

Cardiac Working Group in the spotlight

When cardiac surgeons began collaborating in 2000, they initially doubted state data that showed variations in outcomes for their patients. Today, using their own regional data, the surgeons and their teams are using it to provide better care for every patient. Their professional commitment is saving lives and money.

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In 2000, a group of cardiothoracic surgeons from competing centers, under the auspices of PRHI, inaugurated the PRHI Cardiac Working Group (CWG). Today, CWG participants from 10 cardiothoracic surgery programs include surgeons, cardiologists and their teams working together to determine and implement best practices in coronary care. In addition to maintaining a regional Cardiac Registry, the CWG holds biannual Cardiac Forums and conducts topical working groups.

Getting started

The CWG initially focused on coronary artery bypass graft surgery (CABG). In 2000, at PRHI's request, the Pennsylvania Health Care Cost Containment Council (PHC4) prepared a report on

CABG outcomes and readmission data in the Pittsburgh region. Readmission data provided particular insight.

A typical hospital in metropolitan Pittsburgh might show that about 5% of post-CABG patients were readmitted to that hospital. However, because PHC4 tracks patients across all institutions in the Commonwealth, something few states do, the report showed that rural patients were most often being readmitted to their local hospitals. Actual readmission rates hovered closer to 20%, with postoperative infections the most common reason.

Using these data, physicians began to realize that they and their teams had an opportunity to

Continued, page 4

CWG Cardiac Registry shows gender disparities

Women and cardiac surgery

Every year, about 250,000 American women die as a result of coronary artery disease, making it the nation's leading cause of death among women. While advances in coronary artery bypass graft (CABG) surgery have lowered mortality rates among men, several studies show that the rates for women remain twice as high.

Yet questions recur: is the mortality rate among women really higher, or do other factors explain the disparity? If the mortality rate is indeed higher, is it because women are sicker when they come in

for treatment, because they are smaller and the surgery more difficult, or for other reasons? And most important, what can be done about it?

Dueling studies cloud the issue

Writing for the Society of Cardiovascular Anesthesiologists, Kamel Patel, MD and Mark Chaney, MD¹ list three national registries that show far higher operative mortality for women: the Coronary Artery Surgery Study (CASS) Registry, showing 2.5% for men, 5.3% for women; the Society of Thoracic Surgeons National Cardiac

Patel, Komal, and Chaney, Mark A, "Do women fare worse than men following cardiac surgery?" *J Soc Cardiovasc Anesth*, Feb 2006.

Continued, page 8



Physician Champion Profile: Michael Culig, M.D.

Improving transfers and improving care

Patients often “travel” from unit to unit during a hospital stay. Cardiothoracic surgeon Michael Culig wondered whether each transfer could be handled in an ideal way, with seamless care and safety for every patient. Awarded a Physician Champion grant to investigate this question, Dr. Culig has found a way to make improvements using Perfecting Patient Care™ principles.

When a patient is admitted to a hospital for coronary artery bypass graft (CABG) surgery, he or she begins a multi-stop tour through the hospital system. Some hospital designers have wondered why the patient—the person in need of care—doesn't remain in one place while all

services come to him or her. Instead, the patient “travels” from the medical unit to the pre-surgery area to surgery to the intensive care unit (ICU) to the intermediate step-down unit and finally, home.

During any one of these hand-offs between units, confused

information and inconsistent processes can place patients at increased risk of error. In his Physician Champion project, Michael H. Culig, M.D., a cardiothoracic surgeon and long-time PRHI supporter, wanted to apply Perfecting Patient Care™ methods to ensure smoother transfers of post-surgical patients to the ICU, thus minimizing the time they are under sedation or on ventilation to improve outcomes and reduce complications.

“Why can't we?”

Application of the Perfecting Patient Care™ System begins with the question, “Why can't we?” This question challenges participants to work toward an ideal condition or state, removing the barriers to improvement. In the case of post-surgical care for cardiac patients, a “perfect transfer” might feature:

- Perfect communication between all nursing units and the OR would ensure that every patient arrives at the OR on time, in perfect condition, with the pre-operative antibiotic administered.
- Every patient would have a perfect transfer to ICU.
- Every patient would have a perfect transfer from ICU to the intermediate step-down unit.
- Follow-up interviews would confirm that all had perfect discharges.

For example, on transfer from surgery (photo, p.3) to the ICU, patients often arrived with tangled IV lines (top photo, this page). The question was, “Why can't we ensure that every patient arrives in the ICU with perfect lines?” Answering the question and untangling the lines involved working with everyone in the work pathway—from surgery, transport, and ICU—to find a way to solve the problem.

Now, keeping lines untangled has become part of a surgical checklist. IV lines are organized toward the end of the operation and set up so that when the patient arrives in the ICU, confusion, effort and time are reduced. Initially, the ICU nurses were very gratified, and all on the team came to recognize the importance of the work. RN time spent fixing the IV lines on transfer went from 25 minutes to 5, reducing the “hassle factor” for the nurses, but more important, making it much safer for patients.

Why small improvements are important

“When things go wrong, confusion over the lines can be one of those things in a cascade of events that leads to catastrophe,” says Culig. “Having quick, easy access to the correct line—that single improvement—can keep a cascade of error from unfolding. When we systematically eliminate



Problem: patient arrives in ICU with tangled IV lines. RNs must spend 25 minutes to untangle them. The confusion poses risk for patients. “Having quick, easy access to the correct line—that single improvement—can keep a cascade of error from unfolding,” says Michael Culig, MD.



Creating a picture of the ideal situation involved use of a mannequin and a “Swan Pillow.” The work continues on process improvement with every transfer.



each part of a complex problem, we create a much safer environment for patients.”

The problem of tangled lines was initially tackled in 2003. However, maintaining the progress proved difficult. Employee turnover diluted collective understanding of the problem. Through the Physician Champion program, Dr. Culig hopes physician leadership will help create “a culture in the OR and each nursing unit where enough individuals understand the power of work redesign that they will develop their own responses, so they have ownership, and it won’t be something imposed from outside.”

Teamwork : OR to ICU

Work continues on the crucial transfer from the OR to the ICU. One experiment has involved specifying Physicians Assistants (PAs) as transfer experts who

oversee every aspect of a patient’s transfer. Initial results with this approach are promising. Work continues on ways to trigger PA involvement.

Other factors can create a less-than-perfect transfer. The group has discovered that the transfer of a patient to the intermediate step-down unit comes with a potential for medication error. Changes made in the regimen while the patient is in ICU being readied for transfer can create problems in the intermediate step-down unit. Again applying principles of Perfecting Patient Care, communication between the ICU and step-down unit continues to improve, along with patient safety.

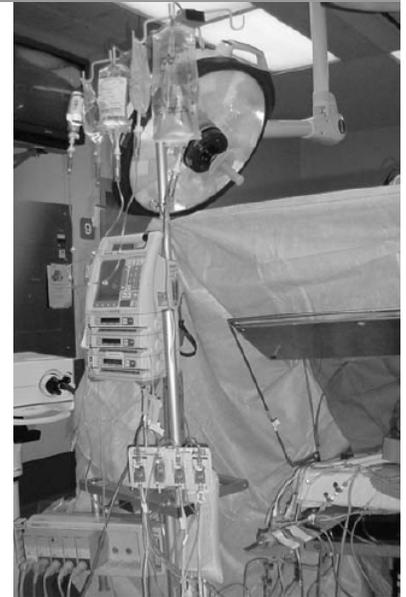
Dr. Culig believed that confusion at discharge led some patients to be readmitted or have less-than-perfect outcomes. He hired a nurse to call patients the day after they

went home and do a medication reconciliation with the patient, comparing what had been ordered in the hospital to what the patient was taking.

“There was a lot of confusion,” said Dr. Culig. “In many cases, medications had not been ordered or were not being taken.”

Patients are now given office visits 1-2 weeks after discharge, instead of the usual 5-6 weeks. These visits are helping to reconcile additional medication problems and confusion. Some small infections were caught early, preventing potential readmission.

Work redesign is difficult. The concept, however, is simple. Says Dr. Culig, “When handoffs are smoother, patients will have better outcomes.”



Lines are orderly in the surgical suite. New post-surgical checklist creates an orderly process for patient transfer to the ICU.

Work redesign is difficult, but the concept is simple.

“When handoffs are smoother, patients will have better outcomes.”

—Michael Culig, M.D.

Physician Champion profile: Michael Culig, M.D.

Michael H. Culig, MD is Vice-Chief, Division of Cardiac Surgery at Western Pennsylvania Hospital where he has been attending staff since 1990. He is also Chairman of the Cardiac Working Group Advisory Board and Medical Director for the PRHI Gender/Hematocrit Project. Dr. Culig is a Physician Champion, one of eight regional physicians funded to apply PRHI’s Perfecting Patient Care™ (PPC) principles to improve practice through evidence-based research.

Dr. Culig graduated from Harvard University in 1978 and from Harvard Medical School in 1982. He completed his general surgery residency at Mercy Hospital, Pittsburgh and his thoracic surgery residency at Parkland Hospital, Dallas, Texas. Dr. Culig is certified by the American Board of Thoracic Surgery and the American Board of Surgery. He is also the American Director of Project Coronary in Lviv, Western Ukraine; and serves as President of Pittsburgh Cardiovascular Aid International. He also co-chairs the PRHI Cardiac Working Group.

*From Page 1***Cardiac Working Group in the spotlight**

The performance bars tend to be higher in Pittsburgh because overall the region performs better than the national averages.

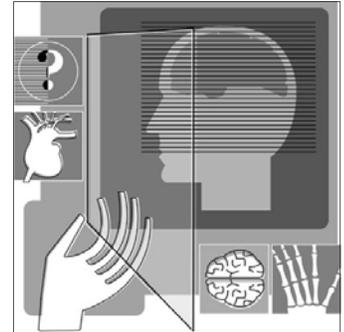
improve care and reduce cost. A cardiac data registry, like that in Northern New England (NNE) made sense (see box).

Data collection begins

Cardiac surgery units signed on and began collecting data on the four processes of care recommended by NNE in 2002. This simple beginning led to the creation of the PRHI Cardiac Registry, which currently tracks over 90 process and outcome variables on CABG surgeries, and has data on more than 10,000 cases from 10 of the region's 13 cardiac surgery units. Data

collection is designed not to be onerous, but rather to be part of what the surgical team already does.

"The hospitals collect predefined patient information in a common format," says Karyl Troup-Leasure, PhD, of PRHI Analytics. "The information PRHI receives, as a neutral party, is blinded for confidentiality before it ever arrives. It allows institutions to share information with confidence."

Advantages of a local consortium and registry

The CWG Cardiac Registry serves as a resource for tracking regional and individual facility performance and identifying best practices. PRHI Cardiac Registry reports and Cardiac Forums provide coronary teams with a way to

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CWG and Registry: A little history

In the 1990s, a group of cardiovascular surgeons in New England discovered that following four simple, inexpensive care processes—the cost of which was less than \$3—reduced the risk of post-surgical death by up to 25%. The group, which became the lauded Northern New England Cardiovascular Study Group (NNE), found that tracking data on coronary artery bypass graft (CABG) surgery in a common format through a registry allowed surgeons and their teams to learn together. Collective data came from thousands of cases across the six-hospital consortium each year, instead of the hundreds an individual surgeon might see. The registry accelerated learning, unlocking not only the “what” but the “why” of certain processes and outcomes. Pittsburgh adopted the NNE model in 2000, and these processes are now recommended by the Society of Thoracic Surgeons (STS).

The four processes are:

- 1. Encourage pre-operative aspirin use. Make sure patients remain on low-dose aspirin to within five days of surgery.*
- 2. Adequately control heart rate, through use of beta blockers. Patients with heart rates below 80 beats per minute demonstrate decreased risk of mortality.*
- 3. Use internal mammary artery, when appropriate. Use of the saphenous (leg) veins has been common, but results improve when the mammary artery is used.*
- 4. Minimize dilution of the patient's blood during surgery to prevent anemia. The entire pathway of caregivers can work to reduce unnecessary blood loss and carefully manage the volume of fluids given.*

share data and experiences and develop an awareness of what works best.

The Society of Thoracic Surgeons (STS) keeps a valuable national database that marks trends in coronary care across the country. The PRHI Cardiac Registry enables the region to compare itself to national benchmarks. However, a local consortium and regional registry have several important, additional advantages.

A regional registry supports the development of regional risk models for outcomes. While STS supports benchmarking with

national performance levels, it does not indicate how a region's hospitals compare to one other. In fact, the high standard of care in the Pittsburgh region results in risk adjustment models that are typically more stringent than the STS national models. In other words, the performance bars tend to be higher in Pittsburgh because overall the region performs better than the national averages.

- The PRHI Cardiac Registry can turn out analyses far faster than a national organization. The closer such feedback is to "real-time," the more

actionable it is.

- If a facility or the region needs to look at a trend, problem, or improvement, PRHI can conduct an *ad hoc* query regionally or by facility. PRHI's Analytics can turn such a request around in a few days. If the data indicate a noteworthy trend, the CWG can quickly convene experts from across the region to discuss it.
- If the surgeons decide to delve deeply into one area of interest—such as perfusion—they can choose to add variables to the database that will allow them to



To register, contact Diasmer Bloe,
bloe@jhf.org * 412-594-2584

Healthcare Acquired Infections TECHNOLOGY FORUM

In depth
presentations by:
Cereplex
MedMined
TheraDoc
Vecna

Monday
June 26, 2006

Omni William Penn Hotel
Pittsburgh, Pennsylvania
8:00 am – 3:30 pm

This forum will inform regional hospitals of current infection surveillance technologies, provide unbiased information regarding these products, and facilitate the purchasing decision making. Learn how these products can help improve your efficiency, reporting and bottom line. Inviting the participation of infection control practitioners, infectious disease specialists, information technology patient safety officers, chief financial officers and chief executive officers seeking technologies that help reduce healthcare-acquired infections, improve work flow and meet reporting demands.

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From Page 4**Cardiac Working Group in the spotlight**

look at those processes in depth, beginning immediately.

- National registries risk-adjust based on a large, general population. The PRHI Cardiac Registry has developed its own risk adjustment based on the patients of Southwestern Pennsylvania. The information is more useful when it is specific to the population served.
- CWG facilities can be compared by region, by group (urban vs. rural, for example), or by facility. These local refinements make the data much more useful.

PRHI issues periodic updates to the Registry, as well as individual facility reports. PRHI staff members, Peter Perreiah and Karyl Troup-Leasure often meet with CWG members at individual facilities. This one-on-one support helps members to understand the data, what it reveals, and where improvement is possible.

Cardiac Forums

The Registry also creates an opportunity for surgical teams to meet and discuss best practices. The Cardiac Forums have grown from local data-sharing experiences to national events. Famed cardiologist, Blase Carabello of Baylor University and the Houston Veterans Administration Hospital, addressed a well attended Cardiac Forum in January 2006, in response to CWG partners' interest in valve surgery. For the upcoming September Forum, renowned cardiovascular

anesthesiologist, Nancy Nussmeier, will address the Cardiac Working Group on gender-related outcomes. This topic arose out of new data from the CWG Cardiac Registry highlighting outcome disparities by gender in CABG surgery.

The Registry and the Forums also offer the opportunity for surgeons to hold one another accountable to apply best practices. In 2005, a group of cardiac surgeons from competing institutions met for the first annual regional morbidity and mortality conference, discussing among themselves, for the purpose of learning, every death from cardiac surgery that occurred in the prior year.

What is being learned

The PRHI Cardiac Registry links improvements in the processes of care to better patient outcomes. Now with data on more than 10,000 cases, the Cardiac Registry continues to monitor the four factors identified by STS to improve outcomes: 1) the adequate use of pre-operative beta blockers; 2) pre-operative aspirin; 3) anemia due to blood dilution during surgery; and 4) the use of the internal mammary artery as a harvest site.

Current analyses of 2002-2004 regional Registry variables reveal that pre-operative beta-blocker use increased by 4% and pre-operative appropriate aspirin or other anti-platelet use increased about 2%. The CWG has set an aggressive agenda for the complicated problem of



Every caregiver in the pathway has a role to play in improving patient outcomes following cardiac surgery.

improving practices to prevent anemia throughout cardiac surgery care.

The increasing use of coated stents and other cardiology procedures has shifted the mix of patients coming in for surgery in the region. 'Elective' CABG surgeries, for example, have declined from over 60% of cases to under 40%, while 'urgent' CABG cases have increased from about 35% to about 50% of cases. Urgent and emergent cases tend to be more difficult.

Process improvement strategies, such as the Perfecting Patient Care™ System that PRHI offers, can further enhance and accelerate the application of known best practices (see article, page 2).

2006 Agenda

The PRHI CWG has set an aggressive agenda for the rest of this year and into 2007.

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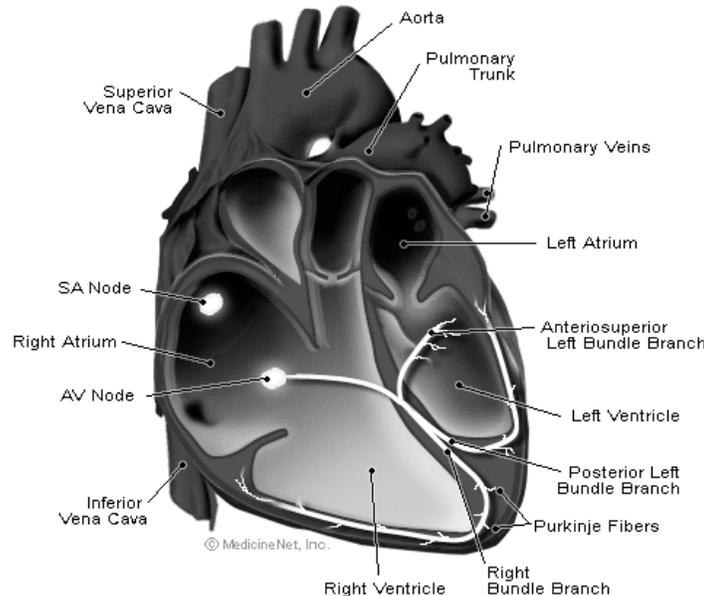
Areas include:

Closing the gender gap. Data on current practices show that the typical female patient at about 1.8 times the male risk of in-hospital death or serious complication. Moreover, conservative estimates from the 10 CWG hospitals suggest that annually 232 in-hospital deaths or complications could be avoided with cost savings totaling about \$4.6 million. By engaging the entire team of clinicians that give care before, during and after cardiac surgery to apply the best practices already known, the CWG expects to narrow the gender gap on outcomes. (See article, page 1.)

Valves and stents. The CWG is enthusiastically expanding its impact to other areas of coronary care, including valve surgery, combination CABG/valve surgery and percutaneous coronary interventions (PCI), commonly called stents.

In fact, the number of CABG surgeries over the last five years has leveled off, due in large part to the increased use of coated (drug-eluting) stents. This change in practice presents further opportunity for collaboration, and the CWG is now organizing area hospitals and cardiology teams to launch a registry on PCI.

Because so many more PCIs than CABGs are now performed, participants believe that the PCI registry will identify actionable findings within the first 18 months. This will enable the



Areas of inquiry include reducing gender disparity, learning quickly from the data about processes involving valves and stents (PCIs), and reducing the incidence of new-onset, postoperative atrial fibrillation.

region's coronary care teams to make more informed practice decisions, improve outcomes and decrease costs.

Atrial fibrillation. "Postoperative new-onset atrial fibrillation (PAF) remains the most common and vexing problem confronting cardiac surgeons. It afflicts as many as 40% of patients undergoing coronary and valve surgery and has been refractory to many attempted methods of prevention, both pharmacologic and nonpharmacologic."¹

PRHI's CWG is studying the causes, prevention, and treatment of this post-operative complication, in which an electrical "storm" causes the upper chambers of the patient's heart, the atria, to quiver or fibrillate 300 to 600 times per

minute. Although nationally, between 30-40% of patients may experience atrial fibrillation, in Pittsburgh, only about 20% do.

Yet, as in other areas where the region seems to be performing relatively well, physicians and surgical team members now wonder whether they can further substantially reduce the incidence of atrial fibrillation. As they learn from one another in the coming months, further improvement is anticipated.

For more information

If you are interested in learning more about PRHI's Cardiac Registry or Cardiac Forum, please contact Dr. Troup-Leasure at ktroup@prhi.org, or 412-586-6716.

Increased use of coated stents and other procedures has increased the acuity of patients coming in for CABG surgery. 'Elective' CABG surgeries have declined from over 60% of cases to under 40%, while 'urgent' cases have increased from 35% to 50% of cases.

¹ Saltman, Adam E., "New-onset postoperative atrial fibrillation: A riddle wrapped in a mystery inside an enigma." *J Thorac Cardiovasc Surg* 2004;127:311-313

*From Page 1***Women and cardiac surgery**

Surgery Database, of 334,913 patients showing 2.6% for men, 4.5% for women; and the National Cardiovascular Network Database (1993-99), showing that women under 50 were three times more likely than men to die, and to have more serious complications. Yet yet one report, the Bypass Angioplasty Revascularization Investigation (BARI) suggested that 5-year mortality rates for women

and men were comparable, and that in patients who were equally sick, gender was not a risk factor.

“We can risk-adjust away much of the gender differences,” says Peter Perreiah, who leads PRHI’s cardiac work. “However, we are still left with the fact

that women do much worse than men in the CABG surgery process. The question becomes whether we can change the care pathway to better meet the different needs of female patients. Our goal is to provide every patient similar, superior odds for a good surgical outcome.”

Says cardiothoracic surgeon Michael Culig, MD, “We can challenge ourselves to do better with older and sicker patients.”

Women are different

A recent Wall Street Journal article says, “Before they reach their 60’s, women are less likely than men to

develop heart problems, but once the disease does occur, women often fare worse than men.” (In Heart Disease, the Focus Shifts to Women, Wall Street Journal, April 18, 2006.)

Women do seem to arrive for CABG surgery older, with more comorbid conditions like diabetes, and require more urgent or emergency surgeries than men. One study showed that more than 97% of the excess deaths occurred in women with diabetes, or who had emergency surgery.

Women are less likely than men to have undergone cardiac testing before their first heart attack, leading some researchers to wonder why women are not being identified sooner. A study begun in 1996 by the Women’s Ischemia Syndrome Evaluation (WISE), followed 936 women who had angiograms due to chest pain. In men with such symptoms, occluded coronary arteries would have shown up 75% of the time: with the women, it was only about 33%. The study suggests that microvascular heart disease may be more prevalent in women, a disease in which tiny vessels around the heart, too small to be detected by traditional angiography, become occluded and cause ischemia, or lack of oxygen to the heart.

The surgery is different

CABG surgery itself is trickier in women, because their coronary arteries are small. Data also suggest underuse of the preferred thoracic artery grafts in women. Women are more likely to have bleeding, anemia, and infections. Most equipment created for cardiac surgery is made for the average-sized patient, which is

larger than the averaged-sized woman.

For example, CABG surgery still largely relies on the use of the heart-lung bypass machine, most of which are still geared toward the average-sized patient, a man. Avoiding blood dilution while the patient is on the machine is an important indicator of how well the patient will recover (see “Cardiac Forum highlights role of perfusionist,” PRHI Executive Summary, October 2003). Some surgeons avoid use of the machine altogether, an “off-pump” procedure. Writing in the Journal of the Society of Cardiothoracic Anesthesiologists’ February 2006 edition, Nancy Nussmeier, MD, cites studies that show “lower in-hospital mortality in women who underwent off-pump surgical revascularization than in women treated with on-pump surgery.” (Nussmeier, Clinical Professor at the Texas Heart Institute, will keynote PRHI’s Cardiac Forum in September. See page 7.) However, studies conflict on this point as well.

PRHI Cardiac Registry may help untangle the mystery

Because of the large number of cases in our region, the PRHI Cardiac Registry is in a position to help add to the national understanding of gender differences. Of particular interest to the surgical teams in Southwest Pennsylvania are three guidelines already endorsed by the Society of Thoracic Surgeons:

- Use of the internal mammary artery—a thoracic artery, rather than a leg vein—as a graft vessel. Nussmeier notes that the benefit is especially great for women, because these

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grafts do not occlude as easily as veins.

- Tight control of blood glucose levels before, during and after surgery. (See “Can controlling blood glucose reduce post-surgical infections?”, PRHI Executive Summary, June 2005.) Controlling blood glucose, even among patients who are not diabetic, helps

reduce post-surgical infection rates and other complications.

- Tight control of hematocrit levels, avoiding blood dilution while a patient is on the bypass pump.

Nussmeier also calls for investigation into rates of participation in post-operative cardiac rehabilitation programs

and how they relate to readmission rates.

“We can control the processes of care during surgery and hospitalization,” said Michael Culig, MD, a cardiothoracic surgeon long affiliated with the PRHI work. “Tracking those processes across the region can only help us as we work to close the gap for our women patients.”

Working Hearts, making a difference in Pittsburgh

One out of every three women in the United States was affected by heart disease and yet when you asked them to name their greatest health risk they could not. Unwilling to accept this statistic, the Jewish Healthcare Foundation provided seed funding to launch Working Hearts® in 2002.

Working Hearts® grew quickly to become a coalition of more than 70 community organizations dedicated to the credo “Strong Women/Strong Hearts.”

The plan was to get women to know their numbers (body mass index—BMI, cholesterol, glucose, blood pressure) and realize that making incremental changes in their lifestyles could greatly affect their risk for developing heart disease.

Building on success, Working Hearts® expanded its mission in 2005 to address the needs of working-age men and women. An informed employee can be a “well” employee.

May Community Challenge

Begun in 2005, the Working Hearts® May Community Challenge successfully engaged more than 30 teams in the community in activities to promote positive change toward better health. Here is just a sample of the responses from our participant survey:

- 86% learned about the May Community Challenge from their workplace
- 90% stated that the suggested activities are on par with their physical abilities
- 93% learned more about the minimum amount of time suggested for daily physical activity
- 89% learned more about daily nutritional recommendations
- 98% learned more about the variety of physical activities available in our community.

Results from the 2006 May Community Challenge will soon be posted on the Working Hearts Website at www.workinghearts.org



Working Hearts Day 2006



Display by Bike Pittsburgh and Venture Outdoors show attendees different ways to get healthy in the great outdoors.



Cholesterol and blood glucose screenings are quick and easy.

From Page 9**Working Hearts, making a difference in Pittsburgh****Other services**

Other events and services available through the Working Hearts Coalition include:

Workinghearts.org: our continually updated website provides helpful information and links to address lifestyle-related health risks.

Working Hearts® Coalition: our network of more than 70 partners regularly takes our message to over 250,000 men and women in our region and provides expert speakers for community and workplace functions.

Working Hearts® Bookmarks: these free, compact educational materials cover

such topics as “Ask the Doctor” and “Top 10 for Reading a Label.”

Working Hearts® Lunch and Learns: staff and Coalition Partners offer educational sessions on heart health where people congregate: in workplaces, at conferences, luncheons, social events, shopping malls, healthcare sites, schools, etc. Sponsored by LHAS of Western PA.

Working Hearts® Speakers Bureau: experts are available, at no cost, on a number of topics related to heart health.

Working Hearts® Leadership Breakfast: an annual, free opportunity to learn about current heart-health issues and network with corporate and community leaders and human

resources professionals. This event kicks off the Working Hearts® Campaign and provides a forum to share strategies that promote heart-healthy work environments.

Working Hearts® Day: an annual, free, open-to-the-public educational experience that includes heart-health screenings and results, consultations, panel discussions, demonstrations and vendor exhibits.

Working Hearts® May Community Challenge: this outreach event provides people with the tools and activities they need to begin to make behavior changes that lead to a greater likelihood of adopting positive, lasting habits. Registration is free.



First Lady Laura Bush unveiled the First Ladies Red Dress Collection in May 2005. Seated is former first lady Nancy Reagan. Mrs. Bush has raised the profile of women's heart disease, publicizing it as the number one cause of death among American women.



Created by the National Heart, Lung and Blood Institute, the red dress pin has become a national symbol for women's heart health.

Heart disease: the First Lady's cause

On February 3, 2006, National Wear Red Day, Americans across the country wore red to unite in the national observance and to give women a personal and urgent wake-up call about their risk for heart disease. The National Heart, Lung, and Blood Institute (NHLBI) created and launched the Red Dress as the national symbol for women and heart disease to inspire women to take action to protect their heart health.

Mrs. Bush supports education campaigns for heart disease. She is a partner with the National Heart, Lung, and Blood Institute in publicizing The Heart Truth, which is that heart disease is the leading cause of death among women in America. Mrs. Bush educates women about their risks and emphasizes the importance of

healthy eating, exercise, and preventive screenings.

One in three women dies of heart disease, not cancer. Yet few women realize their risk of cardiac disease.

The national Heart Truth campaign, echoing the message of regional groups such as Working Hearts, seeks to educate women about their risk of heart disease, and especially about ways to control and reduce it.

Community action and education are seen as keys to reducing heart disease among women. Simple and sole reliance on the medical profession will not suffice. Physicians generally applaud community education and outreach efforts aimed at lowering disease risks.

Just knowing your risk factors, says Mrs. Bush, will help. Heart disease is striking at younger ages, and the risk increase when any one of these factors is present:

- Family member has heart disease.
- High blood pressure
- High serum cholesterol levels
- Smoking
- Inactive lifestyle

Mrs. Bush is helping to spread an important message, that heart disease risks can be reduced and managed.

Watch the video of Mrs. Bush's speech, *A Call to Action: Women and Heart Disease*, at:

<http://www.guidant.com/women/call.shtml>

Save the date

PRHI Cardiac Forum

September 30, 2006

Special Presentation

Gender in Cardiac Surgery:

Is what's good for the gander good for the goose?

Guest speaker, Nancy Nussmeier, M.D.

Dr. Nussmeier is the Director of Cardiovascular Anesthesia Research at the Texas Heart Institute and a Clinical Professor at Baylor University and The University of Texas Health Science Center at Houston. She also serves on the Board of Directors, Society of Cardiovascular Anesthesiologists. Her specialty interests include gender-related outcomes, cerebral protection, transfusion reduction and cox-2 inhibitors.

Other topics: We will discuss what the PRHI Cardiac Registry is telling us regionally about gender and outcomes. Perfusionists and others will report back on 2006 agenda items.

Who: Plan to attend if you are a PRHI Cardiac Working Group member, or wish to become one. Consider attending if you are a cardiothoracic surgeon, cardiologist, anesthesiologist, nurse, perfusionist, data analyst, or cardiac program administrator.

Where: The Rivers Club
301 Grant Street
Pittsburgh, PA 15219

When: Saturday, September 30
8:30-noon

Cost: No charge

Credits: This activity accredited by the Pennsylvania Medical Society and Pittsburgh Regional Health Initiative for 3 Category 1 CME credits and can be applied toward patient safety/risk reduction licensure requirements.

Sponsor: Mercy Hospital of Pittsburgh

Online registration is available at www.prhi.org

For further information contact Karyl Troup-Leasure, PhD, at ktroup@prhi.org; 412-586-6716

Calendar, Spring-Summer 2006

Day	Date	Time	Event	Place	Contact	CMS Offered?	Regis- ter?
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Thurs	August 10 Oct. 12	8a-5p	PPC 101	PRHI Learning Center PRHI Offices Centre City Tower 24th floor 650 Smithfield Street	Barbe Jennion, 412-586-6711 bjennion@prhi.org	Yes	Yes
Mon- Thurs	July 17-20 Sept 12- 13/25-26 Nov 13-16	8a-5p	Perfecting Patient Care™ University	TBD			
Mon	June 26	8a- 3:30p	Healthcare-Acquired Infection Technology Conference	Omni William Penn	Diasmer Bloe 412-594-2584 bloe@iht.org	Yes	Yes

Coming up:
Cardiac Forum
September 30

PRHI Executive Summary is also posted monthly at www.prhi.org
Please direct inquiries to: Pamela Gaynor, Director of Communications and External Relations
412-594-2581, pgaynor@prhi.org
Contributing writer/editor, Naida Grunden

Pittsburgh Regional Health Initiative

650 Smithfield Street, Suite 2400

Phone: 412-586-6700

Fax: 412-412-586-6701

www.prhi.org

Email: info@prhi.org