Pittsburgh Regional Healthcare Initiative

PRHI Executive Summary

May 2002

Department of Health and Human Services

National Regulatory Review Commission hears testimony

Pittsburgh was one of several cities across the nation where testimony was taken by the Department of Health and Human Services (HHS) Regulatory Review Commission. HHS Secretary Tommy Thompson charged the Commission with recommending ways to reduce the burden that ineffective or harmful regulations place in the way of high quality health care. The Commission is chaired by distinguished Mayo Clinic physician, Dr. Douglas L. Wood.

At the April 17 hearing, PRHI Director Ken Segel outlined PRHI's framework for change, stressing our conviction that while many regulations are sound, the crushing burden of "top down" regulations can inhibit performance by our healthcare institutions. In fact, they have produced significant stress and rigidity in the system.

Segel cited an example of enormous waste rooted in the requirement that patients be discharged and readmitted when moving from a med-surg unit to rehab, even within the same hospital. The regulation requires all medications to be returned to the pharmacy, restocked and then reissued. Setting new regulations requires a much closer connection between policy makers and the point of care. Waivers should be available for regulations deemed wasteful. Segel invited commission members to become members of the Help Chain, connected to the point of patient care at PRHI's four hospital Learning Lines.

Also on the docket was a panel from the UPMC Health System, including PRHI Leadership Obligation Group member, Elizabeth Concordia. She testified about the burden of wasteful, redundant reviews by dozens of outside regulatory authorities. These reviews cost a surprising amount of clinical and administrative staff time in preparation and participation—time taken away from patient care.

UPMC Southside Pharmacy Learning Line "The Un-Batching Experiment"

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Clinical Initiatives

PHC4 cardiac report confirms SWPA progress

The release of "Pennsylvania's Guide to Coronary Artery Bypass Graft Surgery" is a milestone. Pennsylvania is unique. It is the only state where hospitals are mandated to collect patient data through the Pennsylvania Health Care Cost Containment Council. The Health Council's report details information about the number of cases, in-hospital and 30-day mortality, length of stay, readmissions and cost. It lists information by doctor and by hospital. And it shows the mortality rate declining—most of all in Southwestern Pennsylvania.

Another milestone was the media coverage of the report (*Death rate following heart bypass surgery declines in state*, by Christopher Snowbeck, May 8), because it presumes that consumers and their care providers will use the

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Secretary O'Neill joins Feinstein at Catholic Health East

The theme of the Catholic Health East 2002 Management Conference in Washington, DC, was *Synergy, Strategy, Spirit: Leading from Within*. On May 6 two prominent speakers addressed the group on the topic of PRHI: Treasury Secretary, Paul O'Neill, and PRHI Chair, Karen Wolk Feinstein, PhD. Mr. O'Neill spoke about: "Collaboration With Passion: the Strategic Partnership of Providers, the Community and Patients." Dr. Feinstein's topic was: "A Community Gets Together: the Story of Pittsburgh."

Inside . . .

Perfecting Patient Care

Vickie Pisowicz
412.594.2589
pisowicz@jhf.org

The *Perfecting Patient Care System* supports the testing and implementation of a system-based approach to healthcare management, drawn from the Toyota Production System (TPS) and Alcoa Business System.

UPMC Southside Pharmacy Learning Line: The Un-Batching Experiment

"It's a matter of learning to look at work differently," says Kelley Wasicek, Manager, Pharmaceutical Services, UPMC South Side, about the Perfecting Patient Care (PPC) Learning Line in her unit. "Often it seems counterintuitive."

One of the most difficult and fundamentally different ways of looking at work is as a patient-focused "pull" system. Ordinarily, work is a series of tasks and demands placed upon workers by supervisors or others on up the chain of command. This system relies on "Push"—push on the worker to produce, and push on the product to the customer, often regardless of whether the customer has a need for it.

An Example of Push

The pharmacy's method of unit dose batching was a good example of a "push" system in action. The pharmacy filled, checked and delivered all its intravenous (IV) orders up to 48 hours in advance and "pushed" them out. The problem was that, in that amount of time, patients were transferred or discharged, medication orders changed. The pharmacists had prepared medication to meet a need that, for one reason or another, no longer existed. Having numerous extra doses on the floor increased the chance for medication error. And in the end, every a large percentage of the IV medication came right back to the pharmacy, where they required time-consuming restocking and crediting.

"We basically prepared all these IV's and took them out for a walk," said Wasicek.

Moving Closer to the Ideal

Pharmacy staff wanted to move closer to a system where their work would be "pulled" by their clients, the nurses (and ultimately, of course, the patients). Stated as the *Ideal*, the patient "pulls" from the system what is needed in a way that is defect-free, one by one, with no waste, immediately, in an environment that is physically, emotionally and professionally safe. Only what was needed was prepared, reducing the potential for error and waste.

To move their system closer to the ideal, two years ago the pharmacists examined their batching process and halved the advance time, from 3 days to 32 hours. Shortening the lead-time led to a reduction in IV returns, to 25- 39%. Still, pharmacy technicians wasted hours preparing and restocking IVs that were ultimately returned.

Wasicek and her team decided to experiment with shorter IV fill intervals. Acting on a main tenet of the PPC system, "learning by doing," pharmacy staff began to experiment with the frequency and timing of filling and delivery. They have been able to shorten lead times to between 3 and 15 hours, depending on the scheduled administration time for a particular dose. Fewer than 17% of the IVs are returned .

"The Pharmacy Department is not staffed 24 hours a day, so we have to do some preparation ahead of time," said Wasicek. "And while our system is still not ideal, we are providing meds much closer to 'just in time' and showing some good results."

The batching experiment is beginning to save time—5 minutes here and 5 minutes there. It adds up.

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"We basically prepared all these IV's and took them out for a walk."
—Kelley Wasicek, Manager, Pharmaceutical Services, UPMC South Side

What is an A-3?

It's no mystery. The term A-3 is the name given to 11" by 17" sheets of paper--the size used for this planning device. A-3s are tools derived from the Toyota Production System (TPS). In the Perfecting Patient Care system, A-3s are used to map out problems as they exist, observe the current condition, define what the ideal situation would look like, hypothesize how to get from here to there, and build in tests.

Why do we use them?

A-3s are a disciplined way of examining problems and creating solutions. In TPS, every problem is mapped this way, usually by hand, and used as a springboard for specific actions and measurements of progress. PRHI has adopted the A-3 across all disciplines represented.

Clinical Initiatives

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

Geoff Webster
PRHI Associate Director
412.456.0973
websterchc@stargate.net

PRHI's partnership among clinicians, businesses, hospitals and insurers aims to achieve perfect patient care in six pilot areas* by constructing outcome data that caregivers trust; and supporting collaborative efforts to improve care based on those data.

guide to make intelligent choices about their health care. The public display of data was intended to spur scrutiny, which is believed to be an important driver of improvement. These data are also intended for use by doctors and care teams as motivators and guides to continual quality improvements.

Voluntary Response

In Pittsburgh, we're going several steps further. The Pittsburgh Regional Healthcare Initiative (PRHI) is a voluntary coalition of 40 hospitals, over 300 clinicians, four major health plans, and over 60 employers and community leaders. Southwestern Pennsylvania is the only region in the country where medical practitioners and hospitals have come together—*across competitive lines*—to share sensitive information and learn how to improve care.

It all represents a new and enlightened way of thinking in the region. Systems are admitting to problems, and the region is improving its performance collectively. Administrators, trustees and purchasers are poised to reward hospitals and clinicians who diligently identify and report problems in care delivery and diligently attempt to solve them at their root causes.

Three years ago, PRHI began studying the Health Council data, finding trends and incongruities that warranted discussion. PRHI's regional coalition holds work group meetings in specific clinical areas, one of which is cardiac surgery. Cardiac physicians from competing hospitals and surgical groups mobilized to use the data, and even suggested ways to improve subsequent Health Council reports. In analyzing the data for coronary artery bypass graft surgery in Southwestern Pennsylvania, these physicians found unwarranted variations in patient outcomes. The ability to look at a large number of cases provided insights and opportunities to learn. The ability to collaborate provided a focus on patients and opportunities to improve.

Southwest PA Fares Well in Report

The latest Health Council report confirms the value of this approach. Southwestern Pennsylvania leads the state in patient outcomes from bypass surgery. No hospital and no cardiac surgeon in Southwestern Pennsylvania had a higher-than-expected mortality rate following the surgery. No other region had comparable results. At some hospitals, readmissions following bypass were somewhat higher than expected, but through PRHI, our region now has a coalition in place to analyze and address this and other challenges. No other region has such a powerful means to address problems.

PRHI links with other ambitious reform efforts. One example is the Northern New England Cardiovascular Disease Study Group, which saw its regional bypass mortality rates drop by over 24%. PRHI has hosted two Cardiac Forums, featuring guest speakers from the Northern New England Group. These speakers shared with our region's cardiac health teams four simple strategies that they credit with the improvement—strategies that cardiac surgeons in our region have begun to adopt: 1) uniform use of low-dose aspirin pre-operatively; 2) control of pulse rate, including use of beta blocking drugs; 3) use of the interior mammary artery as the bypass conduit; and 4) avoidance of diluting the blood too much during surgery.

Link to Infection

Another major PRHI endeavor centers on prevention of hospital-acquired infection in the region's 40 hospitals. Since these infections are the second leading cause of readmission and mortality following bypass surgery, patients will continue to benefit from regional collaboration and learning. PRHI received a $4.8 million grant from the Agency for Healthcare Research and Quality, allowing among other things, the addition of five field managers. These managers will monitor 40 hospitals as they begin reporting medication error and hospital-acquired infection in the same format, to accelerate learning and improvement across the region. Again, Pittsburgh is the first region in the country where such information is being collected and shared in this way.

The Quality Myth

The work of the PRHI coalition, echoed in the most recent Health Council data, is turning one persistent healthcare myth on its head—the myth that says high-quality care is expensive. To the contrary, the best way to wring cost out of the healthcare system is by providing high-quality care for every patient. When the quality and safety of patient care improve, complications, readmissions, prolonged rehabilitation and mortality decrease. The human toll in pain and suffering decreases. Waste and error are removed. Everybody wins.

— Karen Wolk Feinstein, PhD., PRHI Chair

Patient Safety

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

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

AHRQ/PRHI Patient Safety Program

Where we are and where we're going

Over the past six months, with the generous support provided by the Agency for Healthcare Research and Quality (AHRQ), PRHI and its local and national collaborators have been laying the groundwork necessary for achieving our patient safety goals: zero nosocomial infections and zero medication errors region-wide.

On April 15-16, 2002, the full AHRQ/PRHI program team came together for a two-day meeting in Pittsburgh, the third such meeting since the program was initiated in November 2001. Representatives from PRHI, the University of Pittsburgh Schools of Medicine and Pharmacy, Carnegie Mellon University, Centers for Disease Control and Prevention, Purdue University, RAND and U.S. Pharmacopeia met to discuss operational, assessment and communications issues; assign tasks; and coordinate ongoing activities. Nancy Foster, AHRQ program officer, traveled from Washington, DC, to share information about other federally funded programs designed to improve healthcare quality and safety.

Included in these meetings was a half-day of public sessions held on April 15. Over 140 healthcare professionals from our regional hospital partners joined the program team to discuss the program and coordinate institutional participation moving forward.

Fundamental to the AHRQ/PRHI program is the belief that achieving perfect patient care requires more effective learning systems that allow us to capture as much information as possible about how errors evolve and what factors contribute to them, and to share that knowledge as widely as possible to advance measurable, system-wide change.

Progress to date spans all four pillars of the learning system model.

1. A leadership strategy that directly involves leaders of the medical community as champions of change.

- The 30 hospitals that signed agreements to work with the PRHI-AHRQ patient safety program have been assigned to one of five designated regions, and have agreed to work with the PRHI field manager assigned to their region. Ten other hospitals have expressed interest in working with the program.
- A growing network of hospital contacts has been established and will continue to grow. The network includes:
  - Hospital CEOs
  - Hospital site captains
  - Nosocomial Infections Advisory Committee
  - Medication Administration Advisory Committee
  - Five regional Medication Administration Working Groups
- The hospital site captains will act as the program's primary contacts within each hospital and help to coordinate integration of the PRHI field managers into existing hospital quality improvement structures.

2. Uniform and widespread reporting that provides the best, most complete information available about nosocomial infections and medication errors within institutions and across our region.

- 29 hospitals are currently reporting nosocomial infection rates using the NNIS system; 20 hospitals are reporting medication errors using the MedMARx system. All 30 hospitals, and possibly others, are expected to be reporting on both systems by September 2002.
- Currently all hospitals reporting with the MedMARx system are sending their data through PRHI. The CDC is also sending NNIS data to PRHI. By mid-summer 2002, all data will be sent directly to the AHRQ-funded Data Coordinating Center (DCC).
- The DCC has established a rigorous security protocol and data delivery process.
- The format of quarterly data reports has been significantly improved, and collection of feedback on report utility and usefulness will soon be under way.

3. Open, honest, and widespread information sharing through which experimentation and innovation in patient safety are encouraged in institutions and beyond the boundaries of any single organization.

- Improved dissemination and tracking of reports has been under way since April 2002.
- Meetings of the Nosocomial Infections and Medication Administration Advisory Committees occur monthly to review the quarterly data reports and discuss findings. Five regional Medication Administration Working Groups have also been established and will meet regularly.

4. Effective, ongoing problem solving at the point of patient care that leads to improved processes of care and successful medical outcomes.

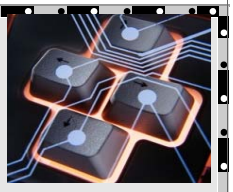
- Five Perfecting Patient Care System (PPC) Learning Lines, based on the Toyota Production System (TPS), are currently operating in five regional hospitals, supported by PRHI's Center for Shared Learning.
- Other hospitals continue to integrate results from the reporting and information sharing described above in their own quality improvement structures.

An important, long-term goal of the program is to demonstrate that a region-wide commitment to perfect patient care will result in broad-based, measurable improvement in patient safety outcomes. By October 2002, we will have collected one year's-worth of data on nosocomial infections and medication errors to serve as a baseline for comparison of future NNIS and MedMARx results.

Also by October 2002, baseline information will be available on participating hospitals' level of patient safety programming, level of implementation of the NNIS and MedMARx systems, and readiness to use reporting data in their hospital's quality improvement structures to reduce infections and medication errors. With this information and other data collected over the next 2-1/2 years, we intend to show that dramatic and sustainable improvements in patient safety are possible on a region-wide basis. Study findings will be disseminated through peer-reviewed journal articles and other publications intended to inform others of our region's success.

—Donna Keyser, PhD, RAND Pittsburgh AHRQ Grant Communications

Center for Biomedical Informatics



Donald A. B. Lindberg Medical Informatics Lecture

Friday, June 28, 2002 — *Biomedical Science Tower, South Wing University of Pittsburgh Conference Center, Room S-100*

The Lindberg Lecture is part of a day-long symposium titled "Information Technology and the Empowered Healthcare Consumer." The symposium is for clinicians, information technology professionals, medical librarians, educators and administrators interested in the role of information technology in modern health care.

Technological innovations have made biomedical information (including the patient's own medical record) available to healthcare consumers. Some have hailed these developments as a new era of empowered consumers. Others are less optimistic.

Featured lecturer is Dr. Patricia Flatley Brennan, Moehlman Bascom Professor of Nursing and Engineering at the University of Wisconsin, Madison. Dr. Brennan is internationally known for her research in patient/consumer informatics. From 1999 to 2001, she served as president of the American Medical Informatics Association.

* * * Registration begins May 20, 2002 * * *

Forms located at ***http://cbmi.upmc.edu***
or contact Joseph Cummings, Coordinator, ***jcumm@cbmi.upmc.edu***
Cost: $30, UPMC faculty/staff; $50 non-UPMC professionals; $20, health professions students/trainees

About the Lindberg Lecture: Established in 1997, the Lindberg Lecture addresses key issues in biomedical informatics and is named for Dr. Donald A. B. Lindberg, who as director pioneered development of advanced information systems at the U.S. National Library of Medicine.

The *Un*-Batching Experiment

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Based on previous observations, the batching experiment could save up to 89 minutes of pharmacist time and 13 hours of tech time per week.

"Now if we can figure out a way to 'batch' the saved time," says Wasicek, "that would seal our success."

Wasicek sees merit in this experiment because, "it's authentic work, not a contrived scenario. We try to engage everyone, including our customer, in the design of the work, then decide what's working and what's not."

Education and Training

Education is key for inquisitive pharmacists. Wasicek points out that the comfort level required for change can only be achieved through a thorough understanding of the principles underlying the PPC system. The pharmacy staff is attending the PPC University sessions, four full days of intensive instruction. Part of the instruction deals with the use of A-3s, the road maps that specify goals and methods. On a practical level, each staff member has an opportunity to work as Team Leader, solving problems in the course of work.

"We are learning the value of a good A-3," says Wasicek. "When you 're not sure what to do, if you have a question or a problem, you can refer to the highly specified design on the A-3."

Instead of supplier-driven "push," the pharmacy staff is experimenting with ways to respond to the "pull" of client need.

PRHI Partner Spotlight

Provider Advisory Council

Anthony, Kenneth
President and CEO
HEALTHSOUTH Rehabilitation Hospital of Sewickley

Bacharach, Paul
President and CEO
Uniontown Hospital

Beck, Raymond
President And Chief Executive Officer
UPMC Passavant

Bensaia, Barbara
President & CEO
Canonsburg General Hospital

Brooks, Daniel
Vice President and Chief Medical Officer
Heritage Valley Health System, Inc.

Calig, Joseph
President and CEO
Allegheny Valley Hospital

Caplan, Marcie
Chief Executive Officer
UPMC Southside

Cibrone, Connie
President & CEO
Allegheny General Hospital

Clark, Douglas
Executive Director
Latrobe Area Hospital

Collins, James
President And Chief Executive Officer
West Penn Hospital

Concordia, Elizabeth
President
UPMC Presbyterian and UPMC Shadyside

Danoff, Sandra
Director, Corporate Planning & Marketing
UPMC Health System

Davis, David
President And Chief Executive Officer
UPMC Lee Regional

Deigan, Faith
Administrator/CEO
HEALTHSOUTH Rehabilitation Hospital of Greater Pittsburgh

DeLisi, Frank
President And Chief Executive Officer
Suburban General Hospital

Dishart, Paul
Director, Medical Education
UPMC St. Margaret

Elish, Herb
Chair
Allegheny General Hospital Board of Trustees

Frazier, Renee
Executive Officer
VHA Pennsylvania

Garone, Marlene
Vice President, Operations
West Penn Hospital

Goertzen, Irma
President And Chief Executive Officer
UPMC Magee-Women's Hospital

Heinike, Jay
President And Chief Executive Officer
UPMC Horizon – Greenville Campus

Hemming, Tom
President
UPMC Rehabilitation Hospital

Holder, Diane
President and Chief Executive Officer
UPMC Western Psychiatric Institute

Jennings, Jan
President and CEO
Jefferson Hospital

Kane, Irene
President And Chief Executive Officer
UPMC Beaver Valley

Khoury, Raymond
President and CEO
St. Francis Health System

Lombardi, Anthony
President and CEO
Monongahela Valley Hospital

Mitry, Norman
President and CEO
Heritage Valley Health System, Inc.

Moreland, Michael
Director
VA Pittsburgh Healthcare System

O'Brien, Charles
President and CEO
West Penn Allegheny Health System

Orme, Clifford
President and CEO
Lifecare Hospitals of Pittsburgh, Inc.

Ott, Ronald
President & CEO
UPMC McKeesport

Oxendale, Roger
Chief Operating Officer
Children's Hospital of Pittsburgh

Peluso, Joseph
President and CEO
Westmoreland Regional Hospital

Priselac, Margaret
President
UPMC Braddock

Provenzano, William
President
Ohio Valley General Hospital

Rawson, Ian
President
Hospital Council of Western Pennsylvania

Romoff, Jeffrey
President
UPMC Health System

Roth, Loren
Professor, Vice Chairman, and Chief of Clinical Services
UPMC

Sacco, C. Daniel
Vice President, Planning & Managed Care
West Penn Allegheny Health System

Senker, Thomas
President & CEO
Forbes Regional Hospital

Sirio, Carl
Associate Professor
University of Pittsburgh School of Medicine

Snead, Benjamin
President & CEO
St. Clair Hospital

Sobehart, Richard
Chief Executive Officer
UPMC St. Margaret

Stewart, Joseph
President and CEO
Butler Health System

Thomas, Telford
CEO
Washington Hospital

VanDyke, Walter
Executive Director
Heritage Valley Medical Center

Violi, Ronald
Chairman and Chief Executive Officer
Children's Hospital of Pittsburgh

Wilson,John
President and Chief Executive Officer
The Children's Institute

Zanotti,Marie
COO and Executive Director
Sewickley Valley Hospital

Zoller,Greg
President and Chief Operating Officer
Pittsburgh Mercy Health System

Zwigart,Donna
Chief Executive Officer
St. Francis Medical Center

Progress Report



PRHI Partner	Bloodstream Infect'n Data 4th qtr 2001	Bloodstream Infect'n Data 1st qtr 2002	MRSA* 1st qtr 2002	MedMARx Contract?	MedMARx System in use?
Aliquippa Community Hospital	*NEW PARTICIPANT*				
Butler Memorial Hospital*					
Children's Hospital of Pittsburgh	✓			✓	✓
Children's Institute					
Greene County Memorial Hospital	*NEW PARTICIPANT*				
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	✓			✓	✓
Jefferson Regional Medical Center	✓			✓	✓
St. Clair Memorial Hospital*	✓				
St. Francis Health System	✓			✓	✓
Uniontown Hospital	✓			✓	✓
UPMC Health System					
Bedford Memorial	✓			✓	
Braddock	✓				✓
Franklin	*NEW PARTICIPANT*			✓	
Horizon	✓			✓	✓

PRHI Partner	Bloodstream Infect'n Data 4th qtr 2001	Bloodstream Infect'n Data 1st qtr 2002	MRSA* Data 1st qtr 2002	MedMARx Contract?	MedMARx System in use?
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	✓	✓
Washington Hospital	*NEW PARTICIPANT*				
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	✓			✓	✓

* *Collaborating w/ national VHA Patient Safety Initiatives*

✓ *Fulfilled* ◐ *In progress*

Calendar at a glance, May 2002*

Tony Kelly, Administrative Coordinator
412.594.2567, *kellyj@jhf.org*

Tuesday, June 4	Infection Control Advisory Committee	8 am
Wednesday, June 5	Diabetes Working Group	6-8 pm
Tuesday, June 11	Medication Administration Advisory Committee	3—4:30 pm
	Perfecting Patient Care (TPS) Information Session**	6—9 pm
Wednesday, June 12	Go-and-see (*Gemba*) session** The Western Pennsylvania Hospital	8 am-noon
Thursday, June 20	Buying Healthcare Value Committee	2:30-4 pm
	Clinical Advisory Committee Magee Women's Hospital	6-9 pm

*all meetings at JHF offices unless otherwise noted
**Call Helen Adamasko at 412-594-2581

Contact Information

Karen Wolk Feinstein, PhD
PRHI Chair
412.594.2555
feinstein@jhf.org

Ken Segel
PRHI Director
412.594.2558
segel@jhf.org

Naida Grunden
Communications Director
412.594.2572 *grunden@jhf.org*

PRHI Executive Summary is also posted monthly at ***www.prhi.org***

Please direct inquiries to:

The *American Hospital Association Newsletter* features article on PRHI in May 13 online issue.

Go to:

http://www.ahanews.com/asp/news.asp?i=17240

Pittsburgh Regional Healthcare Initiative
650 Smithfield Street, Suite 2330
Pittsburgh, PA 15222

www.prhi.org