Pittsburgh Regional Healthcare Initiative

PRHI Executive Summary

What stands between the current quality of patient care and the level of excellence we seek to achieve?

We have heard from our constituents about the barriers: reimbursements that do not always reward the right care for patients; multiple, wasteful reporting systems that do not coordinate information or formulate it into useful insights; and barriers presented by legislation such as the Health Insurance Portability and Accountability Act (Hipaa).

As a regional initiative, PRHI is gathering information about these barriers—real and perceived—to share them with legislators, insurers, payers, and others involved in the maze of healthcare requirements and ask for targeted improvements. This edition of PRHI Executive Summary delves into some of the details we've found in the maze. ***Your feedback, examples and strategy ideas, are essential to this effort! Contact Ken Segel, ksegel@prhi.org.***

June 2004

Inside:

Your examples of a broken reimbursement system

Reimbursement's perverse incentives

PRHI partners have told us that the way we pay for health care is too often not in the patient's best interest. People in health care want to meet the needs of the people for whom they care. But we have created payment systems that pay for errors and rework, and tacitly encourage overuse or under-use.

The complex, inflexible reimbursement system does not reward higher quality or better outcomes, and does not invest in quality improvement. Intellectually, policy makers, payers and insurers embrace "pay for quality," but the concept has not yet been deployed at sufficient scale to shape behavior or outcomes in the healthcare delivery system.

The following examples, most provided by PRHI partners, illustrate particular problems with dominant reimbursement systems.

✧ **The entire health care delivery industry keeps two sets of books.** The practice of insurers securing discounts from providers' "list prices" has created a fictional reimbursement system. In FY '02, actual revenue to Pennsylvania hospitals was 30% of what they billed for care. [1] This adds to cynicism, obscures true prices, and further separates measures of resource consumption from quality. It also raises serious fairness concerns. Uninsured people are typically billed at "full price" by hospitals, while the hospitals accept massively discounted payment for insured customers.[2]

✧ **Errors (rework) are paid for. Reimbursement remains the same whether care is perfect or defective.** The backbone of the reimbursement system is the Medicare DRG, or Diagnostic Related Group. In more than 100 DRGs, a hospital-acquired urinary tract infection (UTI) causes the patients' care

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to be classified as "complicated." Although hospital-acquired infections are almost always preventable, reimbursement to the hospital almost doubles when they occur.[3]

In Pennsylvania during FYI '02, patients with UTI's stayed 149,796 additional days in the hospital (vs. patients with the same conditions and risk factors that did not contract UTIs). This translates to $202,226,625 in additional payments to hospitals (average payment per hospital day in Pennsylvania is $1,350).[4]

A commercially insured patient with an IV line is judged to have higher acuity, creating a higher rate of payment. This can create the incentive to leave IVs in for more days than required, exposing the patient to risk of infection and medication error.

Although readmissions are usually preventable, they result in huge hospital charges. For FY '02, 73,527 people were readmitted to Pennsylvania hospitals for the 38 conditions studied by the Pennsylvania Health Care Cost Containment Council. If only those hospitals with HIGHER than average readmission rates, reduced them ONLY to the statewide average, 7331 fewer people would have had to be readmitted, resulting in $191,470,421 less in hospital charges (and an estimated $57,441,126 less in payments to hospitals).[5]

✧ **Providing better care for chronic disease can actually cost providers.** Hospitals that provide exemplary care for chronic disease, including care coordination and effective discharge counseling, see fewer readmissions than those that do not. Yet they are rarely reimbursed for the cost of their programs. Nor is their loss of revenue from reducing readmissions offset in any way.[6]

One Pittsburgh-area hospital system developed a program to help patients manage congestive heart failure, the largest single cause of admission for this hospital, as it is for Medicare. The program focused on careful discharge planning for admitted patients and more effective outpatient management. The hospital system saw admissions for heart failure fall significantly during the operation of the program. Over several years of negotiation, it could not get any payer to reimburse for its activities or reward its reductions in hospital admissions. Last year, the inpatient components of its heart failure program became part of a pilot quality incentive program with a major insurer, but its outpatient program has no support from any payer.

✧ **By tying payment to patient acuity without corresponding quality checks, we risk over-treatment**. Commercial managed care companies often reimburse hospitals at differing rates, or deny additional days of care, based on the patient's diagnosis and intensity of service. Traditionally, a patient with an IV line is judged to have a higher acuity, creating a higher rate of payment. Hospital and medical staff leaders have pointed to the incentive this creates to leave IVs in for more days than patients require, opening the patient to additional risk of both infection and medication error.

✧ **By artificially restricting care to certain settings, we can negatively affect patients and caregivers.** In July, 2003, Medicare instituted a prospective payment system for long term acute care facilities. The facilities can no longer be reimbursed for extra care for specific services, such as electro-convulsive therapy (ECT) for psychiatric patients. As a consequence, patients requiring ECT are now transferred to inpatient facilities, and transferred back to the long-term facility following treatment, inconveniencing both patient and provider, and increasing cost. Restrictions like these result in patients being moved between facilities across many different settings in the healthcare delivery system.

✧ **We pay for doing the wrong thing.** Americans with heart disease are undergoing revascularization procedures (such as cardiac bypass surgery and stents), intended to clear heart vessel blockages, in huge numbers. Yet as early as 1986 clinical science indicated that these procedures do not address the root cause of 75 to 80 percent of heart attacks—unstable plaque that can burst from any location, including less occluded

vessels. Evidence shows that for most patients (those without severe angina) medical treatment may be more appropriate and less dangerous than surgery.[7] For example, stents can cause minor heart attacks in up to 4% of patients.

✧ **While we pay for defects and inappropriate care, we don't pay for quality. For example, effective chronic care is not fully reimbursed.**[8] A series of case studies analyzed in *Health Affairs* showed that neither Medicare nor most private payers cover most techniques that can improve chronic disease outcomes, such as group visits, physician-patient e-mail, and smoking cessation. Medicare is only incrementally expanding support for preventive procedures, such as screening and wellness exams. Providers who offer these activities are rarely reimbursed for them, nor are they rewarded for improved patient outcomes.[9]

✧ **Physicians and other providers are generally paid for activity rather than outcome.** This may lead to overuse. Under Medicare fee for service, physicians are reimbursed for each office visit by a patient, or physician visit to a sick patient in a hospital. Physicians and hospitals have few incentives for preventing hospitalization. Further, hospitals are generally paid a flat rate per admission, complicating quality improvement activity.

Surgeons are paid to perform surgery, but are rarely rewarded for discouraging surgery when it may not be the best course for the patient.

Until recent rule changes, many oncologists derived a significant portion of their income from inflated reimbursements for chemotherapy drugs. Even under current rules, Medicare now reimburses at 120% of market value for all chemotherapy agents. The potential incentive to over-treat has been lessened, but not eliminated.

✧ **Payment methods meant to address overuse (especially capitation) are not sufficiently safeguarded to prevent under-use or poor care.** Paying providers monthly or annual stipends per patient can result in sharp drops in access to care. Farsighted managed health plans have started to monitor consumers' access, and make a portion of reimbursement conditional upon it. However, these approaches are not yet in place in most managed health care plans in the United States.

Send Us Your Facts!

✧ *Have you seen reimbursement policies that reward the **wrong** thing for patients, or create "cruel disincentives" for doing the **right** thing?*

At the urging of its partners, PRHI is working with policy makers in state and national agencies to address: 1) the perversities of the current reimbursement systems, and 2) overlapping reporting requirements that don't add value for patients.

To work on these problems, we are collecting examples "from the field." If you have examples to share, please forward them to Ken Segel at ksegel@prhi.org or 650 Smithfield St., #2150, Pittsburgh, 15222.

✧ **The dominant model, administrative pricing, prevents customization to pay for the care that specific patients need, especially those with chronic disease.** "People and payers who might be quite willing to pay a premium for more

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1 PHC4 hospital financial report

2 "How those with least are charged most," Pittsburgh Post-Gazette, March 25, 2004

3 Source: Pennsylvania Health Care Cost Containment Council, presentation to the Pittsburgh Business Group on Health, 4/28/04.

4 *IBID*

5 *IBID*

6 *The Business Case for Quality: Case Studies and An Analysis*, Leatherman, et. al, Health Affairs, March/April 2003

7 *New Heart Studies Question the Value Of Opening Arteries*, New York Times, March 21, 2004

8 *The Business Case for Quality: Case Studies and An Analysis*, Leatherman, et. al, Health Affairs, March/April 2003

9 *IBID*

10 *IBID*

From Page Two

Reimbursement's perverse incentives

fully integrated chronic disease care, for the option of a group visit, or for detailed management of their lipid medications do not have the option to do so because of fixed fee schedules and complex payment rules. This is particularly true under Medicare. In effect, people do not have the option to pay for what they want, even if what they want is better than what they have."[10]

✧ **Tying a significant portion of reimbursement or prospective payment to the actual outcomes of care (paying for quality) can protect patients from overuse, under-use and misuse.** Few "pay for quality" demonstrations use a large enough portion of providers' income to create incentive to achieve specified outcomes or processes of care. Hospital executives report that tying 5% of revenue to quality measures would significantly raise the prominence of quality performance in financial management.

—by Ken Segel, ksegel@prhi.org, 412-535-0292, ext. 104

Getting the right thing for patients: How you can help

Would you like to see major demonstration projects in SWPA, where, for example, reimbursement rewards the right thing for patients? PRHI is working toward this and other actions. We seek to SHOW, not just tell, legislators and policy makers about conditions "in the trenches."

Please send your examples and your own policy ideas, to PRHI:

Ken Segel, *ksegel@prhi.org* or Naida Grunden, *ngrunden@prhi.org*

Ending the duplication and waste

Transforming "Reporting" into a valuable tool

More than 100,000 pages of Medicare regulations govern the operations of hospitals and clinicians. This tangle of regulation and private oversight subjects hospitals to an array of overlapping but generally uncoordinated reporting requirements for clinical, safety and operations information. ***Learning***—the point of all the reporting—can get buried in the process.

Hospitals are also subject to numerous, duplicative onsite inspections from public and private oversight bodies, generally referred to as onsite "surveys." Most surveys are still designed based on outdated methodologies.

The growing commitment to quality, safety and transparency offer an opportunity to align hospitals' external reporting with valid and useful measures of day-to-day performance for internal managers. The recent consolidation of clinical process measure reporting among CMS / AHA / JCAHO (see below) – with financial requirements from CMS to participate – is a positive development that should serve as a catalyst for further coordination of reporting and greater openness around

clinically valid care measures.

There is a glimmer of hope on the survey side as well, with JCAHO moving its activity toward unannounced surveys – which promises to provide a more accurate picture of actual operations, reduce the tremendous waste and cynicism associated with preparation for announced inspections, and move hospitals toward a focus on quality as organizational bedrock vs. a compliance issue. JCAHO has also begun piloting "patient tracer" surveys, where JCAHO inspectors and hospital leaders follow the care of specific patients to assess quality and problem solving capacity. One local hospital CEO has actually adapted the patient-tracer methodology and uses it weekly to identify problem-solving opportunities across the organization. However, JCAHO can shift even more aggressively in these directions and other bodies – especially the State – must commit to reducing surveys, coordinating necessary surveys, and modernizing survey methods.

Below are preliminary action recommendations for PRHI. The following three pages contain a table showing typical hospital reporting and survey requirements in Pennsylvania, from the point of view of a hospital manager.

We are eager for feedback and suggestions from PRHI partners regarding this material. Please direct your comments to Ken Segel (ksegel@prhi.org) and Naida Grunden (ngrunden@prhi.org)

Preliminary Action Recommendations for PRHI

Your feedback is sought!

Reporting

- Tie future clinical data efforts to emerging CMS/AHA/JCAHO measures to maximum extent possible.
- Work with State government stakeholders to unify reporting of medical errors and infections among the Patient Safety Authority, PA Health Care Cost Containment Council and any other state body with emphasis on simple capture and problem-solving usefulness.

Surveys

✧Promote JCAHO unannounced survey regime and "patient tracer" methodology. These techniques are patient-centered and reflect the realities of day-to-day management. Meanwhile, urge JCAHO to reduce and simplify its underlying set of standards.

✧Consider with hospital and health plan partners pilot "accreditation" efforts based on how well and quickly valid clinical information from "point of care" is shared and acted upon across the institution. National Committee on Quality Assurance has expressed unofficial interest in Pittsburgh as a potential pilot site.

✧Advocate with the State and to the extent possible private bodies to radically reduce number of surveys, and coordinate and modernize approach for any necessary surveys. Move to all unannounced and non-punitive surveys, and follow actual patient care.

Typical Hospital Reporting and Survey Requirements, *(simplified)*

Typical Reporting Requirements					
Entity/Agency	Entity/Agency Role	Data Reported	Reason for Reporting	Frequency	Comment
American Hospital Association	Partnering w/CMS, JCAHO to develop uniform approach to collecting hospital performance data and sharing that information w/public	10 initial process data elements: heart attacks, heart failure, CA pneumonia	Voluntary, but CMS has tied full 2005 payment update to participation	Quarterly	Measures considered clinically valid; strongly associated w/better outcomes
Center for Medicare & Medicaid Services (CMS)	See above	See above	See above	See above	
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Accreditation for hospitals; provides hospitals "deemed" status for CMS. Also part of AHA/CMS partnership Sentinel Events	Core measures (Initially hospitals could select among broad set of measures and systems. Increasingly congruent w/AMA, CMS partnership. Errors, near misses as defined by JCAHO	Required for accreditation	Quarterly	Most hospitals in PA use Mediqual system to report JCAHO core measures JCAHO sentinel event reporting requirements have shaped how many hospitals approach error reporting
Quality Insights of PA (QIP)	Contracted by CMS for PA to assist in quality improvement. Implements CMS national initiative to improve care across continuum	Clinical: AMI, CHF, CA Pneumonia, surgical infections Some utilization/billing issues	Collaboration required as a Medicare provider	Varies by area, audit request	
Pennsylvania Health Care Cost Containment Council (PHC4)	Monitors and reports quality and cost indicators of health care services provided in PA hospitals	Key clinical data elements (drawn from chart review and billing codes) from inpatients cv. LOS, mortality rates, complication rates, readmission rates, patient safety indicators, and hospital charges. Submitted via Mediqual system (required)	Required by State Law	Quarterly	Reauthorization required reducing reporting to less than 50% of charts. Most hospitals use Mediqual system to meet JCAHO/AHA/CMS reporting as well. New infection reporting requirement to focus initially on four major categories of infection. Overlap w/PSA, PRHI
Commercial Insurers	Insurance companies' traditional quality monitoring and pay for performance pilots	Assurance activity varies by plan. Most look at same population as CMS. Pay for quality pilots use process and outcome measures in select areas.	Assurance activity is a contractual requirement. Pay for quality programs tie small part of revenue to attaining quality targets	Varies by plan	Only a few plans have pilot pay for quality efforts. Financial stakes modest to date.
Leapfrog Group	Public reporting to measure compliance with specific safe practices	3 quality measures initially; expanding to 30	Voluntary, encouraged by purchasers	Annual survey	
Pittsburgh Regional Healthcare Initiative	Regional collaborative to improve performance of the health care system	CLABS (ICU/MRSA), MRSA VAP, MRSA operative wounds (hips, knees, sternums), medication errors (via Med Marx), cardiac surgery data	Shared learning	Varies	(Other PRHI clinical information derived via HC4 data set – no additional collection burden on hospitals)

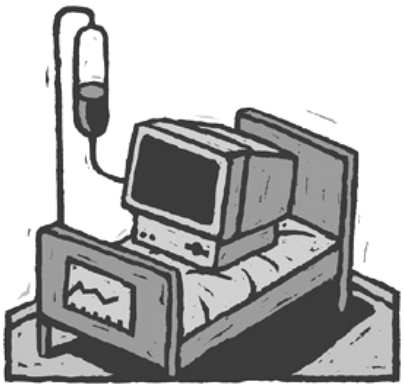
Entity/Agency	Entity/Agency Role	Data Reported	Reason for Reporting	Frequency	Comment
PA Department of Health (DOH)	State licensing agency	Serious events, elopements, fall/med errors resulting in injuries, patient injury or accident, infrastructure failures, EMTALA issues	Required by PA Chapter 51 and Medical Care Availability & Reduction of Error Act (Act 13)	Within 24 hours of event	All to be reported to Patient Safety Authority (PSA). PSA passes information on required events to DOH. Hospitals mistrust DOH re: punishment for error reporting.
Patient Safety Authority	Independent PA agency charged by M-Care Act to help reduce medical errors in PA	Serious events and incidents Technically includes healthcare-acquired infections and all unsafe conditions	Required by M-Care Act (Act 13)	24 hr of serious event; monthly for incidents. Info passed to DOH	Program being trailed at 20 hospitals. Alerts and safety bulletins being sent to hospitals, but not open at this point to decentralized entry or allowing open access to database for learning.
FDA	Federal agency	Events where patient death/injury may have been caused or contributed to by a medical device	Required by Safe Medical Device Act	Within 10 days of event	
Typical Survey Requirements					
Entity/Agency	Entity/Agency Role	Data Reported	Reason for Reporting	Frequency	Comment
JCAHO	Hospital Accreditation	Inpatient and outpatient areas	Every 3 years	5	JCAHO has announced that all surveys will be unannounced beginning in 2006
JCAHO	Home care accreditation	Home care	Every 3 years	3	JCAHO has announced intention to have all surveys occur at same time
PA Department of Health; Division of Acute and Ambulatory Care	State license	Inpatient and ambulatory areas	Every 3 years	5	
"	State license	Home care licensing for state AND Medicare home health participation	Every 3 years	4	None of various PA DOH surveys occur on same days
"	Inpatient Psychiatry	Inpatient psychiatry	Every year	1	"
PA Department of Health; Division of Emergency Medical Services	State licensing	Certain emergency medical services	Every 3 years	1	"
PA Department of Health	Life safety inspection	Inpatient / ambulatory areas	Every 2 years	5	"
PA Department of Health; Bureau of Laboratories	State and Clinical Lab Improvement Amendment licenses	Pathology / labs	Every 2 years	1	"
PA Department of Public Welfare (DPW)	State licensing	Outpatient Psychiatry	Every 2 years	1	Not at same time as partial psych survey
PA DPW	State licensing	Partial hospitalization program (psych)	Every 2 years	1	Not at same time as outpatient psych survey

Entity/Agency	Entity/Agency Role	Data Reported	Reason for Reporting	Frequency	Comment
PA Department of Environmental Resources (DER)	State licensing of radioactive materials and x-ray equipment	Nuclear medicine & parts of cardiology and radiology depts	Every 2 years	3	Not coordinated w/other State surveys
Allegheny County Health Department	Infectious Disease Review	Charts: Reporting of infectious disease	1-2 times per year	1	
Allegheny County Health Department	Food Safety Inspection	Main kitchen and cafeteria	Every year	1	
Allegheny County Health Department	Food Safety Inspection	Gift shop	Every year	1	Not same date as ACHD review of main kitchen & cafeteria
Environmental Protection Agency (EPA) for the Food & Drug Administration (FDA)	Mammography regulations	Mammography imaging areas	Every year	1	Separate survey dates for each site where mammography performed
Food and Drug Administration (FDA)	Federal license	Blood bank	Unannounced, at least every 2 years	1	Note that this survey is unannounced.
Health Resources & Service Administration (HRSA)	Progress of federal grants	Various	Every 2 years	1	
Commission on Accreditation of Transport Services (CAMTS)	Program accreditation	Certain emergency services	Every 3 years	2	
Accreditation Council for Continuing Medical Education (ACGME)	CME accreditation/ institutional review	Whole institution	Every 4 years	1	
Accreditation Council for Continuing Medical Education (ACGME)	Accreditation	Certain services	Every 5 years	1	
American Board of Internal Medicine	Certification of house staff evaluations	Various programs	Every 5 years	1	
American Association of Blood Banks	Accreditation	Blood Bank	Every 2 years	2	Not same date as FDA review of blood bank
American Institute of Ultrasound in Medicine	Certification for ultrasound units	No on-site survey; just documentation submission	Every 3 years	N/A	
College of American Pathologists	Accreditation	Pathology & certain labs	Every 2 years	1	
College of American Pathologists	Accreditation	Blood gas lab	Every 2 years	1	Occurs w/in 2 weeks of pathology review
PA Trauma Systems Foundation	Accreditation	Trauma	Every 3 years	1	
Residency Review Committee for Internal Medicine	Accreditation	Various programs	Every 18 months (approx.)	3-5	
Workers' Comp insurance carrier	Safety issues / contractual	Inpatient and ambulatory		No set schedule	

Health Insurance Portability and Accountability Act

Demythologizing HIPAA

In April 2003, Paul O'Neill asked a large group of decision-makers from health plans, laboratories and employers if they agreed that this would be a worthwhile goal for the Pittsburgh region: *to provide physicians with the data they need when they need it to treat patients with chronic conditions according to the best-known practices.*



When the group said yes, the Pittsburgh Health Information Network, or the PHIN, was born. Mr. O'Neill then challenged every stakeholder in the room to produce a list of the barriers they perceived to stand in the way of accomplishing this worthy goal.

In other words, Mr. O'Neill asked, "Why can't we?"

In the weeks that followed, stakeholders began sharing what they thought would surely be insurmountable legal and technical hurdles. After all, the purpose of the PHIN would be to build a regional database to collect relevant data on diabetic and depressed patients, and make it readily available to physicians at the point of care—touchy business in the brave new era of the untested Healthcare Portability and Accountability Act, known as HIPAA. This law, put in place to safeguard patient privacy, was seen as a potential show-stopper for the PHIN.

But PRHI's Depression and Diabetes Working Groups went to work researching and resolving each perceived barrier one by one. Legal questions revolved, not unexpectedly, around HIPAA and patient privacy, and we soon found ourselves involved in systematic "myth-busting." What we found was that rather than inhibit the PHIN, HIPAA actually enabled it! Below are just a few of the barriers and assumptions we were able to resolve with expert legal advice on health privacy laws.

HIPAA Myth-busters

Myth 1: By participating in a central chronic disease database, contributing data holders would have to rewrite and reprint their existing privacy and disclosure of information statements.

Myth-Buster: If we organize under "the stipulations for Use and Disclosure of PHI for Healthcare Operations of Another Entity" provided for in HIPAA, then existing language already covers data sharing under the umbrella of healthcare operations. Relationships can be legally established through individual Business Associate Agreements with the organization managing the central database.

Myth 2: Organizations that enter into a business associate contract with each other can be held liable for each other's misconduct. In other words, if one organization shares data with a third party and a patient's privacy is compromised, the initial organization will be liable.

Myth-Buster: HIPAA has actually reduced liability by establishing an industry standard of due care. In other words, before HIPAA, what care providers were responsible for was not defined; now, parameters have been defined. Business Associate Agreements define the roles of the covered entities as they relate to sharing protected health information. Covered entities expect their associates to perform in the ways stipulated, but the ***covered entities are not liable for their associates' behavior****. If there is a breach of protection, the covered entity should notify the associate and secretary, and should not provide any further protected health information (PHI) until the breach has been repaired.*

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Demythologizing HIPAA

Myth 3: In order for a patient's data to be shared across physicians treating the same patient, individual patient consent is required.

Myth-Buster: Legally, individual patient authorization is not required. Because the chronic disease registry is sharing PHI under permissible disclosures (i.e. healthcare operations for quality improvement) patients are already being informed and giving authorization for this use in existing disclosure of information notices. However, in an effort to comply not only with legal requirements but also with reasonable expectations of privacy from practitioners and patients, we decided to build a system that would require patient consent for a treating physician to access data originating from other care providers.

Myth 4: Perhaps diabetes data could be stored in a central regional repository, but not depression data, as mental health records have much more stringent privacy safeguards.

Myth-Buster: The only additional protections from HIPAA for mental health data involve psychiatric notes (which the PHIN will not be collecting). In PA state law, the only additional protections on mental health data are for (A) Involuntary Outpatient care and (B) Inpatient care. We have confirmed that we can easily separate inpatient data from outpatient data through coding, and that involuntary outpatient data is so rare, it does not constitute a barrier to our model. To date we have not found any state laws providing additional protections to ***voluntary outpatient mental health claims data****—(namely office visits and anti-depressant prescriptions and refills, the target data for PHIN)*

From this process, our task forces and working groups have learned not to take the first wave of concerns and fears at face value. Careful research can often resolve what at first blush appear to be insurmountable barriers.

Currently, the PHIN has enlisted two medical plans, two laboratories and 10 physician practices to conduct pilot testing of the system later this summer. We will continue to document progress in the ***PRHI Executive Summary***.

To become involved in PRHI's Chronic Disease program, please contact Rebecca Smith, rsmith@prhi.org.

Updating data registry

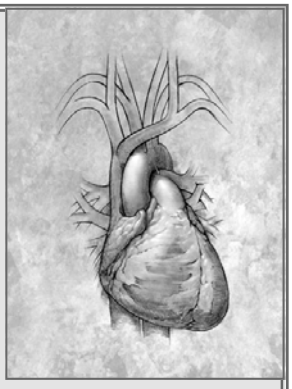
Cardiac Registry undergoes "Spring Cleaning"

The concept of PRHI Cardiac Working Group (CWG) started when local clinical leaders agreed that a group patterned after the Northern New England Cardiovascular Disease Study Group would provide a way to significantly improve cardiac care in the region. The bricks and mortar of the CWG began to take shape in the design of a regional cardiac registry in March of 2001 when dedicated data coordinators and clinicians continued one important meeting in total darkness, during a power failure. These partners continued to meet until the design of the first registry was finalized in December of 2001.

The use of Version 1.0 of the registry prompted more discussion and clarification of the design of registry fields. Many of these discussions were led by the data coordinators from each of the teams, who are at the front lines of the data collection conflicts. The April 2002 Cardiac Forum addressed the regional structure and collection conflicts, and Version 2.0 emerged by consensus. Discussion at that forum made it clear that even though 60% of the partner facilities belong to the Society of Thoracic Surgeons (STS), coordinators of the largest cardiac surgery database, there was variation in the way questions were answered. This resulted in the first "spring cleaning" of the

Date changed!

PRHI Cardiac Forum
July 7, 2004



Due to a scheduling conflict, our host requires the date of the Cardiac Forum to be CHANGED from June 23rd to Wednesday, July 7, 2004. We are sorry for the inconvenience.

Cardiac Forum VI

Regional Improvements in CABG Surgery

Specific topics to be announced

When: Wednesday, July 7, 2004, Registration 5:30 PM,Forum 6:00 – 8:00 PM

Where: Allegheny General Hospital, Magovern Conference Center, 1st Floor, South Tower
320 East North Avenue, Pittsburgh, PA 15212

Who: Cardiothoracic surgeons, cardiologists, anesthesiologists, nurses, perfusionists, data analysts, cardiac program administrators and Cardiac Working Group members. Please share This Invitation with Your Team Members

PURPOSE

The Cardiac Working Group exists to develop and exchange information concerning the evaluation and treatment of patients with heart disease in the six county area of Southwestern Pennsylvania. It is a voluntary, multi-disciplinary group of clinicians, data analysts, and health care research personnel who seek to constantly improve the quality, safety, and effectiveness, of cardiac care.

PRINCIPLES

- ✧ The goal is pure, simple and unambiguous – improve patient care continuously.
- ✧ The forum in which we work is safe, institution-neutral, and open to all. Trust is essential.
- ✧ Our effort is driven by learning not by judgment.
- ✧ Data and information comprise the foundation of our learning, clinical experiments and decisions.
- ✧ There is an obligation to make improvement knowledge, common knowledge among health care professionals.

RSVP: Dennis Schilling, PharmD, Pittsburgh Regional Healthcare Initiative
PHONE: (412) 535-0292 X 116
FAX: (412) 535-0295
E-MAIL: dschilling@prhi.org

PRHI Cardiac Registry.

On Tuesday May 25, 12 data coordinators joined a conference call to do this year's spring cleaning and develop Version 3.0 of the PRHI Cardiac Registry. When IS the last PreOp hematocrit? Why hasn't our definition of unstable angina kept pace with the current standard of care? Aren't the differences between STS and PRHI definitions around antiplatelet drugs confusing? Which make more sense? These and other questions were discussed in a very fruitful call. Of the existing fields 8 were discussed or clarified, 6 were deleted, and one was sufficiently changed that it constituted a new field addition.

"This was a powerful effort to keep our regional registry vital and reflective of the needs of our community", said Dennis Schilling, PRHI Clinical Coordinator. "These partners are what make our region a learning center that others can only dream of."

These discussions will be codified and distributed to the teams for a comment period before the final Version 3.0 goes into effect for those patients undergoing isolated coronary artery bypass graft surgery who were discharged on or after July 1, 2004. Additional copies of the approved dataset will be distributed at the cardiac forum scheduled for July 7th at Allegheny General Hospital.

**CEUs and/or CMEs offered. For further information or to enroll, call Patience Calendar, 412-535-0292, ext. 100*

Calendar, July 2004

Please check www.prhi.org before the meetings to double-check times and places.

Monday, July 5	Chronic Care Working Group, Centre City Tower Conference Center, 5th floor – Montour Room	5-7 pm
Tuesday, July 6	Infection Control Action Group PRHI Offices, Centre City Tower, 21st floor	8-10 am
Wednesday, July 7	***Spring 2004 Cardiac Forum*** Allegheny General Hospital, Magovern Conference Ctr	5:50-8 pm
Tuesday, July 13	Medication Action Group, PRHI Offices	3-4:30 pm
	Obstetrical Working Group, PRHI Offices	5:30—7p

Contact Us

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