# Pittsburgh Regional Healthcare Initiative

## *PRHI Scorecard 2001-2002*

**November 16, 2001**

**Where we want to go . . .**

**Where we are . . .**

**How we think we'll get to our destination . . .**

**And how we'll know if we are making progress.**

## What is our vision?

The Pittsburgh Regional Healthcare Initiative is a collaborative effort of the institutions and individuals that provide, purchase, insure and support health care services in Southwestern Pennsylvania.

Healthcare delivery is the region's largest single industry and shapes the life of each member of the community. We are working together to:

→Achieve the world's best patient outcomes ...

→Through superior health system performance ...

→By identifying and solving problems at the point of patient care.

Through our efforts to achieve perfect patient care, we believe we will address many of the major challenges facing health care in our region and across the country. We believe these challenges – rising costs, frustration and shortage among clinicians and workers, financial distress, overcapacity, and lack of access to care – are all symptoms of the same root problem: *failure of the system to focus solely on patient needs.*

## What are we trying to achieve?

We are working to achieve perfect patient care in the six counties of the Pittsburgh Metropolitan Statistical Area (Allegheny, Beaver, Butler, Fayette, Washington, & Westmoreland counties) using the following, *patient-centered* goals:

→ *Zero* medication errors.

→ *Zero* healthcare-acquired (nosocomial) infections .

→ *Perfect* clinical outcomes, as measured by complications, readmissions and other patient outcomes, in the following areas:

- Invasive cardiac procedures (cardiac bypass surgery, angioplasty, and diagnostic catheterization).
- Hip and knee replacement surgery.
- Repeat cesarean sections for women with no clinical indications for them.
- Depression.
- Diabetes.

These are the most aggressive and ambitious performance goals in American health care.

# How does health care work today? What are we trying to change?

How well are we meeting patient needs in our chosen entry points for system redesign?
The following outcomes are measures of our current condition:

| | | |
|---|---|---|
| Healthcare-acquired Infections | 7% of all hospital patients contract an infection during their stay | Based on most credible national data. Local data not yet available |
| Medication errors | 1% of all hospital patients are subject to a damaging medication error during their stay | Based on most credible national data. Local data not yet available |
| Invasive cardiac procedures | 17% readmission rates – bypass<br>949 total readmissions – bypass<br>7.5% complications – bypass<br>441 complications – bypass<br>2.3% death rate – bypass<br>134 deaths – bypass<br>*(7/1/98-6/30/99)* | Actual rates from PRHI study |
| Hip and knee replacement | 14.4% complications – hip<br>11% complications – knee<br>277 readmissions – hip and knee<br>*(10/1/97 – 9/30/98)* | Actual rates from PRHI study |
| Repeat, low-risk cesarean sections | 1437 repeat low risk c-sections (7/1/97-6/30/98) | Actual rates from PRHI study. Goal is not to eliminate all repeat low risk c-sections. |
| Depression | 12.7% of hospitalized patients readmitted w/in 30 days<br>Follow-up w/in 7 days of hospitalization = 6.6% to 75.5%, across all health plans<br>Follow-up for those on antidepressants = 10.4% to 38.7% | Actual rates from PRHI study, to be released in September 2001 |
| Diabetes | To be determined | Subject of upcoming PRHI study |

### *Why are we performing at this level?*

Because currently, the health system does not focus on the needs of the patient. The "client" in health care is variously believed to be the physician, the insurer, the payer—and only on occasion, the patient.

Such a fundamentally disorganized system leads to less than optimal patient outcomes and the corollary problems of rising costs, dissatisfaction of clinicians and workers, excess capacity and poor access to care.

As these problems mount, the pressure created by those who manage, pay for, and insure healthcare stress the disorganized system. Unfortunately, pressure alone will not lead healthcare delivery toward a *system* capable of delivering perfect care to patients.

### *External pressure on healthcare providers doesn't necessarily lead toward patient focus and a responsive system. Why, then, does it persist?*

Because until now, no other strategy has seemed feasible.

### *Why does no system-based alternative seem to exist?*

- No common understanding of healthcare delivery as a system of interdependencies.
- No agreement that problems must be identified and solved through patient focus.
- Those providing patient care are not empowered to improve the system based on patient need.
- Those who provide patient care may not have enough knowledge or experience in improving the system

based on patient need. ("We have to work *around* the system to get our patients what they need.")

### *What related problems must we address in the healthcare community?*

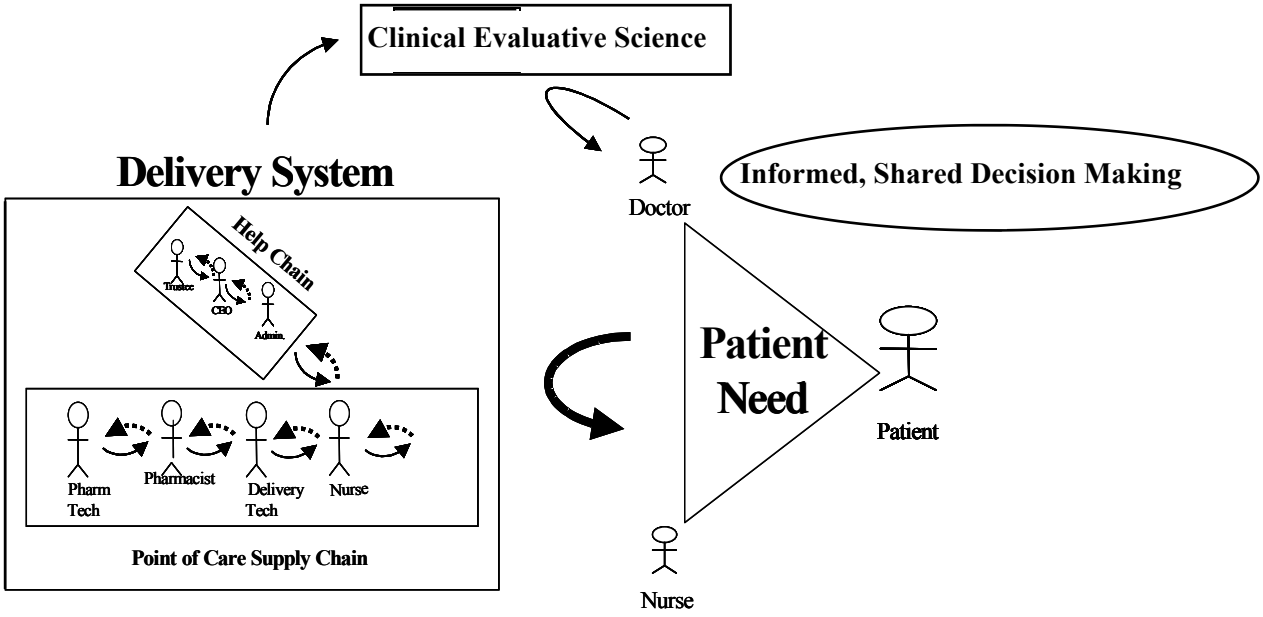
♦ We have no agreement as a community to learn together from patient needs and problems. This learning community must include professionals, as care teams, across institutions, and as healthcare stakeholders touching the system at different points.

♦ Individual patient problems are not well documented and understood.

♦ Cynicism exists at all levels of the healthcare system about the motives of other stakeholders. This prevents the formation of accountable partnerships.

♦ Cynicism also exists about "quality improvement." Previous experiences have generally produced disappointing, fleeting gains.

## How do we want health care to operate in our region?




### Focus on patient need

This picture describes how we want healthcare delivery to work in our region's institutions—***starting with patients' needs***. In this revised healthcare system, the care team allocates its resources based on each patient's need. In effect, the patient "pulls" the resources he or she needs. This system—derived from the ***Toyota Production System*** (TPS)—is capable of adjusting to and meeting varying patient needs quickly and flawlessly.

### Using scientific methods

Professionals collect information about the care they provide, using it in a cycle that increases scientific knowledge of patient need and the ways to meet it.

♦ *CES = Clinical Evaluative Sciences.* This term refers to "evidence-based medicine" in day-to-day patient care. That is, healthcare providers continue to evaluate the treatment and care they give, with an eye toward continuous improvement.

♦ *ISDM = Informed Shared Decision Making.* A prerequisite for patient-focused care, in which patients and physicians work together to determine the patient's needs, sharing parallel information.

### With managers who help

Implicit in the TPS system are:

♦ The "Supply Chain," involving flawless teamwork among those actually delivering care to patients.

♦ The "Help Chain," where care team members turn to their supervisors for help in problem-solving.

Managers become partners in problem-solving, in a collaborative—not punitive—atmosphere. In turn, supervisors may call on their superiors for help, as the "Help Chain" extends to the top of the organization.

## How do we get from where we *are* to where we *want to be*?

***#1 Establish region-wide collaboration, unimpeachable goals focused on patients, and safe ground for learning.***

PRHI has established broad, committed partnerships, represented by:

- A Community Charter and CEO Working Group Statement outlining the commitments and "ground rules" of the region's healthcare and corporate executives to achieve PRHI's patient safety goals.

- A less formal agreement between the region's physician and hospital community and the healthcare purchasing community (business, business association and labor union purchasers). This group has agreed to a professional "safe" zone for tracking and improving patient outcomes in PRHI's clinical pilot areas.

Support from executives and leaders, while essential, is not enough. Without the active support of those who provide patient care, along with other workers and managers, little progress is possible.

***#2 Measure outcomes and errors to galvanize the energy to change.***

Recognizing the necessity of physician involvement, the region's healthcare purchasers invited physician leaders from across the region to define (a) the areas to be examined and (b) the clinical questions to be examined. All agreed to begin by using the renowned Pennsylvania Healthcare Cost Containment Council database (PHC4). Because of the degree of physician involvement, physicians now "own" and support the process.

The purchasing community expects that physicians and hospitals will use this information and other resources to show measurable improvement over time. In exchange for leadership and evidence of improvement, the purchasing community will refrain from full public dissemination of these outcome data and the use of these data to penalize specific providers.

PRHI's patient safety initiatives are meant to focus partners on errors as opportunities for learning and improving the system of healthcare delivery. The learning takes place through identifying each error down to its root cause, and solving each problem in the course of work.

Before the launch of PRHI's patient safety initiatives, no credible shared databases existed among the region's providers for identifying patient safety incidents. Accordingly, the first focus of our patient safety projects has been to implement the country's most credible means of counting errors in our areas of focus.

PRHI is proud to have established a formal partnership with the Centers for Disease Control and Prevention to jointly pursue our pilot project—the elimination of blood stream infections in PRHI hospitals. The pilot employs a variant of the CDC's highly regarded system for tracking healthcare acquired infections. Our joint efforts to eliminate these infections are regarded by the CDC as a potential model for the nation.

The coming year will see an additional focus for infection—MRSA, which are antibiotic-resistant bacterial infections.

PRHI facilities have selected a similarly reputable system to track medication errors. The

MedMARx system, managed by the respected U.S. Pharmacopeia, is based on a new national classification system for medication errors. With more than 400 hospitals using MedMARx nationally, it is creating a national data set to aid and judge our improvement efforts. A core focus for PRHI has been to help its partner institutions create the "blame free" cultures necessary for staff to admit and document these medical errors.

Some hospitals and physicians will be able to make great improvements solely based on PRHI's outcome and safety data and their own internal response. However, sustaining improvements in the complex and disorganized healthcare environment will be more difficult. To increase the rate of sustainable improvement across the region, PRHI supports wide-ranging teams of clinicians and institutions to share learning and state-of-the-art improvement methods.

***#3 Identify care processes that lead to superior patient outcomes, and share that information.***

Among our clinical outcome pilots, the cardiac and orthopedic communities have responded enthusiastically to the PRHI's approach. All major cardiac surgery groups in the region have agreed to join a common data registry that *links patient outcomes with the processes of care*. This registry goes well beyond traditional "benchmarking," allowing clinicians to zero in on the most effective care, and the best way to provide it.

Similar planning is under way among the region's orthopedic surgeons psychiatrists, and those who care for patients with diabetes.

In patient safety, PRHI and its local and national partners conduct regular "shared learning" sessions, helping each facility learn from the problems and solutions encountered by others.

***#4 Learn how to deliver the right care perfectly every time.***

It is not enough to determine ***what*** care the patient requires. Rather, healthcare must improve ***how*** it delivers the right care to each patient every time, in very complex environments. The great uncertainty is ***"how."***

Previous efforts to apply the tools of "CQI" to healthcare have generally produced disappointing results. PRHI believes that experiments in *system-based management* will prove the most fruitful, and will produce dramatic improvements in healthcare delivery.

Through its **Center for Shared Learning,** and with support from Harvard Business School consultants and physicians, PRHI partners are now conducting experiments in system-based management drawn from the Toyota Production System and the Alcoa Business System. PRHI's hypothesis is that this management system will translate well to healthcare, because it allows complex delivery processes to adjust quickly to the needs of different customers (patients), delivering just what is required, every time.

PRHI has established three experimental sites, and has shared learning across the community and to the highest level of PRHI leadership. Additional experimental sites are planned for 2001-02.

We expect these experiments to suggest modifications to our other improvement partnerships, which we will incorporate as they emerge.

***PRHI Goals:***

- ***Zero medication errors***
- ***Zero healthcare-acquired infections***
- ***Perfect clinical outcomes in five areas***

## Deliverables 2001-02: What will we have to show for our efforts?

| *Goal* | *Current #hosp'ls* | *Target #hosp'l* | *Who?* | *Action* | *By when?* | *Status ****** |
|---|---|---|---|---|---|---|
| ***ZERO HOSPITAL-ACQUIRED INFECTIONS*** | | | | | | |
| Establish real & verified baseline bloodstream infection rates at Intensive Care Units (ICU) | 29 | 29 | PRHI | Coordinate collection, analysis & shared learning system with CDC | Quarterly | ◇ |
| | | | Hosp'l/ Clinician | Submit timely surveillance & reporting | As requested | ◇ |
| | | | Insurer/ Corp'n | Adjust policy to reduce barriers @ point of care | As requested | |
| Aspire to 20% or better reduction in bloodstream infections at all PRHI hospital ICU units | 0 | 29 | PRHI | Coordinate learning across collaboration | 12-02 | |
| | | | Hosp'l/ Clinician | Start process improvements to prevent infections; show reductions | 12-02 | |
| Measure baseline rates of antibiotic-resistant infection (MRSA) ; design & share interventions to control it | 0 | 29 | PRHI | Administer & coordinate activities among CDC & participating organizations | 6-02 | |
| | | | Hosp'l/ Clinician | Submit timely surveillance & reports; design interventions | | |
| Establish TPS pilots for infection control | 1 | 2 | PRHI | Establish and support learning lines | 6-02 | |
| | | | Hosp'l/ Clinician | Ensure pilot sites meet TPS participation criteria (see TPS section in this table) | 5-02 | |
| Institute surveillance program to eliminate clinical wound site infections with cardiac, orthopedic projects | 0 | ??? | PRHI | Coordinate infection & clinical teams; Administer cross-site demonstration | 6-02 | |
| ***ZERO MEDICATION ERRORS*** | | | | | | |
| Use MedMARx system @ all PRHI hospitals to collect & share data on medication errors | 13 | 30 | PRHI | Coordinate, hold accountable | 3-02 | |
| | | | Hosp'l/ Clinician | Bring remaining hospitals on-line | 3-02 | |
| Increase reporting rates by an average of 50% from pre-MedMARx levels | 1 | 30 | PRHI | Aggregate data, coordinate analysis & shared learning | 12-02 | |
| | | | Hosp'l/ Clinician | ♦ Encourage reporting<br>♦ Provide staff support for reporting<br>♦ Submit timely reports of med errors | Ongoing | |
| Establish real medication error rates in target areas selected from baseline data, and exceed 25% reduction in those rates | 0 | 30 | Hosp'l/ Clinician | Start prevention measures to address root cause of errors: show reduction | 12-02 | |

*****Key for Project Status, 2001-02: ⇧ Ahead of schedule ◇ On schedule ⇩ Behind schedule

# Deliverables 2001-02: continued

| *Goal* | *Current # hospitals* | *Target # hospitals* | *Who?* | *Action* | *By when?* | *Status* |
|---|---|---|---|---|---|---|
| ***CARDIAC BYPASS OUTCOME IMPROVEMENTS **** | | | | | | |
| ♦ Cardiac registry operating in all cardiac surgery sites<br>♦ Reduce mortality, atrial fibrillation, and readmissions | 0 | 11 | *PRHI* | ♦ Seek start-up funding<br>♦ Hire data analyst & clinical coordinator<br>♦ Host *Cardiac Forum*<br>♦ Host workgroup meetings<br>♦ Identify processes that lead to best outcomes<br>♦ Follow-up site visits w/ each institution<br>♦ Oversee follow-up w/each clinician by clinical coordinator<br>♦ Work group members attend CSL training on evidence-based medicine | 10-01<br>1-02<br>10-01<br>Monthly<br>3-02→→<br>3-02→→<br>3-02→→<br>3-02→→ | |
| | | | Hosp'l/ Clinician | ♦ Implement at pilot hospitals; expand to all doing bypass<br>♦ Attend regional forums<br>♦ Implement processes associated with best outcomes: show reductions<br>♦ Invest to sustain registry and support its use | 12-01<br>3x/yr<br>As identified<br>As identified | |
| | | | Insurer/ Corp'n | ♦ As results reduce costs, reinvest savings in improvement programs<br>♦ Attend regional forums<br>♦ Attend TPS information and go-and-see sessions<br>♦ Encourage federal, state, funder & institutional investment in registries<br>♦ Attend all pertinent PRHI committee meetings | As realized<br>3x/year by 6-02<br>As requested<br>As scheduled | |
| ** Prototype for other clinical areas* | | | | | | |
| ***OTHER CLINICAL IMPROVEMENT PRIORITIES*** | | | | | | |
| ♦ Integrate Highmark radiation oncology registry with PRHI<br>♦ Document reductions in unwanted variation in radiation dosages at all radiation oncology sites | 30 | 40 | PRHI | ♦ Negotiate registry transition<br>♦ Circulate insights to all institutions and practices | 1-02 | |
| | | | Hosp'l/ Clinician | ♦ Participate and use knowledge to improve outcomes<br>♦ Increase use of computerized dosage recommendation tool for decision support at point of care | ASAP | |
| | | | Insurer/ Corp'n | ♦ Highmark continues financial & staff support. As governance transfers to PRHI, other insurers support proportional to their involvement in radiation oncology<br>♦ As results reduce costs, reinvest savings in improvement programs | Ongoing<br>As realized | |

# Deliverables 2001-02: continued

| *Goal* | *Current #hosp'ls* | *Target #hosp'ls* | *Who?* | *Action* | *By when?* | *Status* |
|---|---|---|---|---|---|---|
| ***OTHER CLINICAL IMPROVEMENT PRIORITIES*** *(continued)* | | | | | | |
| Orthopedic registry operating at 75% of orthopedic surgery sites | 0 | 34 | PRHI | Expand workgroup for registry<br>Select targets | 1-02 | |
| | | | Hosp'l/ Clinician | Participate and use knowledge to improve outcomes | 10-02 | |
| | | | Insurer/ Corp'n | As results reduce costs, reinvest savings in improvement programs | As realized | |
| Outpatient registries in depression and diabetes operating | 0 | TBD | PRHI | Develop registry elements:<br>♦ Diabetes<br>♦ Depression<br>Select targets | <br>2-02<br>7-02 | |
| | | | Hosp'l/ Clinician | Invest to sustain registries and support their use | 3-02 | |
| | | | Insurer/ Corp'n | Release claims data in specific areas to support data registries<br>As results reduce costs, reinvest savings in improvement programs | | |
| ***MEASURE IMPROVEMENT IN CLINICAL OUTCOMES ACROSS THE COMMUNITY*** | | | | | | |
| Generate at least three second-round outcome measurement reports (with PHC4 data) to document progress across the community.<br>Targets:<br>1. Repeat C-section<br>2. Orthopedic work<br>3. Cardiac work | Round1<br>"<br>" | Round2<br>"<br>" | PRHI | Repeat reports with guidance from clinical advisory & purchasing committees | 4-02*<br>8-02*<br>12-02* | |
| | | | Hosp'l/ Clinician | Submit complete PHC4 data on time | Quarterly | |
| | | | Insurer/ Corp'n | Hold hospitals responsible for data submittal | Quarterly | |

*These dates may vary, depending upon Clinical Advisory Committee decisions on sequencing.

# Deliverables 2001-02: continued

| *Goal* | *Current #* | *Target #* | *Who?* | *Action* | *By when?* | *Status* |
|---|---|---|---|---|---|---|
| ***TOYOTA PRODUCTION SYSTEM,*** | | | | | | |
| Learning lines operating at sites meeting learning line criteria | 3 | 5 | PRHI | Provide primary teaching at UPMC, West Penn Allegheny and one other hospital. Hire 1 more teacher | 12-02 | |
| | | | Hosp'l/ Clinician | Must meet learning line criteria:<br>♦ Isolate learning line; no other consultants or directives<br>♦ Dedicate 100% time problem solver/team leader<br>♦ Weekly involvement on the floor, learning and problem solving—patient, nurse, doctor, supervisor, administrator, president, CEO, trustee<br>♦ No layoffs as a result of productivity improvements<br>♦ Admit additional partners (insurers, purchasers) as problems occur<br>♦ Open site for "lend-forwards" (those in training) | Prior to learning line start | |
| | | | Insurer/ Corp'n | Meet learning line criteria:<br>♦ Available as problems are identified<br>♦ Willing to experiment with policy or procedure changes | Prior to learning line start | |
| Get regional help chain functioning | 0 | regionwide | PRHI | Assemble stakeholder representatives<br>Continue TPS training & engagement<br>Design monthly sessions in identifying problems & necessary policy improvements | 1-02 | |
| Conduct bi-monthly TPS information sessions and subsequent *go-and-see* sessions | 200 people/yr | 275 people/yr | PRHI | Conduct monthly info sessions<br>Conduct monthly *go-and-see* sessions at learning line | Ongoing 10-01 | |
| Develop comprehensive leadership curriculum for community leaders that incorporates ISDM, CES, & TPS | In progress | Complete | PRHI | Develop leadership curriculum similar to Alcoa University | 12-02 | |
| Train community leaders in PRHI/TPS model | 10 leaders | 150 leaders | PRHI | Conduct monthly university sessions for learning line leadership | 1-03 | |
| Increase primary system teaching capability | 2 teachers | 10 teachers | PRHI | Hire 2 CSL teachers<br>Develop 5 internal learning line teachers | 1-03 | |

# Scorecard: How are we doing?

## Patient Safety: Bloodstream Infection and Medication Error Reporting Systems

These accountability charts will continue to be included from time to time in the monthly newsletter, *PRHI Executive Summary*

*Charts on these pages current as of 11-16-01*

| PRHI Partner | First Quarter NNIS Blood Stream Infect'n Report to CDC 4-01 | 5-01 | 6-01 | MedMARx med. error report Con-tract? | System in use? | Q1 2002 BSI MRSA | Q1 2002 ADE reporting? | Q2 2002 BSI MRSA | Q2 2002 ADE reporting? | Q3 2002 BSI MRSA | Q3 2002 ADE reporting? | Q4 2002 BSI MRSA | Q4 2002 ADE reporting? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Butler Memorial Hospital*** | | | | | | | | | | | | | |
| **Children's Hospital of Pittsburgh** | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| **HealthSouth Rehab. Hospitals** | n/a | n/a | n/a | | | | | | | | | | |
| **Heritage Valley Health System, Inc.*** | | | | | | | | | | | | | |
| Sewickley Valley Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| Medical Center—Beaver | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| **Latrobe Area Hospital*** | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| **Lifecare Hospitals of Pittsburgh, Inc.** | n/a | n/a | n/a | | | | | | | | | | |
| **Monongahela Valley Hospital, Inc.** | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| **Ohio Valley General Hospital** | | | | | | | | | | | | | |
| **Pittsburgh Mercy Health System** | | | | | | | | | | | | | |
| Mercy Hospital of Pittsburgh | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| Mercy Providence Hospital | ✓ | ✓ | ✓ | | ✓ | | | | | | | | |
| **South Hills Health System** | | | | | | | | | | | | | |
| Jefferson Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| **St. Clair Memorial Hospital*** | ✓ | ✓ | ✓ | | | | | | | | | | |
| **St. Francis Health System** | ✓ | ✓ | ✓ | ✓ | | | | | | | | | |
| **Uniontown Hospital** | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | |
| **UPMC Health System** | | | | | | | | | | | | | |
| Bedford Memorial | ✓ | ✓ | ✓ | ✓ | | | | | | | | | |
| Braddock | | | ✓ | ✓ | | | | | | | | | |
| Horizon | ✓ | ✓ | ✓ | ✓ | | | | | | | | | |

* *Collaborating w/ national VHA Patient Safety Initiatives*

✓ *Fulfilled* ✓ *In progress*

## Patient Safety: Bloodstream Infection and Medication Error Reporting Systems, continued

| | First Quarter | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NNIS Blood Stream Infect'n Report to CDC | | | MedMARx med. error report sys. | | Q1 2002 | | Q2 2002 | | Q3 2002 | | Q4 2002 | | | |
| PRHI Partner | 4-01 | 5-01 | 6-01 | Con-tract? | System in use? | BSI MRSA | ADE reporting? | BSI MRSA | ADE reporting? | BSI MRSA | ADE reporting? | BSI MRSA | ADE reporting? | | |
| **UPMC, continued** | | | | | | | | | | | | | | | |
| Lee Regional | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Magee Womens Hospital | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| McKeesport | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Passavant | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Presbyterian | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Rehabilitation Hospital | n/a | n/a | n/a | ✓ | | | | | | | | | | | |
| Shadyside | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | |
| South Side | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| St. Margaret | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Western Psychiatric Institute | n/a | n/a | n/a | | | | | | | | | | | | |
| **West Penn Allegheny Health System** | | | | | | | | | | | | | | | |
| Allegheny General Hospital | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Allegheny Valley Hospital | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Canonsburg General Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | |
| Forbes Regional | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| Suburban General | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| West Penn Hospital | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | | |
| **Westmoreland Health System** | | | | | | | | | | | | | | | |
| Frick Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | |
| Westmoreland Regional Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | | | | |

# Scorecard: How are we doing?

## Clinical Initiatives: PHC4* Reporting Rates

### (PHC4 data are used to set PRHI clinical starting points)

These accountability charts will continue to be included from time to time in the monthly newsletter, *PRHI Executive Summary as of April 2001*

| PRHI Partners | Reporting compliance, 2001 | Trend, past 10 quarters (prior to 4-01) | Reporting compliance, 2002 | Trend, past 10 quarters |
|---|---|---|---|---|
| Brownsville General | 90% | ⇧ | | |
| Butler Memorial | 95% | ⇩ | | |
| *Heritage Valley Health Sys.* | | | | |
| •Sewickley Valley | 95% | ⇧ | | |
| •Medical Ctr., Beaver | 95% | ⇧ | | |
| Highlands | 96.25% | ⇩ | | |
| Latrobe Area Hospital | 97.5% | ⇧ | | |
| Monongahela Valley | 100% | ◇ | | |
| Ohio Valley General | 100% | ◇ | | |
| *Pittsburgh Mercy Health Sys.* | | ⇧ | | |
| •Mercy Hospital | 87.5% | ⇧ | | |
| •Mercy Providence | 95% | | | |
| *South Hills Health System* | | ⇧ | | |
| •Jefferson Hospital | 85% | ⇩ | | |
| St. Clair Memorial | 98.75% | ⇧ | | |
| St. Francis Med Ctr | 95% | ⇩ | | |
| Uniontown | 95% | | | |
| *UPMC Health System* | | ◇ | | |
| •Beaver Valley | 100% | ⇩ | | |
| •Braddock | 97.5% | ⇩ | | |
| •Magee-Women's | 96.25% | | | |

| PRHI Partners | Reporting compliance, 2001 | Trend, past 10 quarters (prior to 4-01) | Reporting compliance, 2001 | Trend, past 10 quarters |
|---|---|---|---|---|
| *UPMC, continued* | | | | |
| •McKeesport | 93.75% | ⇧ | | |
| •Passavant | 98.75% | ◇ | | |
| •Presbyterian | 95% | ⇧ | | |
| •Shadyside | 96.25% | ⇧ | | |
| •South Side | 100% | ◇ | | |
| •St. Margaret | 98.75% | ◇ | | |
| Washington Hospital | 96.25% | ◇ | | |
| *West Penn Allegheny H. Sys.* | | | | |
| •Allegheny General | 97.5% | ◇ | | |
| •Allegheny Valley | 98.75% | ◇ | | |
| •Canonsburg General | 100% | ◇ | | |
| •Forbes Regional | 96.25% | ⇧ | | |
| •Suburban General | 95% | ◇ | | |
| •West Penn ** | 86.25% | ◇ | | |
| *Westmoreland Health System* | | ◇ | | |
| •Frick Hospital | 100% | ◇ | | |
| •Westmoreland Reg'l | 98.75% | ◇ | | |
| *Jeannette Dist. Mem.* | 95% | ◇ | | |
| *Monsour Medical* | 82.5% | ⇩ | | |

* Pennsylvania Health Care Cost Containment Council

** Data error rates due to one field error only—field not used in PHC4 calculations

◇ indicates no change in reporting rates for past 10 quarters

# Clinical Initiatives: Trends in Patient Outcomes

## Round 2 Data Reporting for 2002

| PRHI Partners | C-section outcomes data | Cardiac outcome trends | Orthopedic outcome |
|---|---|---|---|
| *Example* | ✚ | ⇧ | ◇ |
| Brownsville General | | | |
| Butler Memorial | | | |
| *Heritage Valley Health System* | | | |
| •Sewickley Valley | | | |
| •Medical Ctr., Beaver | | | |
| Highlands | | | |
| Latrobe Area Hospital | | | |
| Monongahela Valley | | | |
| Ohio Valley General | | | |
| *Pittsburgh Mercy Health System* | | | |
| •Mercy Hospital | | | |
| •Mercy Providence | | | |
| *South Hills Health System* | | | |
| •Jefferson Hospital | | | |
| St. Clair Memorial | | | |
| St. Francis Med Ctr | | | |
| Uniontown | | | |
| *UPMC Health System* | | | |
| •Beaver Valley | | | |
| •Braddock | | | |
| •Magee-Women's | | | |

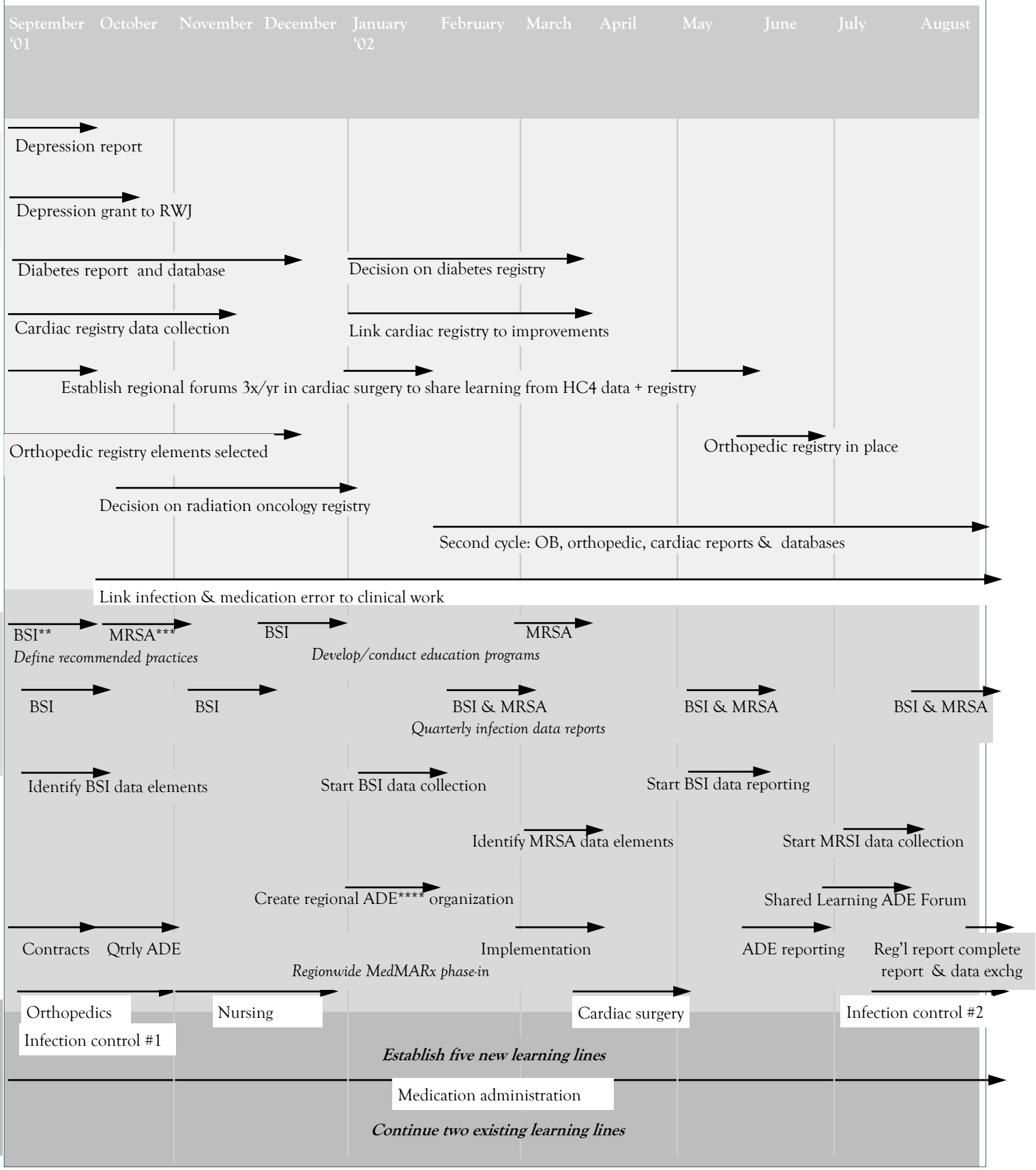
| PRHI Partners | C-section outcomes data | Cardiac outcome trends | Orthopedic outcome trends |
|---|---|---|---|
| *UPMC, continued* | | | |
| •McKeesport | | | |
| •Passavant | | | |
| •Presbyterian | | | |
| •Shadyside | | | |
| •South Side | | | |
| •St. Margaret | | | |
| Washington Hospital | | | |
| *West Penn Allegheny H. Sys.* | | | |
| •Allegheny General | | | |
| •Allegheny Valley | | | |
| •Canonsburg General | | | |
| •Forbes Regional | | | |
| •Suburban General | | | |
| •West Penn ** | | | |
| *Westmoreland Health System* | | | |
| •Frick Hospital | | | |
| •Westmoreland Reg'l | | | |
| *Jeannette Dist. Mem.* | | | |
| *Monsour Medical* | | | |

✚ Data refined since Round 1 reporting in 2001

⇧ ⇩ Trend since Round 1 reporting

◇ Unchanged since Round 1 reporting

## Timeline 2001-02: How do we accelerate our efforts?




* TPS = Toyota Production System ** BSI = Bloodstream infection *** MRSI = antibiotic-resistant infection ****ADE = Adverse drug event (medication error)

# Reflections: What has happened in 2001?

| Progress | Challenges |
|---|---|
| PRHI ideas and progress capture national attention: White House/ Cabinet visit. | Effective communication of core approach with internal and external stakeholders |
| Subsequent PRHI influence on Senate, White House policy initiatives and support of key policymakers for PRHI. | Direct federal support for PRHI difficult to secure without compromising approach. |
| Clinical outcome maps capture energy of key physician segments and make visible systems problems. | |
| Cardiac surgeons have committed to and designed a common patient registry and professional learning system—a prototype for other outcome areas. | |
| First community in country to have competing hospitals agree to count medication errors and nosocomial infections on common database—and to share error information for purpose of learning | Contract signings for patient safety took a year. To speed implementation, should we engage COO/CFO-level officers of hospitals? |
| CDC partnership a national model. Data collection under way at all sites for first infection target. | Difficult to improve care using surveillance data |
| TPS learning line begins to take root and demonstrate power of approach at one site; other sites meet pre-conditions to begin work. | Continued need to connect PRHI participants to learning lines |
| Second generation of Initiative corporate leadership demonstrates community commitment | Uneven levels of strategic commitment from various institutions (hospitals, insurers, purchasers) |
| Diverse funding sources secured | Resources:<br>♦ Coordinating staff (esp. patient safety) and administrative staff<br>♦ TPS teachers<br>♦ Need to secure second-round funding |
| | Capacity strategies not successful; dropped. |

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