The Window on 2013

Jewish Healthcare Foundation Annual Report

REALIZING THE VISION

If one of the objectives of the Jewish Healthcare Foundation and the Pittsburgh Regional Health Initiative is to test better ways of delivering care—interventions that improve outcomes and also contain cost—then we can say that 2013 realized our aspirations. We are grateful for the confidence of large national funders that we could take on big challenges and deliver credible discoveries. We owe a particular debt to the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Health Resource and Services Administration (HRSA) for allowing us to advance our mission to reduce unnecessary hospitalizations.

Thanks to our funders, 2013 projects established transitional service units within hospitals to prevent readmissions, reduced hospitalizations from skilled nursing facilities, integrated behavioral health services into primary care settings, and improved the adherence of persons living with HIV to their prescribed medications. We are experimenting on a scale that was only a dream three years ago. Add to this the energy and persistence of our staff that allowed us to continue with our regular activities offering three different graduate student fellowships, maintaining excellence as the regional fiscal agent for HIV/AIDS funding, delivering a new annual champions program, delivering our training and coaching, giving out the Fine Awards, and advancing the research mission. We continue to make grants as well as implement those we receive.

So, when I review this annual report, I am very grateful: to our three Boards (JHF, PRHI and HCF) for supporting our explorations, to our staff for delivering excellence, and to a health community that has welcomed us into their care settings to test better ways of serving patients. We are particularly grateful to Allegheny County for helping us build out a multi-purpose QI²T training center; we wonder now how we ever lived without this!

Karen Wolk Feinstein, PhD
President and CEO
Jewish Healthcare Foundation

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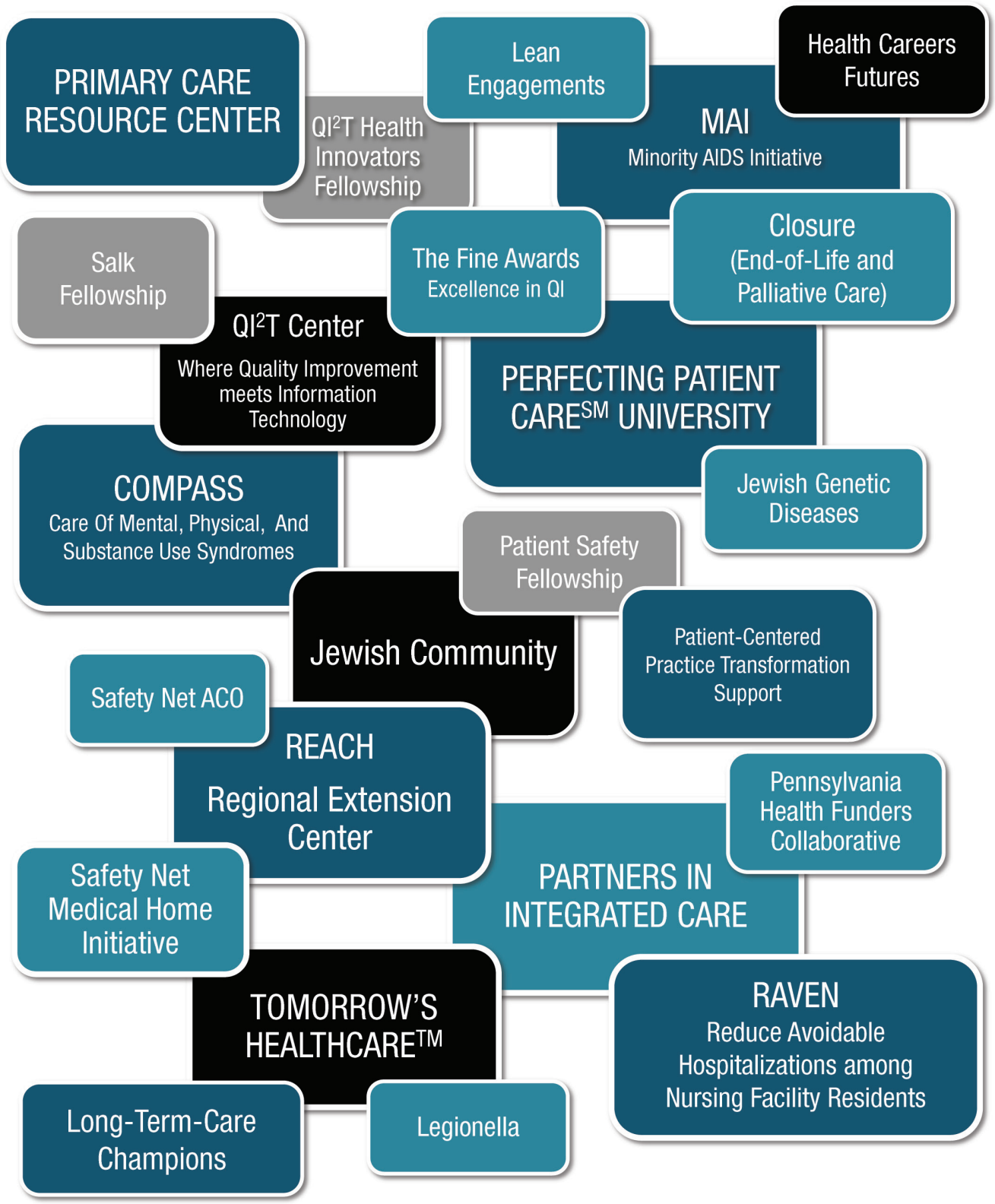
JEWISH HEALTHCARE FOUNDATION

PITTSBURGH REGIONAL HEALTH INITIATIVE
Spreading Quality, Containing Costs.

HEALTH CAREERS FUTURES

2013 PROGRAMS



SHARING THE VISION: REGIONAL & NATIONAL PARTNERSHIPS

Building and leveraging national and regional partnerships is a cornerstone of our strategy for increasing our reach and impact. In 2013, we partnered with numerous organizations, including (but not limited to):

- Network for Regional Healthcare Improvement, with our continuing support as a founding and active member, the hosting of the NRHI Summit, and help in hiring a new NRHI executive director
- Jewish Federation of Greater Pittsburgh, through our $900,000 block grant which is distributed by the Federation to its affiliated agencies to address the health needs of vulnerable Jewish populations, including the elderly, children, families who have children with special needs, and the poor
- Pennsylvania Health Funders Collaborative (PHFC), through our founding and continuing fiscal agency and membership, and leadership in:
  - Funding the Pennsylvania Economy League's fiscal analysis of Medicaid expansion
  - Garnering bipartisan support for a resolution to create an advisory committee to recommend changes in long-term Medicaid managed care
  - Creating a Marketplace enrollment guide for health funders
  - Providing mini-grant support to community organizations' efforts to build awareness of and enrollment in the Health Insurance Marketplace
  - Convening a conference in Harrisburg focused on managed long-term care, the Governor's Healthy PA Plan, the Marketplace, and PHFC's next year's priorities

Joanne Conroy, MD, chief health officer of the Association of American Medical Colleges, kicks off the August 6 convening of 20 leaders in medical education. The challenge: to develop a roadmap for incorporating systems-based competency into medical education and practice.

- Quality Insights of PA/West Virginia Medical Institute, with whom we partner to manage data security and conduct analyses on behalf of PRHI for the Qualified Entity (QE) program
- The Forbes Funds, with whom we partner in the Safety Net Accountable Care Organization initiative which brings together our community's safety net providers to build an infrastructure which maximizes efficiency and sustainability of these critical organizations
- Statewide and regional nursing advisory councils, through the participation of our staff and many of our board members
- United Way, The Forbes Funds, Squirrel Hill Health Center, Giant Eagle, area libraries, and many community groups with whom we are working to maximize the success of local health insurance enrollment activities
- Local funders, as part of a Human Services Integration Fund which supports local agencies' efforts to address critical community human service needs
- Grantmakers In Health and Grantmakers In Aging, through our membership and participation as speakers at their annual conferences
- Association of American Medical Colleges (AAMC), through our financial support and participation in a national meeting focusing on redesigning medical education to address the sixth competency of systems-based practice
- University of Pittsburgh Institute of Politics, with whom we organized a convening of thought leaders on long-term care and Medicaid managed care
- COPD Foundation, which is partnering with the PCRC team to provide advanced COPD training, educational materials, and spirometers to each PCRC hospital
- Princeton Conference, where Karen Feinstein spoke in May at their 2013 conference, "The U.S. Health Care System in Transition"
- Massachusetts Health Policy Commission, where Karen Feinstein presented at their October hearing on "Structural Barriers to Efficiency: Problems and Solutions" as part of the Commission's efforts to garner expert testimony in order to better assess the state's implementation of their healthcare cost containment bill, which became law in August 2012, and to develop policy recommendations for more ways to contain healthcare costs going forward

OUR VISION OF A HIGH-PERFORMING HEALTHCARE SYSTEM: THE LATTICE

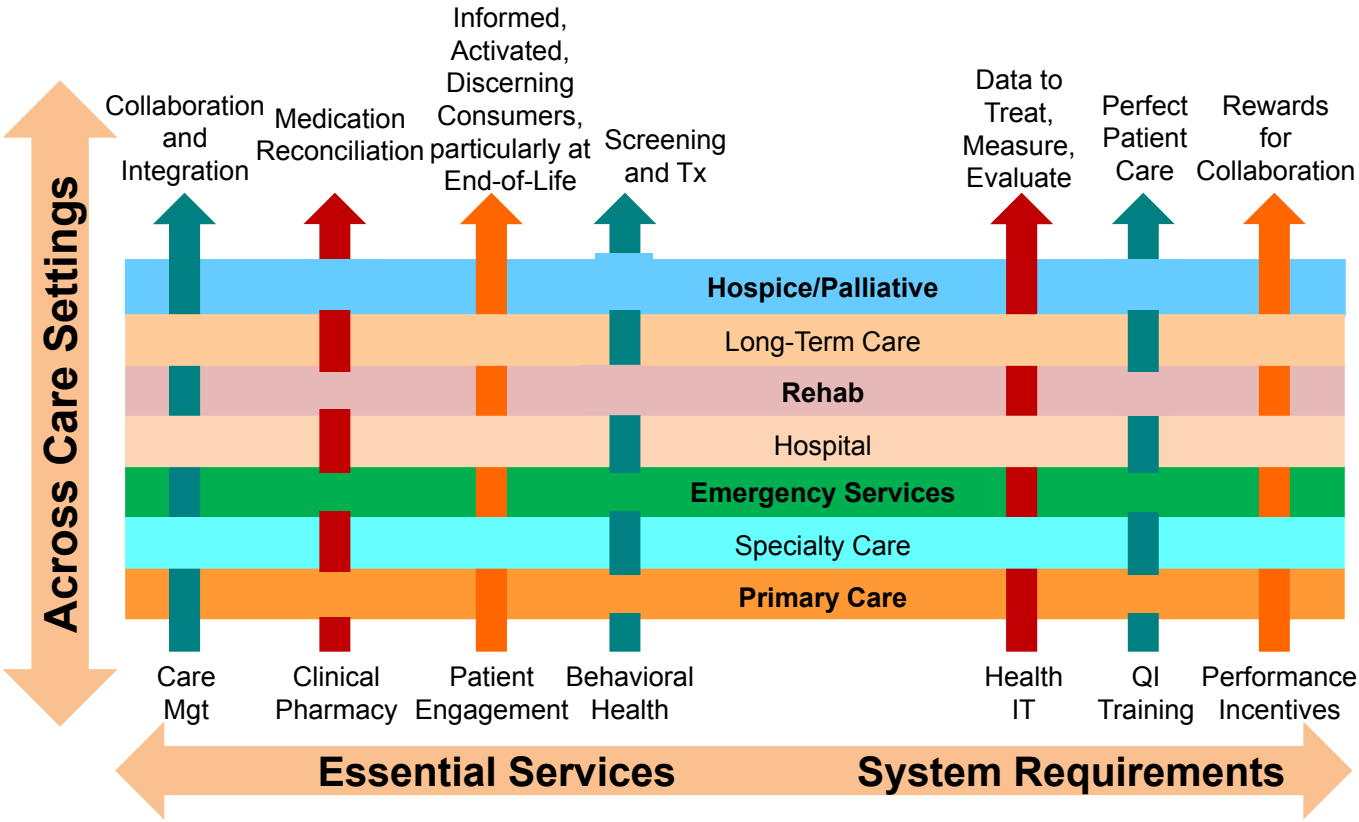
During our first decade, PRHI was able to prove that dramatic advances in quality and cost containment are possible by applying Lean quality improvement methods common to other industries in hospitals primarily. But these methods, while demonstrating dramatic results, produced "islands of excellence" or problem spot removal – quality improvement was not perceived as an organizational imperative, a way of doing business across the whole enterprise. And so, quality improvements did not spread across units or among hospital entities to produce "systems of excellence."

Going into our second decade, we refined our vision and adopted a systems approach. We moved beyond hospitals to the full array of settings that patients and consumers encounter. The lattice below represents our new imperative for a high-performing healthcare system. It integrates patient care across the boundaries of different settings and highlights what our research tells us are the essential services and systems requirements for major, sustained quality improvement. We are currently in the process of testing these system essentials to demonstrate their power to improve quality and contain costs in the interests of consistently better outcomes and population health.

In the pages that follow, we show you what we have accomplished in 2013 to transform not just individual organizations, but the healthcare system overall.

The Systems Vision:

Transforming the Care of Complex Patients



Primary Care Resource Center: Focus on Care Transitions of Chronic Disease Patients to Reduce Hospital Readmissions

Research shows that one in five elderly patients is readmitted to the hospital within 30 days of discharge, including patients with chronic disease who could avoid readmission with better education about their condition and improved care coordination.

In 2012, PRHI received a three-year, $10.4 million award from the Center for Medicare and Medicaid Innovation (CMMI) to help physicians coordinate care for complex patients by creating six hospital-based Primary Care Resource Centers (PCRCs) at Butler Health System, Indiana Regional Medical Center, Memorial Medical Center of Conemaugh Health System, Sharon Regional Health System, Uniontown Hospital, and Wheeling Hospital.

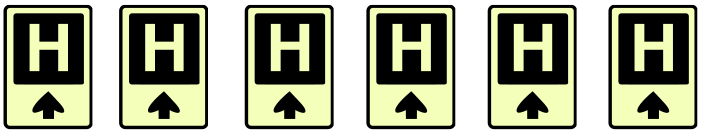
The project is based on a pilot PCRC at Monongahela Valley Hospital (MVH), which opened in 2012. The original concept for the PCRC model was inspired by visits to two secondary care centers in Haifa during a 2009 Foundation study mission to Israel.

In the PCRC model, outpatients receive coordinated, advanced care from a single location, collaborating with a multidisciplinary team trained in PRHI's Perfecting Patient Care℠ (PPC) methods to ensure they receive the support necessary to manage their chronic conditions and avoid preventable hospital readmissions. PRHI is providing funding, quality improvement training, coaching, clinical expertise, and the coordination of best practices at each participating community.

Each PCRC is focusing on patient education and care coordination for patients with three chronic diseases at high risk for avoidable readmissions: chronic obstructive pulmonary disease (COPD), heart failure, and/or acute myocardial infarctions. The objective is to reduce all-cause 30-day readmission rates for these target diseases by 40 percent over the course of the three-year project.

To reach this goal, the PCRC teams provide in-hospital education, including medication reconciliation, and post-discharge plans that include scheduling follow-up appointments, making home visits, and communicating regularly with primary care physicians.

2013 ACCOMPLISHMENTS



Six CMMI grant-funded Primary Care Resource Centers opened, bringing the number of PCRCs in the project to seven, including the MVH pilot site

21 Registered Nurses Hired

7 Pharmacists Hired

6 PCRC Model Presentations at Regional and National Conferences

↓47% Reduction in COPD 30-Day All-Cause Readmission Rates at MVH Pilot

PCRC Patient Enrollment
(July 1, 2013 – November 30, 2013)

	LAUNCH	JULY	AUG	SEP	OCT	NOV	TOTAL
Wheeling	7/1/2013	55	29	39	26	23	172
Butler	8/1/2013	5	55	59	69	56	244
Uniontown	8/19/2013	0	38	76	71	69	254
Sharon	8/26/2013	0	8	40	39	34	121
Indiana	9/30/2013	0	0	5	100	86	191
Conemaugh	9/30/2013	0	0	11			11
TOTALS		60	130	220	350	303	1,063

1,063 patients enrolled in the first 5 months

PCRC team at the opening of the Indiana Regional Medical Center PCRC: (R to L) Chief Medical Officer Keith Kanel, MD, with Jim Burns, Kathy Kay Brown, Lorraine Buck, Scott Frost, and Jen Condel

CARE MANAGEMENT > COLLABORATION & INTEGRATION

RAVEN Implements Evidence-Based Interventions to Improve Care and Reduce Avoidable Hospitalizations for Long-Term Care Residents

The Jewish Healthcare Foundation is one of five partners in RAVEN, an initiative to improve the quality of care and reduce avoidable hospitalizations among long-stay nursing facility residents in western Pennsylvania. JHF is the lead education provider for the project, which is funded by a four-year, $19 million grant from the Centers for Medicare and Medicaid Services to UPMC Community Provider Services and its Aging Institute and Palliative and Supportive Care Institute.

UPMC, JHF, Excela Health, Heritage Valley Health System, and Robert Morris University are working with 19 nursing facilities in western Pennsylvania to improve residents' outcomes, improve the transitions of care between hospitals and nursing facilities, and reduce overall health spending while ensuring access to care and choice of providers.

Within these facilities, the RAVEN team is implementing evidence-based interventions that have proven to be successful in other communities and facilities, including having nurse practitioners on-site to work with existing nursing staff to provide preventive services, enhance the assessment and management of residents' medical conditions, and provide advance care planning as well as support and treatment for those who choose palliative care at end-of-life.

Since the RAVEN initiative began in October 2012, sites have received extensive training on implementing INTERACT (Interventions to Reduce Acute Care Transfers), a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of nursing facility residents.

RAVEN is demonstrating evidence-based interventions to reduce avoidable hospitalizations of nursing home residents in 18 sites across western PA.

RAVEN participants brainstorm improvement opportunities using the PDSA (Plan-Do-Study-Act) framework.

2013 ACCOMPLISHMENTS

- Visited 18 sites and developed individualized education plans for each
- Conducted 18 palliative care education sessions across 10 sites
- Provided LEAN education to representatives from 18 sites
- Provided frontline education on team-building, problem-solving, and communication across 12 sites
- Trained representatives from 12 sites on implementing INTERACT principles into daily practice
- Hosted seven online webinars on developing INTERACT plans and procedures

CARE MANAGEMENT > COLLABORATION & INTEGRATION

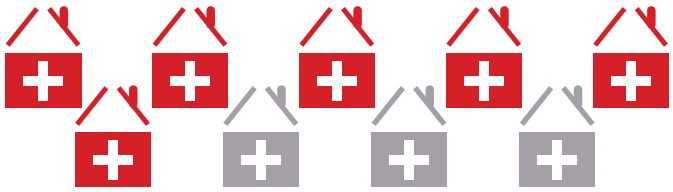
Safety Net Medical Home Initiative (SNMHI) Helps Practices Transition to the Patient-Centered Medical Home Model

In 2013, PRHI marked the end of SNMHI, a four-year program funded by JHF and a $2 million award from The Commonwealth Fund to provide training and on-site coaching to ten local community-based health centers to help them transition to the Patient Centered Medical Home (PCMH) model.

In April, PRHI hosted the final Annual Regional Meeting for SNMHI, which included presentations from participating health centers on their PCMH transformation journeys, and planning for sustainability and continued progress beyond SNMHI. Team members from other regional primary care organizations interested in implementing the PCMH model attended as well.

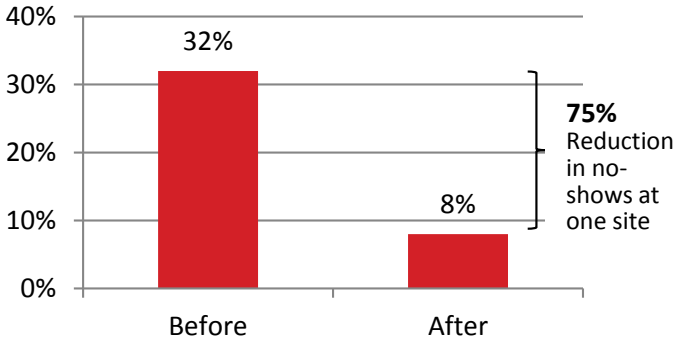
(R-L): PRHI's Jen Condel, SCT (ASCP), MT, Maureen Saxon-Gioia, RN, BSN, Katherine Brewer, and Tina Hahn at the final SNMHI meeting

2013 ACCOMPLISHMENTS



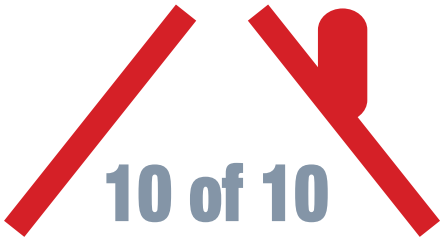
6 of 9

Eligible Pittsburgh sites achieved PCMH recognition from the National Committee for Quality Assurance, with two more in the process of applying.



75%

decrease in no-shows at UPMC Matilda Theiss Health Center



10 of 10

- Now have EHRs
- Improved office efficiencies (e.g. patient rooming, population outreach, etc.)
- Demonstrated significant improvement from baseline on PCMH assessment

CARE MANAGEMENT > COLLABORATION & INTEGRATION

Primary Care Learning Solutions Aid Patient-Centered Practice Transformation

The Patient-Centered Practice Transformation Support Program builds off PRHI's primary care initiatives, including REACH electronic health record implementation and optimization services, SNMHI, and integrated behavioral health initiatives (Partners in Integrated Care, COMPASS). The program is designed to assist Federally Qualified Health Centers (FQHCs) and FQHC-lookalikes in their transition to the Patient-Centered Medical Home model.

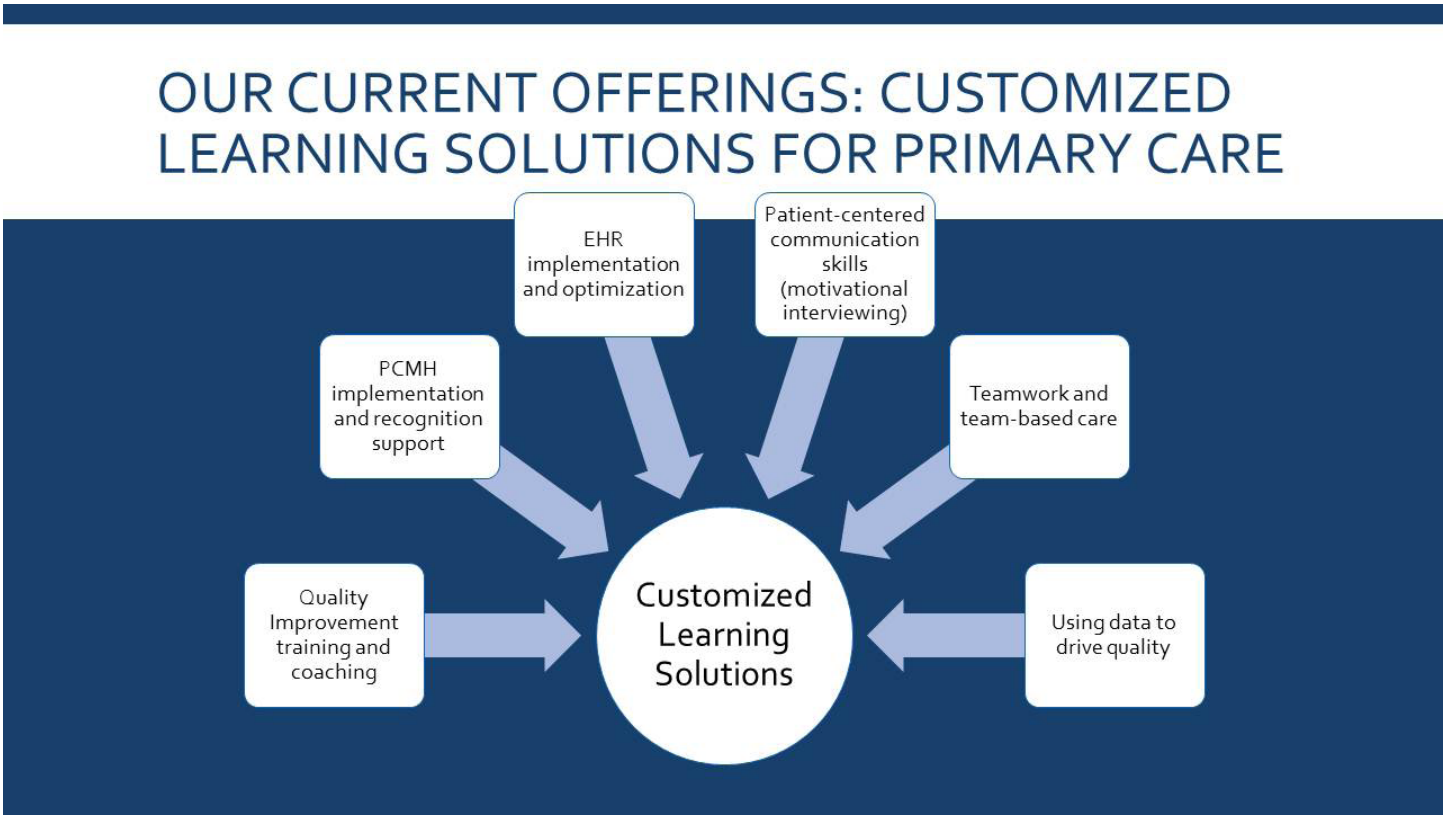
PRHI has developed a comprehensive curriculum and a set of support services for primary care providers, administrators, and staff to enhance knowledge and skills and provide high-value, patient-centered care.

Our team of skilled trainers and coaches has expertise in a variety of areas including:

- Quality improvement methodology, including workflow assessment and workflow redesign
- Patient-Centered Medical Home (PCMH) implementation
- PCMH recognition through the National Committee for Quality Assurance
- EHR implementation and optimization
- Behavioral health and unhealthy substance use screening and intervention in primary care
- Patient-centered communication skills, including Motivational Interviewing and Behavioral Activation
- Teamwork and team-based care

2013 ACCOMPLISHMENTS

- **Developed a suite of services—including an interactive, customizable curriculum and practice-specific coaching—to support patient-centered practice transformation**
- **Working with five primary practice systems, with plans to expand in 2014**



CLINICAL PHARMACY > MEDICATION RECONCILIATION

Integration of Clinical Pharmacy in the PCRC Improves Patient Outcomes

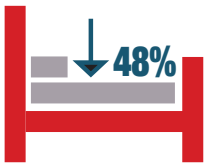
The hospital-based Primary Care Resource Center (PCRC) is aimed at improving quality and reducing healthcare costs by ensuring target chronic disease patients (those with chronic obstructive pulmonary disease, heart failure, and acute myocardial infarction) receive the support necessary to avoid preventable readmissions.

In recognition of the fact that medication adherence is a critical factor in the management of chronic disease, and the numerous studies that suggest that pharmacist-provided direct patient care has positive effects on therapeutic and safety outcomes, PRHI incorporated a clinical pharmacist as part of the PCRC team within each participating hospital. The pharmacist provides education, counseling, medication reconciliation, and follow-up across transitions of care for PCRC-enrolled patients.

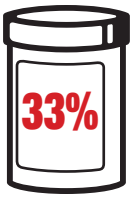
Data are being collected at all PCRC sites, including the Monongahela Valley Hospital PCRC pilot site, to measure the impact of the pharmacist intervention.

2013 ACCOMPLISHMENTS

In the first six months, 67 percent of 175 patients contacted were reached by the pharmacist.



Patients reached by pharmacists were 48 percent less likely to have an acute care visit within 30 days of discharge.



of patients reached required a post-discharge intervention, including addressing identified medication-related issues.

JHF Funds Pharmacy Initiatives to Improve Care Quality, Patient Transitions

PIVOTS Program

The JHF Board approved a one-year grant to the University of Pittsburgh School of Pharmacy (UPSP) for the Pharmacist-led Interventions On Transitions of Seniors (PIVOTS) program, which addresses medication-related problems during transitions from acute-care and long-term care settings, and subsequent increases in morbidity, mortality, and healthcare utilization among older adults. The project is a collaboration among UPSP, UPMC St. Margaret, and Presbyterian SeniorCare.

PATIENT ENGAGEMENT > INFORMED, ACTIVATED CONSUMERS

PRHI Named Nation's 7th Qualified Entity for Medicare Claims Data

In March 2013, PRHI was named a Qualified Entity (QE) by the Centers for Medicare and Medicaid Services, becoming one of now twelve organizations in the country to earn such a designation. The QE certification means that PRHI will receive Medicare fee-for-service claims data for the purpose of providing the region's consumers with impartial, easily understood information on the quality of services provided by doctors, hospitals and other healthcare providers. The QE program, created with the passage of the 2010 Affordable Care Act, provides Medicare claims data to organizations deemed capable of producing quality public reports while also protecting patients' privacy.

PRHI will work with Quality Insights of Pennsylvania, the Commonwealth's Medicare Quality Improvement Organization, to:

- Commit to the highest levels of data security and privacy protection
- Identify quality information especially important to consumers
- Work with healthcare providers to ensure fair, accurate measurements
- Create user-friendly consumer reports

Closure Helps to Change Expectations for End-of-Life

Improving the quality of end-of-life care has been on the Foundation's agenda for well over a decade. About 25 percent of Medicare spending is during the last year of a beneficiary's life, and 40 percent of that is in the last 30 days. And yet, much of this spending is for unwanted care. Many of our loved ones still often undergo costly, and ultimately ineffective and often painful treatments—regardless of their wishes or goals of care. In 2007, JHF launched *Closure*, an education, planning, and outreach effort designed to educate patients, families, and healthcare providers about end-of-life treatment and care options so that they can make informed end-of-life decisions that are consistent with their values, beliefs, and preferences for end-of-life.

2013 ACCOMPLISHMENTS

- *Closure* series implemented at the Jewish Association on Aging
- Palliative-care education introduced at more than 20 long-term care facilities throughout western Pennsylvania through both the Long-Term-Care Champions and RAVEN initiatives
- Continued to disseminate *Closure* guides for implementation nationwide
- Received grant by The Retirement Research Foundation to support POLST education and outreach
- Hosted POLST (Physician Orders for Life-Sustaining Treatment) educational webinar attended by more than 400 professionals
- Sponsored VESTA, a dramatic portrayal of aging and end-of-life issues, for 200 community members
- End-of-Life theme for 2013 Fine Awards for Teamwork Excellence in Health Care received numerous applications (Gold, Silver, and Bronze winners selected from among ten finalists) from organizations committed to improving the quality of end-of-life care
- Palliative care education legislation now pending in Harrisburg
- *Closure* featured in national presentations, including Grantmakers In Health, Grantmakers In Aging, and Coalition to Transform Advanced Care

PATIENT ENGAGEMENT > INFORMED, ACTIVATED CONSUMERS

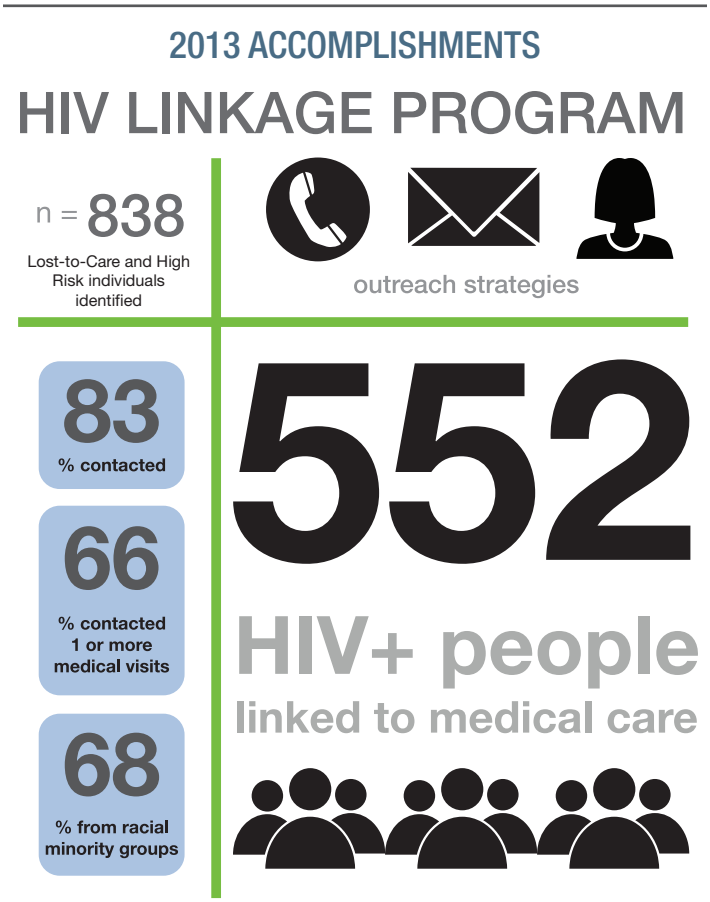
Lost-to-Care Initiative Re-Engages HIV-Positive Patients

In late 2012, the Jewish Healthcare Foundation was awarded a two-year, $1.5 million grant from the Health Resources and Services Administration (HRSA) to develop a program to re-engage HIV-positive individuals in Pennsylvania who are not receiving treatment for their condition. JHF has partnered with 15 AIDS Service Organizations (ASOs) across the state to identify, contact and re-engage HIV-positive individuals who have been "lost to care," meaning they have not visited a physician in 180 days or longer. The MAI team is providing the participating ASOs with a variety of resources, including motivational interviewing and quality improvement training, data collection and technology assistance, and monthly webinars that bring participants together to share best practices in returning HIV-positive individuals to care.

The initiative has been extremely successful, with the MAI team exceeding its 18-month goal of patients returned to care within the project's first year.

The MAI team has shared lessons learned with key stakeholders, presenting preliminary results during the Pennsylvania Department of Health Statewide Capacity Building Meeting and the International Conference on Social Work in Health and Mental Health in Los Angeles. In addition to the 15 current sites, the MAI will expand to five new locations in 2014. Einstein Medical Center (Philadelphia), Family Planning Council (Philadelphia), Mon Yough Community Services (McKeesport), Philadelphia F.I.G.H.T. (Philadelphia), and Pinnacle Health (Harrisburg) will take part in a multi-day training series at the QI²T Center in December to kick off their involvement in the program.

Representatives from MAI partner organizations practice motivational interviewing during a training session.



Data from 15 phase 1 sites of the Lost-to-Care Initiative. The time frame of this data is July 31, 2012 through October 31, 2013. The Lost-to-Care Initiative is funded by Pennsylvania's Special Pharmaceutical Benefits Program and HRSA's Minority AIDS Initiative.

New Program Provides HPV Education to Encourage Immunizations

In response to a partnership request from the Eye and Ear Foundation, JHF board approved a grant to develop a strategic plan for community outreach and education for HPV. The goal is to have the action plan complete and a community convening early in 2014.

BEHAVIORAL HEALTH > SCREENING AND TREATMENT

Partners in Integrated Care (PIC) Initiative Integrates Depression and Unhealthy Substance Use Screening into Primary Care

The toll taken on individuals with chronic physical diseases worsens when they also suffer from depression or unhealthy drug and/or alcohol use, as one condition exacerbates the other and increases the overall costs of care. Yet in many primary care settings, only patients' physical ailments are treated.

With a $3.5 million grant from the Agency for Healthcare Research and Quality (AHRQ), PRHI led a three-year project called Partners in Integrated Care (PIC) to implement and disseminate evidence-based depression and unhealthy alcohol and other drug use in primary care settings. The PIC project marked the first time that three regional health improvement coalitions – PRHI, Wisconsin Collaborative for Healthcare Quality, and the Institute for Clinical Systems Improvement – received national funding for a joint project.

In this project, PRHI helped primary care offices in Pennsylvania develop a combined treatment intervention that implements two existing evidence-based collaborative care management models: Screening, Brief Intervention and Referral to Treatment (SBIRT) for unhealthy alcohol and other drug use and Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) for collaborative depression care management in primary care offices. PRHI disseminated the PIC model to 11 primary care sites across the state.

PRHI will share lessons learned and best practices developed during PIC through the Network for Regional Healthcare Improvement. Recently, PRHI submitted a $4 million dissemination grant request to the Agency for Healthcare Research and Quality to spread the PIC model to six other regions across the country.

2013 ACCOMPLISHMENTS

Pittsburgh Regional Health Initiative – Spreading Quality, Containing Costs.

WIPHL – Wisconsin Initiative to Promote Healthy Lifestyles

WCHQ – Wisconsin Collaborative for Healthcare Quality

ICSI – Institute for Clinical Systems Improvement

nrhi – Network for Regional Healthcare Improvement — *NRHI engaged as dissemination partner*

MHQP – Massachusetts Health Quality Partners, trusted information. quality insights. — *4th RHIC engaged to test dissemination to another region*

For the first time, 4 regional health improvement coalitions (RHIC) received national funding for a joint project, building on their mutual expertise.

- *Marketing & Communications*
- *Train the Trainer*
- *Primary Care Training*
- *Practice Support*
- *Information Technology & Measurement*

5 Comprehensive toolkits—with white papers, brochures, training agendas and content, guidebooks, and more—created for dissemination and implementation of the PIC model (visit prhi.org to view)

57
Primary care sites implemented the PIC model, including 11 in western PA

4,552
patients started depression collaborative care services

3,186
patients received at least one brief intervention for alcohol and/or other drug misuse

BEHAVIORAL HEALTH > SCREENING AND TREATMENT

COMPASS Seeks to Spread Collaborative Care Model for Managing Depression and other Chronic Conditions

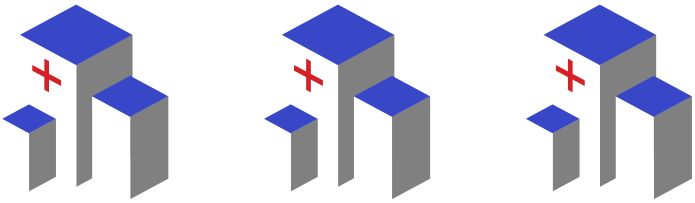
Building upon the PIC initiative, COMPASS (Care of Mental, Physical, and Substance Use Syndromes) addresses both mental and physical chronic disease management in primary care settings, creating a model to identify and treat adult patients with depression and poorly controlled diabetes and/or cardiovascular disease. The Pittsburgh Regional Health Initiative is one of ten partners in the three-year, $18 million cooperative agreement, which is funded by the Center for Medicare and Medicaid Innovation (CMMI) and led by the Institute for Clinical Systems Improvement.

COMPASS
Partnering for Mind-Body Health

As a clinical partner in COMPASS, PRHI was awarded $1.7 million over three years to recruit, train and provide coaching to medical groups in southwestern Pennsylvania as they implement an evidence-based collaborative care management model to improve patients' physical and mental health conditions. COMPASS integrates several existing evidence-based care models (IMPACT, TEAMcare, and SBIRT) and best practices learned through their implementation, including PRHI's Partners in Integrated Care (PIC) initiatives.

The COMPASS model identifies patients with depression and risky substance abuse and then develops an intervention plan. To help patients better self-manage and control their disease, COMPASS provides them with a thorough initial screening for relevant comorbidities; a care team including primary care physicians, physician consultants, a case review team, and a care manager who coordinates treatment and proactively facilitates communication among healthcare professionals; and treatment intensification when there is a lack of clinical improvement.

2013 ACCOMPLISHMENTS



Enrollment starts Feb. 13

Enrollment starts May 13

Enrollment starts June 13

PRHI is training and coaching three medical groups in southwestern Pennsylvania, with a total of 26 primary care offices, as they implement the COMPASS model.

359

People enrolled in COMPASS care since February 2013 (through 12/12/13)

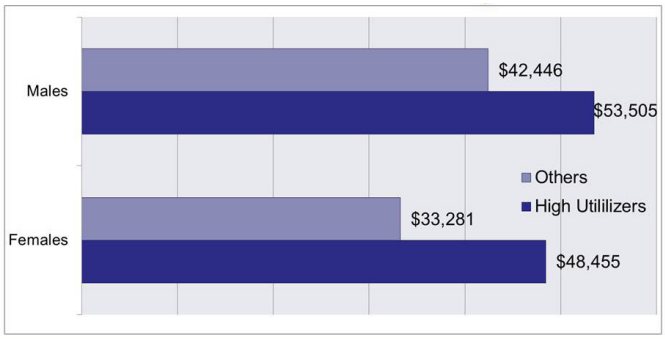
COMPASS Patient Care Coordinators armed with PHQ-9s for depression screenings

HEALTH IT > DATA TO TREAT, MEASURE, EVALUATE

Research Informs Our Work

In recent years, PRHI research has identified patient-specific improvement opportunities that have informed the development of our quality improvement demonstration projects, attracted significant private foundation and public grant support and positioned the organization as a trusted source of innovative and powerful program improvement models.

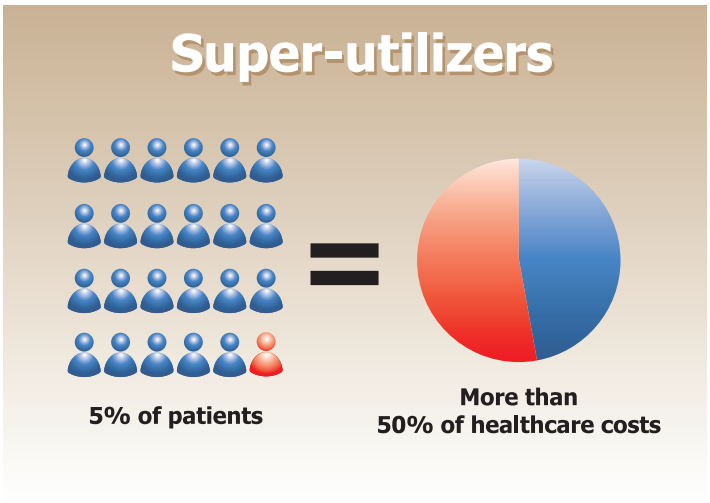
Total Charges:
High Utilizers' hospitalizations are
26% to 46% more costly



High Utilizers are more likely to be
dual eligible* as admissions increase

	Percent Dual Eligible		
	Index Admission	10th Admission	Percent Change
Females			
18-44	20%	19%	-5%
45-64	17%	20%	18%
65+	17%	25%	47%
Males			
18-44	18%	22%	22%
45-64	17%	19%	12%
65+	10%	13%	30%

**Dual eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage.*



2013 ACCOMPLISHMENTS

- Supported PRHI demonstration PIC and PCRC projects through data analysis and reporting on project outcomes and impacts
- Conducted exploratory research in characterizing high utilizers in southwestern Pennsylvania and in characterizing the HIV-positive community in Pennsylvania
- Launched PRHI's consumer engagement strategy, beginning with comprehensive application process, for CMS Qualified Entity certification
- Partnered with CMU's Heinz School in a systems synthesis project resulting in a student-developed prototype website for public reporting, in preparation for our role as a Qualified Entity

HEALTH IT > DATA TO TREAT, MEASURE, EVALUATE

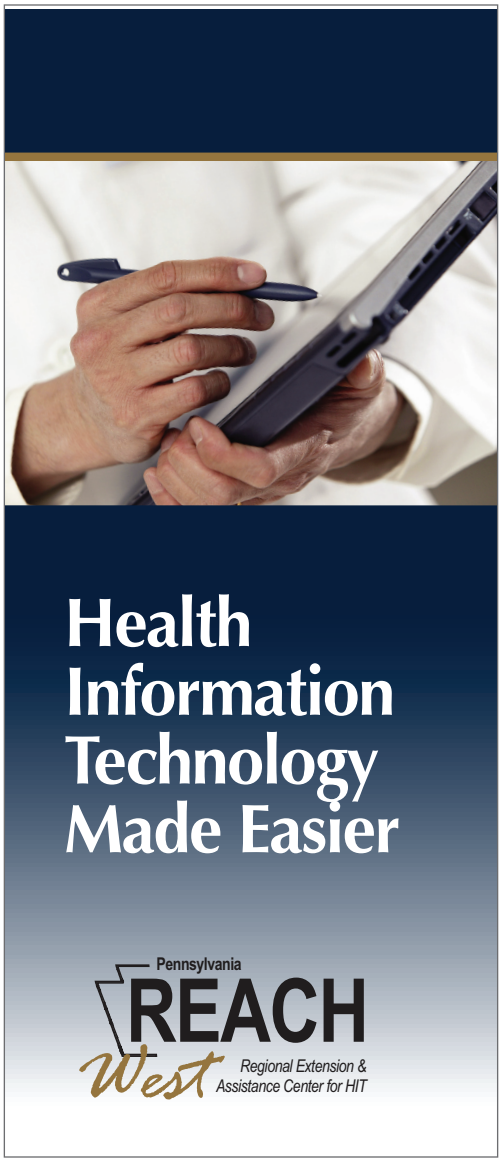
REACH (Regional Extension and Assistance Center for Health Information Technology) Helps Practices Implement EHR Systems and Achieve Meaningful Use

Since 2009, PRHI has served as a regional contractor for the Office of the National Coordinator for Health IT (ONC). In this role, PRHI enrolls and supports healthcare providers in western Pennsylvania as they implement electronic health records.

PRHI gives on-site, technical assistance to providers as they work toward achieving "Meaningful Use," a set of standards defined by CMS incentive programs that governs the use of electronic health records and allows eligible providers to earn incentive payments.

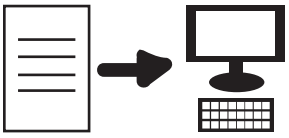
REACH funding was extended until the end of March 2014 to allow PRHI to pursue further training and coaching, including:

- Helping providers achieve Stage 2 Meaningful Use
- EHR training for providers, medical assistants, and licensed practical nurses
- Implementing EHRs in long-term care/post-acute care settings
- Implementing EHRs in Patient-Centered Medical Homes



2013 ACCOMPLISHMENTS

834
primary care physicians at 305 sites have implemented EHRs with PRHI's assistance.



97%
of those physicians are now using EHRs.

81%
have achieved "Meaningful Use," qualifying them for CMS incentive payments.

(as of 12/15/13)

Chief Learning and Informatics Officer Bruce Block, MD (right), meets with REACH team members (L to R) Scott Frost, Sheila Kruman, and Christi Beck

HEALTH IT > DATA TO TREAT, MEASURE, EVALUATE

JHF Partners with Health 2.0 Pittsburgh To Foster Innovation

The Jewish Healthcare Foundation is supporting the first staffed chapter of Health 2.0 Pittsburgh, a grassroots organization dedicated to improving the well-being of people in the region through innovations in healthcare delivery and information technology. Professionals, developers, patients and students are all welcome to join Health 2.0 Pittsburgh, which holds regular meetings to discuss ways to catalyze new technologies in health care and leverage "Big Data."

In 2014, JHF will again mentor some of Pittsburgh's future leaders through the QI²T Health Innovators Fellowship program, designed to enable graduate students to develop novel information technology solutions that improve healthcare quality and affordability.

PRHI Presents at Health Datapalooza IV

Pittsburgh Regional Health Initiative representatives engaged other healthcare information technology thought leaders at Datapalooza IV, held in Washington, DC, in June. Jo Ann Glad, DrPH, senior health services researcher, Brian Turcsanyi, director of technology and analytics, and Dr. Keith Kanel, chief medical officer, represented PRHI at the gathering of over 2,000 entrepreneurs, application developers, and researchers interested in harnessing the power of "Big Data" to solve healthcare issues.

Dr. Kanel presented on the importance of regional health improvement collaboratives, like PRHI, to the business community. Co-presenting with Dr. Kanel were representatives from the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, the National Business Coalition on Health, and the South Carolina Business Coalition on Health.

Pennsylvania Center for Health Information Activation

In December 2013, the JHF Board of Trustees approved a grant to establish the Pennsylvania Center for Health Information Activation (CHIA) under PRHI. The Center will serve as a trusted source of analytic insights in western Pennsylvania and throughout the Commonwealth, with unlimited opportunities to conduct and widely distribute research on healthcare service utilization, cost of care, outcomes, safety and efficiency, population health, and healthcare disparities.

The Center will maximize the effectiveness of PRHI's new designation as the state's Qualified Entity (QE) under the Centers for Medicare and Medicaid Services, build on our track record of quality improvement and provider and patient engagement, and create a neutral and bipartisan forum for advancing health policy for the Commonwealth.

The primary goal will be to support healthcare policymakers, purchasers, providers, and consumers to achieve more symmetrical relationships driven by more access to credible information – an engagement that we anticipate will drive sustainable improvements in quality and value that have been illusive over the past 15 years.

The mission of the Center is getting useful, actionable, and credible information to consumers, policy makers, providers, and purchasers at the right time and in a format that is actionable, and teaching these parties how to access – and responsibly use – this information. There is a need for a neutral party to analyze and circulate good information, in usable formats. Further, there is a need for curricula to help consumers and other stakeholders understand and use that information. And finally, there is a need for information on provider costs and quality that is packaged together with offers to support provider quality improvement and advance strong policy.

HEALTH IT > DATA TO TREAT, MEASURE, EVALUATE

JHF Leads Effort to Prevent Future Legionella Outbreaks

In November of 2012, the VA Pittsburgh Healthcare System reported an outbreak of Legionella, the bacterium that causes a potentially deadly form of pneumonia known as Legionnaires' disease. The outbreak contributed to over 20 confirmed cases of Legionnaires' disease and at least six deaths. In response to this incident, the Centers for Disease Control and Prevention (CDC) requested that the Jewish Healthcare Foundation lead a community initiative to prevent future Legionella outbreaks. JHF is partnering with the Hospital Council of Western Pennsylvania, the CDC, the Allegheny County Health Department, and the VA Pittsburgh Healthcare system in this effort.

2013 ACCOMPLISHMENTS

- In June 2013, JHF hosted an information session with more than 20 local funders, public health officials, and healthcare providers that focused on how Legionella is transmitted and the measures that can be taken to mitigate the risk of an outbreak. Following presentations by leading experts from the CDC, the Pennsylvania Department of Health, the VA Pittsburgh Healthcare System, and the Allegheny County Health Department, attendees discussed the importance of collaborative efforts to prevent Legionella outbreaks, including providing regional training for clinical and building maintenance professionals, and identifying gaps in current Legionella research.
- Building off that initial session, JHF hosted a Legionella education forum in August for more than 75 administrators, clinicians, and facility management personnel from local hospitals and long-term-care facilities. The forum, held at the request of area healthcare providers, provided an overview of the bacteria's nature, as well as new industry standards created to decrease the risk of, or respond to, an outbreak. Dr. Ali Sonel, Chief of Staff of the VA Pittsburgh Healthcare System, shared lessons learned from the VA's response to the outbreak. Dr. Jim Lando, Acting Chief of the Allegheny County Health Department's Office of Epidemiology and Biostatistics, offered his insights on Legionella during a question-and-answer session.
- In October, the Pittsburgh Regional Health Initiative Board of Directors expressed support for the creation of expert guidelines to minimize the risk of Legionella and respond to outbreaks. There are no current best practice guidelines from governmental agencies or other expert organizations to help healthcare providers thwart Legionella outbreaks.
- In December 2013, the JHF Board of Trustees approved a grant to work with the RAND Corporation to develop a set of expert guidelines focused on Legionella prevention and remediation which builds on Allegheny County Health Department and ASHRAE guidelines.

QI TRAINING > PERFECT PATIENT CARE

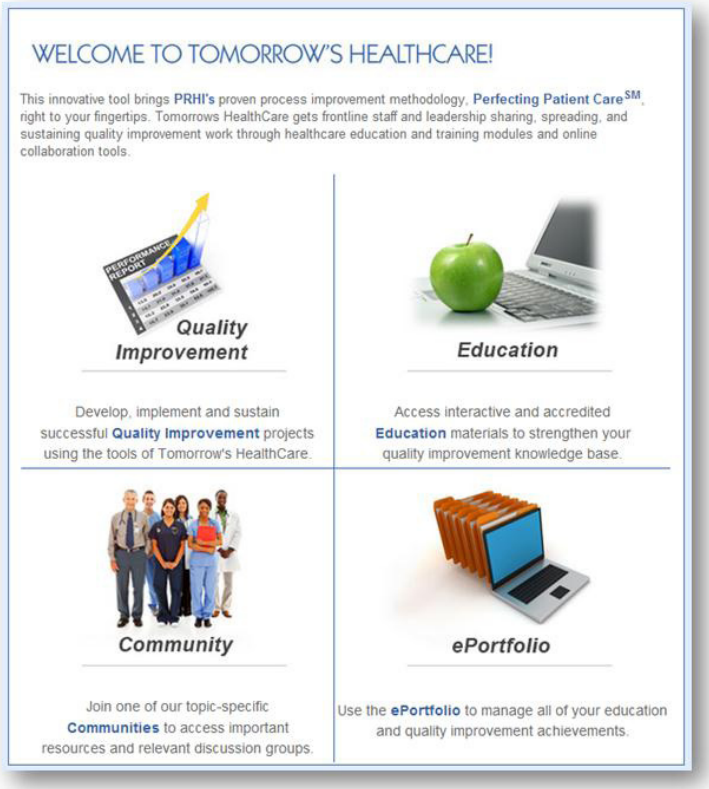
Tomorrow's Healthcare™ Re-Launches, Earns Innovation Award

Tomorrow's HealthCare™, PRHI's online quality improvement, education, and collaboration tool, re-launched in 2013 with a variety of new features to better meet healthcare professionals' needs.

2013 ACCOMPLISHMENTS

- Completely revamped and relaunched a much-improved Tomorrow's Healthcare™, including:
  - A newly designed Community section, with a Facebook-like interface familiar to new and seasoned users alike. The Community section now also features a video gallery and photo albums to document milestones.
  - A "Lean Library" of sample quality improvement projects (A3s), Perfecting Patient Care℠ case studies, and a collection of guides and tools in the Education section.
  - A skills and talent feature in the ePortfolio section, allowing colleagues to connect with in-house experts in a given field.
  - A comprehensive web-based project management system and dashboard in the Quality Improvement section to keep stakeholders up-to-date.
- At Health Datapalooza IV, Tomorrow's Healthcare™ was named a 2013 Computerworld Honors Laureate in the "Innovation" category, which recognizes organizations for designing and developing technologies or products that represent advancements in the fields of information technology, artificial intelligence, and the sciences, and benefit society or business. PRHI was nominated by Jay Srini, a PRHI Board member.

PRHI Director of Technology and Analytics Brian Turcsanyi accepts the 2013 Computerworld Innovation Award on behalf of PRHI.



QI TRAINING > PERFECT PATIENT CARE

PPC Curriculum Customized to Meet Unique Needs of Projects

Perfecting Patient Care℠ (PPC) is the Pittsburgh Regional Health Initiative's signature education and training methodology, equipping acute and long-term care facilities, as well as primary care practices with the tools to eliminate errors and waste while improving patient outcomes.

Representatives from Health Performance Partners engage in PPC exercises as part of PPC's Lean Certificate Program.

2013 ACCOMPLISHMENTS

- PRHI enhanced the PPC curriculum in various ways in 2013, including:
  - Content and examples tailored for project participants' particular care settings (i.e. long-term care, acute care, primary care)
  - Integrated other PRHI curricula (such as motivational interviewing and Data 101) into PPC lean training
  - New activities and simulations to teach PPC concepts
  - Customized timing, format and delivery method for JHF and PRHI grants
- Overall, a total of 325 local, national, and international participants received PPC training in 2013.

Grunden Wins Shingo Prize for *The Pittsburgh Way to Efficient Healthcare*

Former foundation employee Naida Grunden received the Shingo Research and Professional Publication Prize for The Pittsburgh Way to Efficient Healthcare, her book chronicling the efforts of the Pittsburgh Regional Health Initiative and local hospitals to improve patient outcomes by implementing Perfecting Patient Care℠ methodology. The Shingo Prize recognizes research and writing providing new knowledge and understanding of Lean concepts and operational excellence.

THE SHINGO PRIZE
for OPERATIONAL EXCELLENCE

The Pittsburgh Way to Efficient Healthcare in Korean

Long-Term-Care Champions Work to Reduce Readmissions, Improve Communication

In southwestern Pennsylvania, nearly a quarter of patients discharged from hospitals to skilled nursing facilities are readmitted within 30 days, according to data from the Pennsylvania Health Care Cost Containment Council. In 2012, JHF launched a new Champions program, focused on equipping area long-term care workers with the resources and training needed to reduce readmission rates and engage residents and their families.

The Jewish Healthcare Foundation and The Pittsburgh Foundation provided funding for the initiative, which was also supported by community partners including the Area Agency on Aging, Quality Improvement Organization, and the Three Rivers Workforce Investment Board.

The Long-Term Care Champions from Asbury Heights, Jewish Association on Aging, Kane Regional Centers, Presbyterian SeniorCare, and Vincentian Collaborative Systems incorporated INTERACT (Interventions to Reduce Acute Care Transfers) tools into daily practice. INTERACT is a quality improvement program that helps workers reduce preventable hospitalizations by taking proactive measures to detect changes in patients' conditions at an earlier stage, avoiding the health complications and costs associated with such transfers.

JHF coaches provided leadership and management resources, enhanced clinical training, and provided data tracking skills and tools as the Champions developed individualized, facility specific procedures. The Champions also received hands-on training on how to improve communication with residents who have dementia, and implemented JHF's *Closure* model to enhance palliative and end-of-life care.

The Long-Term-Care Champions meet in the QI²T Center.

PERFORMANCE INCENTIVES > REWARDS FOR COLLABORATION

RWJF Payment Reform Grant Supports PCRC Effort

In 2011, the Robert Wood Johnson Foundation awarded PRHI a three-year grant which supports the economic analysis of readmissions and claims data to evaluate the Primary Care Resource Center (PCRC) model's financial sustainability for independent hospitals and physician practices. The PCRC model is based on a carefully constructed payment reform model that will: (1) help keep physicians and hospitals financially whole in the payment transformation, and (2) accelerate the redesign of care for chronic disease patients in ways that create high-quality, efficient care that generates substantial cost savings.

The goal is that demonstrating cost savings associated with the PCRC delivery system reform and improvement effort will be the basis of actual payment reform.

2013 ACCOMPLISHMENTS

- PRHI participated in a national payment reform meeting held in Baltimore in June 2013, co-sponsored by AcademyHealth and the Robert Wood Johnson Foundation, to explore cutting edge ideas in "bending the cost curve."
- Planning is beginning on a payment reform summit, to be held in Pittsburgh in Spring 2014, which will explore the total cost-of-care impact of better care transitions, including the PCRC model, and how payers might make the model sustainable.

2013 Fine Awards Honor Local Healthcare Teams For Commitment to High-Quality, Patient-Centered Care at the End-of-Life

The sixth annual *Fine Awards for Teamwork Excellence in Health Care* recognized three local teams for their commitment to quality, patient-centered care at the end-of-life. Sponsored by The Fine Foundation and the Jewish Healthcare Foundation, the *Fine Awards* reinforce the critical role teamwork plays in health care.

The winners were:

Gold Award ($25,000 to team; $10,000 to Highmark (to be donated)): Highmark for "Advanced Illness Services (AIS): Enhancing Care at End-of-Life"

- Provided palliative care coverage to Medicare Advantage members for up to ten lifetime consultations with an interdisciplinary healthcare team, as well as access to pain management pharmaceuticals, coverage of home health needs, and family training and bereavement services.
- Implemented a predictive tool to identify members for AIS intervention based on markers such as diagnosis, acute care admission, and readmissions within 30 days of discharge.

Silver Award ($15,000 to team; $8,000 to UPMC PSI): UPMC's Palliative and Supportive Institute (PSI) for "Palliative Care Integration Across the Continuum"

- Created interdisciplinary palliative care programs in community hospitals, long-term care facilities, ambulatory care, and within home health care.
- Standardized data collection methods of palliative care interventions and developed automatic alerts for patient readmissions or admissions to another site.
- Implemented various strategies to provide patient-centered care and improve communication, including aligning treatment with patients' wishes, daily contact between healthcare professionals treating the patient, and a comprehensive discharge and post-discharge follow-up plan.

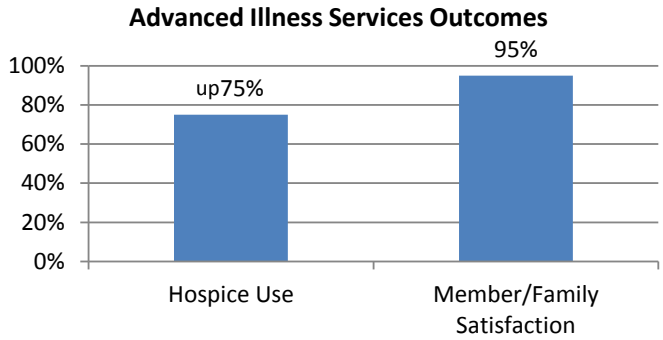
2013 Fine Awards Honor Local Healthcare Teams For Commitment to High-Quality, Patient-Centered Care at the End of Life *(continued)*

Bronze Award ($10,000 to team; $6,000 to Community LIFE): Community LIFE for "Honoring Choice"

- Provided patient-centered care and improved communication, including aligning treatment with patients' wishes, daily contact among healthcare professionals treating the patient, and a comprehensive discharge and post-discharge follow-up plan.

2013 Gold Fine Award Winner–Highmark

HIGHMARK'S AIS INCREASES MEDIAN LENGTH OF STAY IN HOSPICE



Median Length of Stay: Now 34 days (before, 50% of clients would die within 8 days of entering hospice services)

UPMC INTEGRATES PALLIATIVE CARE, REDUCES UNPLANNED RESIDENT TRANSFERS

↓281%

Unplanned transfers from UPMC senior communities decreased by 281 percent from March of 2011 to March of 2013.

C- LIFE'S HONORING CHOICE INCREASES PATIENTS' PAIN MANAGEMENT

38th ⟶ 75th

Patient satisfaction scores in pain management improved from the 38th percentile in 2011 to the 75th percentile in 2012 among national Program for All Inclusive Care (PACE) organizations.

The three teams were selected from among ten finalists evaluated by a selection panel comprised of thought leaders in end-of-life. The finalists included:

- **Children's Hospital of Pittsburgh of UPMC** for *Development of the Supportive Care Program*
- **Community LIFE** for *Honoring Choice*
- **Family Hospice and Palliative Care** for *Compassionate Caregiver Training*
- **Highmark, Inc.** for *Advanced Illness Services: Enhancing Care at End-of-Life*
- **Jefferson Regional Medical Center** for *Palliative Care – A Paradigm Shift*
- **Kane Regional Centers – Scott** for *Effects of Advanced Care Discussion in Patient Care Conferences at a Long-Term-Care Facility*
- **Memorial Medical Center of Conemaugh Health System** for *Palliative Care Program*
- **St. Clair Hospital** for *Designing Electronic Support to Ensure Optimal Advanced Care Planning*
- **UPMC Palliative and Supportive Institute** for *Palliative Care Integration across the Continuum*
- **UPMC Shadyside** for *Birth of an End-of-Life Care Team on an Oncology Unit*

FOUNDATION FELLOWSHIPS & INTERNSHIPS

Programs Provide Valuable Knowledge, Skills, Connections

Patient Safety Fellowship

The Patient Safety Fellowship aims to create an army of healthcare professionals with the knowledge and skills necessary to provide high-quality, error-free care. Thirty multidisciplinary Fellows participated in an eight-week, customized version of Perfecting Patient Care℠ (PPC) University, covering topics including visual management, root cause analysis, process mapping, and A3 problem solving. The Fellows then applied their PPC knowledge in real-world settings, conducting observations at two long-term-care facilities (Asbury Heights and Kane Regional Medical Center – McKeesport) and presenting their findings and recommendations on how to improve long-term care in our region.

2013 Patient Safety Fellows present their observations, analysis and recommendations on how to improve long-term care to community members, including participating long-term-care facilities.

2013-14 Jonas Salk Fellowship

From October of 2013 to March of 2014, millions of previously uninsured Americans will select coverage plans through the Health Insurance Marketplace, created with the passage of the Affordable Care Act. This year's 33 Jonas Salk Fellows will collaborate with regional businesses and non-profits to create and implement innovative programs to help consumers select health insurance plans during the open enrollment period. Teams will present the results of their enrollment programs and lessons learned in March.

The multidisciplinary Fellows will also have the opportunity to learn from healthcare thought leaders during a speaker series, and partner with area agencies to implement solutions in real time.

The 2013-14 Jonas Salk Fellows

JHF Summer Internship

Nine interns gained valuable experience in the healthcare field this past summer, contributing to a variety of projects including a revamp of the Jonas Salk Fellowship and the rollout of the Primary Care Resource Center project. Karen Feinstein provided the interns with an overview of the Jewish Healthcare Foundation and its two operating arms, the Pittsburgh Regional Health Initiative and Health Careers Futures. The interns collaborated with staff members and were encouraged to participate in meetings and speaker sessions that piqued their interest.

JHF's 2013 summer interns (L to R): Emily Sasser, Erin Ehler, Dasha Adamchik, Philip Cynn, Ruth Shaw, Ke Yan, and Suzanna Styles. (Not pictured: Chong Zhang and Erika Lowry)

FOUNDATION FELLOWSHIPS & INTERNSHIPS

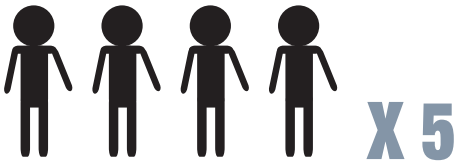
QI²T Health Innovators Fellowship

2013 marked the inaugural year of the QI²T Health Innovators Fellowship, designed to give entrepreneurial graduate students and young professionals the resources they need to successfully develop novel information technology solutions that improve health and healthcare quality. The QI²T Health Innovators Fellowship was launched as a cornerstone of JHF's QI²T Training Center, which equips healthcare workers with the IT skills to drive quality improvement.

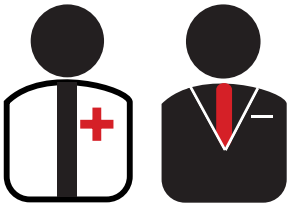
The inaugural QI²T fellows

The Fellows engaged with a network of entrepreneurial mentors, physician advisors, and guest speakers during the 10-week program. The Fellows assembled into teams, developing products aimed at improving the patient experience and lowering costs, and then pitched their products to a panel of healthcare and entrepreneurial experts. The winning team developed *Peer*, a forum allowing patients to review their healthcare experience in real time. Each member of the winning team received a prize.

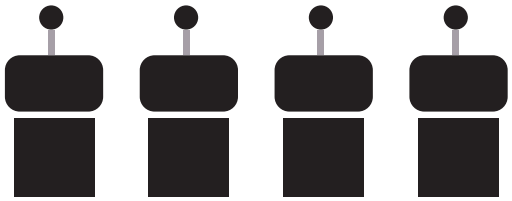
2013 ACCOMPLISHMENTS



The 20 QI²T fellows assembled into five multidisciplinary teams to develop their healthcare products.



Each team of QI²T fellows was guided by a clinical and entrepreneurial mentor.



The QI²T fellows engaged with four expert speakers in health care and business.

Each member of the winning QI²T fellow team received a cash prize.

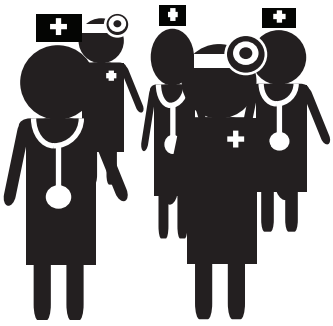
QI²T CENTER EVENTS FOSTER LEARNING

Since its grand opening in December of 2012, the QI²T Training Center has served as a hub for engaging frontline workers, executives, administrators, providers, data analysts, developers, and students craving the knowledge and skills needed to improve healthcare quality and lower costs through the innovative application of information technology.

The QI²T Training Center, created with grants from the Jewish Healthcare Foundation and the Allegheny County Infrastructure and Tourism Fund, hosted a variety of trainings, events and meetings in 2013, including presentations from:

- Robert Henkel, Ascension Health president and CEO, on Ascension's journey to deliver safe, reliable and evidence-based care;
- Paul O'Neill, co-founder of the Pittsburgh Regional Health Initiative, on leadership and the quality improvement methods he used to virtually eliminate safety incidents as chairman and CEO of Alcoa; and
- Jeffrey Brenner, MD, founder and executive director of the Camden Coalition of Healthcare Providers, on using data to identify and treat high-risk, disadvantaged populations.

2013 ACCOMPLISHMENTS

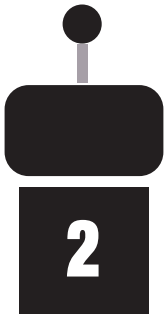


4,000+

The QI²T Center hosted over 4,000 people in 2013.

4

Delegations from four countries on three different continents visited the QI²T Center (Ukraine, Nigeria, Japan, and Scotland).



Two national meetings were held at the QI²T Center, involving the Association of American Medical Colleges and the Network for Regional Healthcare Improvement.

Left: PRHI co-founder Paul O'Neill (l), with Karen Feinstein and JHF board chair Alan Guttman. Center: Dr. Jeffrey Brenner talks to the audience about his work in "Hotspotting" health care high utilizers. Right: Robert Henkel shares his healthcare quality improvement journey at Ascension Health.

JEWISH COMMUNITY: REGIONAL PARTNERSHIPS

JHF Provides Nearly $3 Million in Grants For Human Service Needs Within the Jewish Community

In continuing support of the vision and values of the founders of Montefiore Hospital, whose sale in 1990 provided for the Foundation's endowment, JHF remains an integral part of Jewish life and health care in the Pittsburgh region. In 2013, JHF provided $2.8 million in funding to the Jewish community, including significant grants to the Jewish Association on Aging and the Jewish Federation of Greater Pittsburgh, and several other major and community education grants (see Grantmaking).

Jewish Federation of Greater Pittsburgh

The Jewish Healthcare Foundation provides an annual $900,000 block grant to the Federation, which is distributed to beneficiary agencies to address the health needs of the Jewish community, including the elderly, families with special-needs children, and the poor. JHF's grant, which benefits the Jewish Association on Aging, the Jewish Community Center, Jewish Family & Children's Service, Riverview Towers, and Jewish Residential Services, represents 60 percent of the $1.5 million distributed annually by the Federation to our community for human service needs.

Jewish Association on Aging (JAA)

In 2013, JHF distributed $1.6 million to the JAA as part of our total $33 million commitment to create and sustain the JAA. In addition, JAA staff—as part of our Long-Term Care Champions program—is receiving the education and training required to improve resident care and reduce avoidable hospital admissions and readmissions, including *Closure* at end-of-life, INTERACT (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers), and Perfecting Patient Care℠ training; advanced care planning; and data tracking assistance.

www.victorcenters.org

Jewish Genetic Screenings

Research shows that a quarter of Jewish individuals are a carrier for at least one of 19 preventable Jewish genetic diseases. The "Screen for Nineteen" program, a community education initiative spearheaded by Dodie Roskies, raises awareness about these 19 Ashkenazi Jewish genetic diseases and provides information and screening to at-risk young adults. As a result of these education and advocacy efforts, genetic screenings are now a covered medical benefit of Highmark and the UPMC Health Plan when prescribed by a physician.

The Pittsburgh Jewish Genetic Disease Program was initially funded by JHF (we also serve as fiscal agent), The Pittsburgh Foundation, and the Larry and Rebecca Stern Foundation. JHF sits on the current Program Advisory Committee, which is evaluating ways to advance and measure the impact of education efforts aimed at the medical community, clergy who provide premarital counselling, families, and young adults.

Jewish Hospital Conversion Foundations

Over the past few decades, nearly a dozen "conversion" foundations like the Jewish Healthcare Foundation have been created as a result of the sale of Jewish hospitals. In March, most of the conversion foundations met to discuss ways to collaborate and discussed lessons learned. Nancy Zionts, chief operating and program officer, represented JHF at the gathering, sharing foundation initiatives including End-of-Life/*Closure*, medical education reform, and quality and safety improvement.

JEWISH COMMUNITY: PARTNERSHIP WITH ISRAEL

Perfecting Patient Care℠ in Israel

Our five-year professional exchange with Israel continued in 2013. Since 2009, Israeli and PRHI professionals have shared best practices and collaborated around the challenge of providing patient-centered, high quality and efficient care against a backdrop of rising rates of chronic disease and resource constraints in both countries.

JHF President and CEO Karen Feinstein, PhD, Ran Balicer, MD, PhD, Director of the Clalit Research Institute, and JHF Chief Operating and Program Officer Nancy Zionts at the 5th International Jerusalem Conference on Health Policy

What we learned from previous site visits to secondary care centers in Haifa was leveraged into the $10.4 million Center for Medicare and Medicaid Innovation (CMMI) Primary Care Resource Center grant; and through our partnership with Clalit Health Services (Israel's largest HMO with 14 hospitals, 1,600 primary care clinics, 370 pharmacies, medical research, mental health services, and more), we trained a number of professionals in PPC who, with the help of a PPC-trained Israeli quality improvement coach, implemented five quality improvement demonstrations (to date) which have significantly reduced central line-associated blood stream infections and increased the rate at which myocardial infarction patients receive post discharge cardiac rehabilitation.

In 2013:

- The June study mission included information exchanges with leadership at Clalit Health Services in Jerusalem, the Israeli Ministry of Health, JDC-Brookdale, and the dean for medical education at Bar Ilan's new medical school in Safed; and visits to Lin Medical Center, Western Galilee Hospital in Nahariya, Ziv Medical Center, and Nazareth Hospital. Mission participants included healthcare leaders such as Debra Caplan, senior vice president, Allegheny General Hospital, The Western Pennsylvania Hospital; Lisa Simpson, president and CEO of AcademyHealth; Alan Weil, executive director, National Academy for State Health Policy (NASHP); Don Wilson, medical director for Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization (QIO); Michael Millenson, president of Health Quality Advisors LLC, Illinois; and George Fechter.
- Karen Feinstein ("Containing Costs by Increasing Quality: Applying Lean Across the World") and Nancy Zionts ("Improving Overall Health and Reducing Costs by Integrating Behavioral Health Intervention Services into Primary Care") presented at the 5th International Jerusalem Conference on Health Policy, and Karen also moderated a session.
- November trip followed up on the five Clalit demonstrations mentioned above, revisit our partnership with JDC-Brookdale and the Clalit Research Institute, and decide what the Jewish Healthcare Foundation's next steps are in the Israel partnership resulted in specific 2014 action items, including a potential JHF-JDC cosponsored international workforce summit on the role of the community health worker in health reform, the possibility of creating a certificate of patient safety, based on the PPC curriculum, at Bar Ilan's new medical school in Safed, and a collaborative exchange between PRHI's new chief analytics officer and the Clalit Research Institute as PRHI embarks on our new role as a CMS-designated Qualified Entity.

PUBLIC/PRIVATE FUNDING SECURED IN 2013

Source	Purpose	Amount
PA Department of Health/City of Pittsburgh	HIV/AIDS Program	$3,164,862
CMS/CMMI	Primary Care Resource Center	1,799,400
AHRQ	Partners in Integrating Care	1,214,813
Office of the National Coordinator/HIT	Regional Extension Center (REACH)	1,012,821
CMS/CMMI/Institute for Clinical Systems Improvement	COMPASS	614,190
Highmark	Mon Valley ACN	347,069
CMS/UPMC	RAVEN Grant	272,000
PPC University	PRHI Operations	185,000
Community Infrastructure and Tourism Fund	QI^{2}T Center	182,000
Assorted Foundations	Pennsylvania Health Funders Collaborative	200,000
The Fine Foundation	Fine Awards for Teamwork Excellence	81,500
The Pittsburgh Foundation	Jewish Genetic Diseases	75,000
Hillel Jewish University Center	Jewish Genetic Diseases	63,087
Various Hospitals	Tomorrow's HealthCare™	53,185
Larry and Rebecca Stern Family Foundation	Jewish Genetic Diseases	50,000
Various Funders	POLST Education	22,000
The Harry and Jeanette Weinberg Foundation	Caregivers Program	20,000
Other		8,925
	External Subtotal:	$9,365,852

2013 GRANTS

The following lists are representative of grants funded by JHF, but are not inclusive.

MAJOR GRANTS

Advancing Quality at the JAA

Allegheny Conference on Community Development

Allegheny County Parks Foundation: Trails for Health

Association of American Medical Colleges: System Based Practices

Community Day School: Keeping Tabs on the Holocaust

East End Cooperative Ministries: Community House

EMS Champions

Expanded Summer Internship Program

Federation / JHF: Public Private Partnership

Fine Awards

Get Covered America

Health Careers Pathways

Health Careers Training Center

Human Services Integration Fund

Improving End of Life Care

Improving Quality in Skilled Nursing Facilities

Investing in Excellence in Healthcare: Training in the Jewish Community

Jewish Assistance Fund

Jewish Association on Aging Renaissance Campaign

Jewish Federation of Greater Pittsburgh: Block Grant

Jewish Historical Center

Legionella Expert Guidelines

Leon Netzer Health Professions Internship

Liberating Data for Healthcare Innovations

Long-Term Care Champions

Magee-Womens Research Institute

Maximizing Charitable Investments

Medical Assistants (MA) Champions Program

Patient Protection and Affordable Care Act Health Reform

Pennsylvania Center for Health Information Activation

Perfecting Patient Care℠ in Community-Based Organizations

Pharmacist Advocates in Care Transitions

Pharmacist-led InterVentions On Transition of Seniors (PIVOTS)

Pittsburgh Accountable Care Network Project

Pittsburgh Health 2.0

Pittsburgh Public Service Fund

PRHI: Quality Improvement Meets Information Technology

QI²T Fellowship

Quality Improvement for Clinics and Social Services Caring for Individuals with HIV/AIDS

Reducing the Risk of the Human Papilloma Virus

Robert Morris University: Alvin Rogal Research Award in Safety and Quality

Safety Net Accountable Care Organization

Salk and Patient Safety Fellowships

Teachable Moments: Alvin Rogal Tribute

Technical Assistance

Transforming Primary Care: Practice Managers

United Way of Allegheny County Impact Fund

University of Pittsburgh Graduate School Leadership Portfolio Program

University of Pittsburgh Graduate School of Public Health: Classroom Redesign

UPMC Shadyside Building the Hospital of the Future

US and Israel: A Partnership to Advance Quality in Patient Care

Workforce of Tomorrow

WQED Medical Education Reform

2013 GRANTS (CONT.)

SMALL GRANTS

ALS Association

Carnegie Mellon University: Innovation for Healthcare

Community Human Services Corporation

Delta Foundation: Pittsburgh Red/World AIDS Day

Friendship Circle

Gilda's Club of Western Pennsylvania

Girl Scouts of Western Pennsylvania

Heath Affairs Project Hope: Reinventing Emergency Care

Hillel Academy of Pittsburgh

Jewish Association on Aging - Eight over Eighty

Jewish Federation of North America: Long Term Care

Jewish Residential Services

JFilm: The Pittsburgh Jewish Forum

KidsVoice

Mentoring Partnership of SWPA

NAMI Southwestern Pennsylvania

National Ovarian Cancer Coalition

NHeLP

Parkinson Foundation of Western Pennsylvania

Pennsylvania Health Access Network

Pittsburgh Cultural Trust

Planned Parenthood of Western Pennsylvania

RAND Corporation

The Forbes Funds: Action Plan to Implement the Affordable Care Act

The Forbes Funds: Frieda Shapira Medal

Three Rivers Youth

Tickets for Kids Foundation

UCP/CLASS

UPMC Senior Communities Benevolent Care Fund

Western Pennsylvania Jewish Sports Hall of Fame

World Affairs Council of Pittsburgh

COMMUNITY EDUCATION GRANTS

Grantmakers in Health

Persad Center

Robert Morris University Pittsburgh Speakers Series

University of Pittsburgh Institute of Politics

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