowns: in one study, 69% of healthcare workers' freshly laundered white coats had detectable MRSA contamination.

7. **Clean the patient care environment** effectively: surfaces include floors, beds, linens, overbed and bedside tables and drawers, patient gowns.

8. **Use dedicated equipment or clean all shared equipment** such as blood pressure cuffs, stethoscopes, etc. Wiping with 70% isopropyl alcohol swab significantly reduces colony counts on stethoscopes. Consider disposable equipment when practical.

9. **Flag medical records** of all colonized patients to ensure re-isolation on subsequent admissions.

10. **Control antibiotic use**. Between 1/4 and 1/2 of all hospitalized patients are taking antibiotics, including almost all ICU patients. Half of all antibiotic therapy is either unnecessary or inappropriate. Furthermore, antibiotic prescriptions count for up to 22% of pharmacy budgets.

These suggestions were compiled from a presentation at the PRHI MRSA Conference, October 2, by Dr. Carlene Muto, Co-chair of PRHI's Infection Control Advisory Committee, and Director of Infection Control at UPMC Presbyterian, and in conjunction with the VA Pittsburgh Healthcare System.

See also "SHEA Guideline for Preventing Nosocomial Transmission of Multidrug-Resistant Strains of *Staphylococcus aureus* and *Enterrococcus*," by Dr. Muto et al, in *Infection Control and Hospital Epidemiology*, Vol. 24, No. 5, May 2003, page 362.

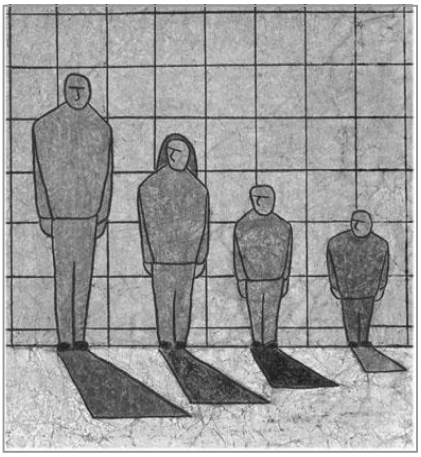
PRHI response to Tribune-Review series

One infection is one too many

By Ken Segel and Naida Grunden

The *Tribune-Review*'s series on hospital-acquired infections put a human face on a terrible problem confronting the nation's healthcare system. Every patient has a right to expect not to be harmed in the course of medical treatment, whether the harm comes from infection, medication error, or from receiving something less than the best known care.

The Pittsburgh Regional Healthcare Initiative (PRHI) has been working with the hospitals of Southwestern Pennsylvania for the past four years to *eliminate* hospital-acquired infection. At PRHI's inception, 42 of the region's hospitals signed charters committing themselves to pursue *zero* hospital-acquired infections, and to share what they learn along the way. Although progress has not been fast enough, the goal of zero has taken root here in a way that's unique in the country, and results are starting to come in.



Underlying this audacious goal is the belief that faulty systems, not faulty people, cause most medical errors. Healthcare workers enter the healing professions with great commitment. Yet too often, underlying systems do not support their work, forcing them to make extraordinary efforts to meet their patients' ordinary needs. It will take incredible will to change the collective mind-set in health care—from one that accepts a certain level of error cloaked as a "benchmark," to one that focuses on fixing problems every day as they occur. When the whole design shifts to day-by-day problem solving, a kind of "domino effect" occurs. Solving one problem seems to solve a host of related problems elsewhere in the system, improving efficiency, increasing patient safety and reducing worker frustration.

Important infection control work is going on in Pittsburgh. PRHI member hospitals voluntarily report infections through the Centers for Disease Control and Prevention's (CDC) National Nosocomial Infection Surveillance System. Ours is the only region in the country where this is happening. PRHI brings competitors together through this common reporting system, not to compare, criticize, compete or punish, but to create a forum for regional learning.

Some hospitals—such as Allegheny General and UPMC Presbyterian—have been unusually forthcoming in sharing infection data with the public. They held press conferences to announce problems. Unfortunately, the *Tribune Review* series, which called for increased public disclosure, did not acknowledge these hospitals for doing the right thing. UPMC, AGH, the VA, Mercy and others quoted in the stories allowed *Trib* reporters unfettered access to their hospitals, and dozens of hours of professional staff time over several months. Unfortunately, their openness was not rewarded with a complete portrayal of the work, which would have noted their openness as well as their improvements.

This kind of coverage can send a message to hospitals everywhere: disclose problems and only public criticism will follow. It can make eliminating the problem more difficult by chilling the very disclosure necessary to bring mistakes into the light, where the rest of healthcare can learn from them. As the *Tribune Review* quoted former Treasury Secretary and PRHI co-founder, Paul O'Neill: "You can't get better by just yelling at people."

The question is: *what does the region have to show for its efforts in infection reduction?* PRHI is not yet able to report scientifically and statistically significant data: that will take years. But Pittsburgh does have progress to report. Central line associated bloodstream

infections among patients in intensive care units (ICUs) seem to be trending down: since the third quarter of 2001, the reported rate in the region declined overall from 4.2% to 2.4%—a 43% decrease. Why? Perhaps it's the increased awareness, along with the checklists and insertion kits introduced across the region by PRHI partners. Perhaps PRHI provides a way for practitioners from different institutions to learn from one another. Or perhaps there are other factors that might make the result look better than it really is. We will need several more quarters of data to determine whether the decline is genuine; nevertheless, the direction is encouraging.

One hospital decided to concentrate on eliminating central line associated bloodstream infections rapidly in two ICUs. Instead of waiting months to look back on retrospective data, practitioners examine infections as they occur, person by person. Openness with patients and families is the rule. Those units have gone for several weeks without a single infection, and their learnings are spreading throughout the hospital and the region. Infection control is not the sole province of the infection control practitioner. It everybody's job.

In the United States, more than half of *Staphylococcus* infections are antibiotic resistant. Our country has the world's second highest rate of methicillin resistant *Staphylococcus aureus* (MRSA). Only Japan has more. Yet today in the Netherlands and Scandinavia, MRSA is uncommon, with sporadic outbreaks quickly contained. At the Veterans Administration Pittsburgh Healthcare System, an 18-month partnership between the VA's acute care hospital, PRHI and the CDC has yielded promising advances against MRSA.

On October 2, PRHI convened a cross-section of nearly 100 healthcare professionals dedicated to infection control. The challenge was issued: *if Scandinavia can eradicate MRSA, why can't Southwestern Pennsylvania?* MRSA is not one hospital's problem. Because hospitals share patients, they share MRSA too. It's a community-wide problem, well suited to a community-wide solution. Now, armed with the knowledge gained at the VA and other partner hospitals, Southwestern Pennsylvania is poised to make great strides against this growing threat. If our region can control MRSA, the other "dominoes" of hospital-acquired infection will also fall.

No magic bullet will stop hospital-acquired infections. But history confirms that a competitive approach won't work. Charts showing rates "at" or "above" or "below" an expected infection rate can be deceiving and breed complacency. As the faces and the stories in the *Trib* series remind us, one hospital-acquired infection is one too many. With a collaborative approach, and the will to change, we may wipe out infections, not just in this hospital and that one, but throughout the entire region.

The *Tribune-Review* ran this response in its entirety on its editorial page on Friday, October 17.

Ken Segel is the Director of PRHI (ksegel@prhi.org); Naida Grunden is the Communications Director (ngrunden@prhi.org). *Tips for Patients* are posted on PRHI's website at **www.prhi.org**. The publication includes the names of PRHI participating hospitals, ways that patients can help make themselves safe in the hospital, and resources for patients with chronic conditions.

Allegheny General Hospital

Rapid improvement: a *"lightning round"*

At Allegheny General Hospital's 5C Learning Line, team members assembled in early October to tackle a long-standing problem. The nursing supply drawers in patients' rooms had both too much and too little: too many obscure items that were only needed occasionally; and too few of the vital items needed every day.

Instead of meeting upon meeting and stalled decisions, this group decided to get right down to work in a kind of problem-solving "lightning round."

Drawer Organization

1. Medications
2. Basic Stock
3. Special Order Stock
4. Admission Supplies
5. Linen

Teaming up to solve the drawer problem quickly were: 5C Nurse Manager Rene Pallotti, Learning Line Leader Debra Ruckert and 5C Charge Nurses Pam Seigh and Sharyn Dorchak. PRHI team members observed, guided, and learned from the effort.

The team didn't start from a standstill. For about 14 days before the experiment began, detailed observations of the drawers and how they were used revealed that much of the stock was idle. The team had time to think about what they use, what they don't, and what the ideally stocked drawer would look like. Then, in a few hours one morning, the 5C team:

- Redesigned the drawer experiment in four rooms (seven nurse servers).
- Reduced stock by 50%. (Extra stock is still allotted, "just in case.")
- Created a restocking system. When stock reaches a low point, clinical staff pull the hot pink reminder card and place it in a receptacle on the nurse server where it can be easily seen. During the once-per-shift filling of water pitchers, the Nurse Aide checks for the hot pink cards to see whether the drawers need restocking. Using the card as a sort of grocery list, the Nurse Aide picks the necessary supplies from the medication or linen room. Once items are picked, they are placed in the appropriate nurse server with the pink card. These items—including the pink card—are then placed in appropriate drawer. The Nurse Aide no longer needs to "remember to check" the drawers. If an item is low, the pink card alerts.
- Designed a system to handle fluctuating needs. If the patient will need for a special item, a hot pink order sheet lists additional supplies. The RN fills this out and places it in the receptacle on the side of the nurse server. The Nurse Aide responds during the pitcher fill.
- Restructured report so that the nurse updates the Nurse Aide about each patient in the assignment.
- Eliminated need for one form that the Nurse Aides were using.
- Nurse Aides designed an easy way to use the Kardex for additional information needs.

(continued, next page)

Basic Supplies - Drawer 2	Stock
Suture Removal Kit	1
4x4	2
2x2	6
IV Connector	3
EKG Patch	5
Saline	4
Alcohol Wipes	6 double
Specimen Cups	1
Tape	
2"silk	1
1"clear	1
1"paper	1

Drawer 2: Before . . .

. . . and after

Waste: needless inventory removed from 23 nurse servers—half of the unit. ***Results***: savings in materials and time.

The group meets each Wednesday on 5C, and continues making small improvements in how they do their work—improvements rooted in their own observations. Frontline workers join other interested employees and leaders. The improvement sessions are guided by teachers trained in the principles of the Perfecting Patient Care System. On future Wednesdays, the group will begin improving supplies and work flow in patient isolation rooms.

Of interest to PRHI Obstetrical Work Group

Joint meeting of Obstetrics and Pediatric Societies of Pittsburgh

Monday, December 1, 2003
6-7 pm
Allegheny County Medical Society
713 Ridge Ave., Pittsburgh 15212

$35 for non-members

To register, call Dianne K. Meister, RN
412-321-5030; fax 412-321-5323

Did You Know?

Learning the Basics of Improvement

The *PRHI Executive Summary* publishes stories each month, examples of healthcare improvements made in the course of work. These incremental improvements are made in accordance with the principles of the Pittsburgh Perfecting Patient Care System, based on the Toyota Production System.

These basic ideas are neither mysterious nor secret. PRHI strives to make them understandable and accessible to anyone who wants to learn.

Have you ever wanted to know more about the Perfecting Patient Care System? Did you know you could? Did you know the cost is low—just reimbursement for materials?

Check out one of the monthly **PPC Introductory Sessions** (the next one is November 11-12). The sessions involve one evening and the following morning.

If you're intrigued, you can enroll in the week-long **PPC University**. Enrollment is beginning for the next one, scheduled for

January 19-23, 2004.

PRHI offers these classes to any interested person, in healthcare and other professions, in Pittsburgh and beyond. People completing them may be eligible for continuing education credits.

To enroll in an **Introductory Session** or the **PPC University**, contact:

PRHI Cardiac Registry

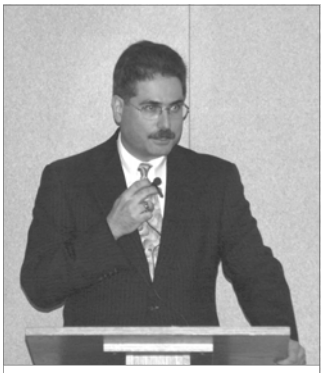
Cardiac Forum highlights role of perfusionist

The cardiac surgery suite is a busy place. The anesthetized patient awaits coronary artery bypass graft (CABG) surgery. About a dozen medical professionals are there too, working toward a single goal: *a quick recovery and renewed health for the patient*. Who are all these people? And how do they help achieve the goal?

In addition to the surgeons, the team usually includes a circulating nurse, a certified operating room technician, one or more physicians' assistants, an anesthesiologist and nurse anesthetist, perfusionists, and often, students. Although not present during surgery, a vital squadron of workers has prepared the operating room: housekeepers, anesthesia technicians, pharmacists and others.

PRHI Cardiac Registry
tracks four specific processes of care that have produced significant improvements in patient outcomes following CABG surgery:

- ✧ Use of the internal mammary artery (instead of leg) as a harvest site
- ✧ Use of pre-operative aspirin
- ✧ Use of enough beta-blockers so pre-op pulse rate *less than 80 beats per minute* when surgery starts
- ✧ Avoidance of anemia due to blood dilution while on the bypass pump (hematocrit not below 21).



PRHI Cardiac Forum was hosted by Cardiothoracic Surgeon Alexander Vasilakis of the Medical Center at Beaver. Dr. Vasilakis is a longstanding member of PRHI's Cardiac Working Group. Keynote address was given by Paul O'Neill.

PRHI Cardiac Forums are open to all members of the cardiac surgery teams from the region's cardiac surgery centers. At the Forum, results from PRHI's Cardiac Registry are reviewed. The Registry tracks numerous processes of care and resulting patient outcomes from 12 of the region's 13 cardiac care centers (*see box, above*). But the Forum also provides a way for healthcare professionals from different institutions to learn from one another, and better understand the choreography of the surgical suite.

The role of the perfusionist

The Cardiac Forum on October 23 at Sewickley Valley Hospital featured the work of the perfusionists. These medical professionals monitor blood flow during the procedure, to ensure that oxygen flows to, or perfuses, all organs in the body. During surgery, the heart is stopped, and blood circulation depends upon a heart bypass pump. At this critical time, perfusionists work to maintain blood circulation required to supply oxygen to the body's organs.

Perfusionists Richard Marcotte of Ohio Valley Perfusion Associates, Inc., and Stephen Stewart from UPMC Shadyside described how process adjustments have led to improvements. The guiding question was: Can we reduce transfusion rates while maintaining adequate perfusion during surgery?

Two experiments corroborate improvements

Marcotte recounted an informal comparison he recently completed. In May 2003, Marcotte's surgery group started improving three processes: increasing the use of (1) aprotinin, a drug to reduce blood loss, (2) the cell saver device, and (3) the RAP heart bypass pump priming technique.[1] They compared results of two groups of 50 patients undergoing CABG from May to August of 2000, and May to August of 2003.

In the 2003 group, with the three process improvements in place, the need for patient transfusions was 48%, compared to 84% for the 2000 group. Re-exploration and bleeding also decreased. (Because the three processes were implemented at the same time, the effect of any single one is unknown.)

Stewart described Shadyside's RAP pump priming technique[1], implemented in response to findings of the Northern New England Cardiovascular Study Group[2]. NNE's work suggests that patients avoiding anemia simply do better. Since the changes, 93.9% of patients have avoided anemia during surgery, up from 71.7%.

Both perfusionists, operating independently in different hospitals, found that their small process improvements helped to improve patient outcomes. Their results seemed to corroborate one another, and NNE's findings.

(more)

[1] See August 2003 *PRHI Executive Summary* for a more complete discussion of RAP.
[2] PRHI Cardiac Registry based on findings from the Northern New England Cardiovascular Study Group.

Cardiac Forum: opportunity to learn

October's Cardiac Forum provided insight into the work of perfusionists, highlighting the ways that everyone on the cardiac surgery team contributes to improved patient outcomes. Of the 92 participants, 23 were physicians, 22 were perfusionists, and 10 were perfusion students. The rest represented other members of the cardiac team. Wide participation will be further emphasized at the next Cardiac Forum, scheduled for late January.

To learn more about PRHI's Cardiac Registry or Cardiac Working Group, contact:
Dr. Dennis Schilling,
PRHI Clinical Coordinator
412-535-0292, ext. 116
dschilling@prhi.org

Shared learning

The Minnesota connection

"Leaders who choose to 'pursue perfection' must take on a daunting challenge: transformation of their health care organizations from their current states to systems that promise and deliver no needless deaths, pain, delays, waste, and helplessness, not just for one or two conditions, but for all conditions, and not just for a few patients, but for entire communities of patients and families. This is leadership requiring an extraordinary depth and breadth of change. It has never been done before in health care. CEOs and other senior executives would benefit from having a fairly well developed theory of what would be necessary in order to achieve a true transformation of care delivery… 'All theories are wrong, but some are useful.'"

James L. Reinertsen, MD
A Theory of Leadership for the Transformation for Health Care Organizations
View the full report at *http://www.reinertsengroup.com/PDF/Transformation.PDF*

On October 8 and 9, the top leaders of the Minneapolis-St. Paul healthcare and business communities invited PRHI to help inspire that region's collaboration to improve the performance of the healthcare system.

Paul O'Neill, Jon Lloyd, MD and Rick Shannon, MD, noted that our region has been a student of Minneapolis for years, and that Minneapolis still outperforms Southwestern Pennsylvania in various health measures. The PRHI leaders outlined PRHI's efforts and challenged the assembled leaders to set common, measurable goals "at the theoretical limit" (zero) and to begin solving problems one at a time, in real time, "on Monday morning."

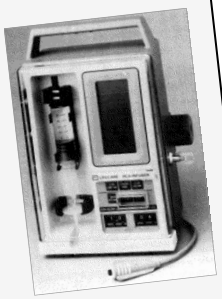
Among the immediate priorities that emerged:

- Begin to take specific patient safety problems to "zero" within 90 days.
- Turn a new medical error reporting system in Minnesota into a "real time learning system" in which incidents and their solutions are shared immediately across the state.

Just since this encounter, learning exchanges between Minneapolis and PRHI partner hospitals have begun to increase.

Problems with the Patient Controlled Analgesia (PCA)Pump: A Look at Human Factors Engineering

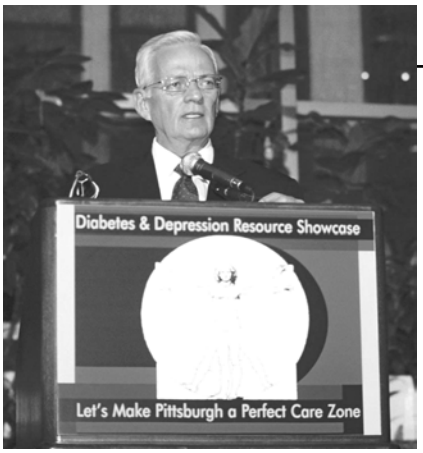
Wednesday, November 19, 2003
4:00 pm to 7:30 pm
Registration begins at 3:30 pm
Dinner will be served
500 Commonwealth Drive, Hospital Council of Western Pennsylvania
For more information please contact Stacie Amorose
412-535-0292 Ext.106
samorose@prhi.org



Making Pittsburgh a Perfect Care Zone

Diabetes and Depression Resource Showcase

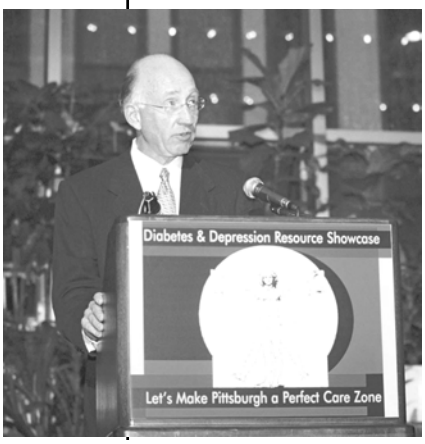
On Monday, September 15, 2003 PRHI partnered with PPG Industries, the Occupational and Environmental Health Foundation and Pfizer to present the **Diabetes and Depression Resource Showcase** at the PPG Wintergarden. The Showcase brought together more than 40 organizations from the Pittsburgh region in an effort to highlight the numerous resources available for those in the community affected by diabetes and depression. Competition was set aside as everyone united toward a common goal: making Pittsburgh a Perfect Care Zone for diabetes and depression.



Paul O'Neill, Former Treasury Secretary, Co-chair, PRHI Leadership Obligation Group

Kickoff press conference: PPG award

PPG Industries, the co-host of the event, accepted an award for its innovation in dealing with depression in the workplace. At the event's kickoff press conference, PPG was presented with the Innovations in Occupational and Environmental Health (IOEH) Award from Pfizer/The Occupational and Environmental Health Foundation (OEHF) and The American College of Occupational and Environmental Medicine (ACOEM). The award was granted for the collaborative study, "Depression in Primary Care: Worksite Intervention and Coordination of Care."



Raymond LeBoeuf, Chairman and CEO PPG Industries

Nicole Johnson
Miss America 1999
International Diabetes Advocate

Mr. LeBoeuf and Mr. O'Neill demonstrate the ease of diabetes screening. Free screenings were offered to participants.

Diabetes and Depression Resources

Following the press conference, members of the public were invited to visit the booths of the more than 40 community organizations, who came together to showcase the various resources available in the Pittsburgh region for those affected by diabetes and depression. Representatives from health plans, research institutions, health systems, hospitals, advocacy groups, libraries and other organizations were on hand to answer questions and demonstrate the resources they have to offer the community. Free diabetes and depression screenings were also available.

Introducing PHIN

At the Showcase, PRHI unveiled the Pittsburgh Health Information Network (PHIN), a secure internet-based network aimed at making it easier for patients and physicians to have current, pertinent patient data at their fingertips, resulting in better patient care. PHIN was created in close consultation with:

- Physicians and other health professionals
- Quality Insights of Pennsylvania (QIP)
- Hospitals and healthcare systems
- Legal experts
- Insurers and managed care organizations
- Laboratories and pharmacy providers
- Health care purchasers
- Consumers

Resource Guide now available

All of the community resources participating in the Showcase are profiled in PRHI's new ***Diabetes and Depression Resource Guide***. The Guide includes a list of informational websites screened by physician members of the PRHI Diabetes and Depression Working Groups. To obtain a copy of the Resource Guide, go to *www.prhi.org*, or contact Naida Grunden at ngrunden@prhi.org, or 412-535-0292, ext. 114.

Pittsburgh Regional Healthcare Initiative

650 Smithfield Street, Suite 2150
Pittsburgh, PA 15222

Calendar, November/December 2003

Monday, Nov. 3; Dec. 1	Diabetes and Depression Working Group Montour Room, 5th Floor, Centre City Tower	5–7p
Tuesday, Nov. 4, Dec. 2	QB Working Group PRHI offices, Centre City Tower, 2150	5–7p
Tuesday, Nov 11; Dec 9	Medication Safety Advisory Committee PRHI offices	3–5p
Tues-Weds, Nov. 11, 12	Perfecting Patient Care Information Session*	6–9p
and	Hospital Learning Line visit* Allegheny General Hospital	8a–12p
Weds, Nov 19	PCA Pump Conference Hospital Council of W/PA 500 Commonwealth Drive, Warrendale	4–7:30p
Mon, Dec 1	Joint meeting, Obstetrics and Pediatrics Societies	5–7p
(*see announcement, Page 7*)	Allegheny County Medical Society 713 Ridge Ave., Pittsburgh 15212 (*fee for non-ACMS members*)	
Thurs, Nov. 20, Dec. 18	Buying Healthcare Value Committee Jewish Healthcare Foundation, Suite 2300	2:30–4p

***Enroll now!* January 19-23, 2004**
Perfecting Patient Care University* **7:30a—5**

**CEUs offered. For further information or to enroll, call Leslie Smith, 412-535-0292, ext. 102*

Paul H. O'Neill, CEO

Ken Segel, PRHI Director
412-535-0292, ext. 104
ksegel@prhi.org

PRHI Executive Summary is also posted monthly at ***www.prhi.org***
Please direct newsletter inquiries to:
Naida Grunden,
Director of Communications
412-535-0292, ext. 114
ngrunden@prhi.org