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The Impact of the Employer Mandate Delay

By Matt Scott

October is a big month for the Affordable Care Act (ACA). There are many in the healthcare industry who welcomed the delay of ACA's employer mandate. While that did take some pressure off employers, it's important to understand how decisions your organization makes in 2014 will impact 2015.

Providing affordable health insurance for employees of skilled nursing home facilities (SNF) has always been a challenge. Some have stopped offering group coverage, while those that do offer coverage report that less than 50% of their employees enroll. Poor participation is mainly the result of unaffordable premiums. Other factors like plan design and network availability also influence employee decisions; however, when premiums are unaffordable, enrollment will decrease and the plan will become unsustainable.

In a few short months ACA's individual mandate will go into effect. It requires all Americans to have health coverage or pay an individual penalty. Many SNF employees who waive or do not have access to benefits today will be evaluating their options closely due to this new federal requirement. Here are a few things to consider if you currently do not offer coverage or have a high number of employees who waive coverage:

- Employees who do not have access to group coverage will be eligible to purchase health insurance in the public exchanges effective January 1, 2014.
- There are no employer penalties in 2014 for not offering compliant coverage; however, the penalties will begin on January 1, 2015.
- Waiting to offer compliant coverage could push employees unnecessarily into the exchanges where they are eligible for subsidies.
- There is a $3,000 employer penalty in 2015 for every employee who receives

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Inside ...

Infection Control: It All Starts With Textiles

By Peter Grundberg

Healthcare systems committed to managing risk associated with infection control need to make sure their textiles are laundered using the highest standards for processing healthcare textiles. By doing so, they can provide a greater level of safety for employees and a stronger experience for their patients. Consequently, healthcare systems prefer to partner with healthcare linen management companies dedicated to obtaining healthcare laundry's highest standard for quality and safety: Accreditation by the Healthcare Laundry Accreditation Council (HLAC).

Why is HLAC accreditation important when choosing a laundry provider? It basically comes down to the level of additional risk mitigation healthcare systems require from their service partners and how serious they are in establishing a smooth and consistent program of clean textiles that adhere to federal regulations and guidelines for handling, processing, and transporting healthcare textiles.

HLAC is a non-profit provider of independent, third-party inspections for commercial laundries, verifying they meet industry's highest standards for processing healthcare linen and garments, including safety, quality, and training procedures. Through a collaborative effort, HLAC developed its standards with input from several groups, including the Association for Professionals in Infection Control and Epidemiology (APICE); Centers for Disease Control (CDC); Association for Healthcare Environmental Services (AHE); International Association for Healthcare Textile Management (IAHTM); Textile Rental Services Association (TRSA); American Reusable Textiles Association (ARTA); Association for Linen Management (ALM); and the Veterans Administration (VA).

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Peter Grundberg

Designing a Website for your Healthcare Business

By Daniel Casciato

As we have mentioned in previous columns, your website is your storefront. It is the hub of all your sales and marketing activity. It transforms your 9-5 business to a 24/7/365 business. Thus in order to drive sales, or in this case, drive clients, having a well-designed site is of extreme benefit.

Avoid these common mistakes

There are some general guidelines that your designer or design team should follow when piecing together your official online presence. To be successful, you need to have a bit of creativity, a lot of common sense and the ability to check your ego at the door.

The design and content should reflect the overall feel of your business; think of a couple of words that best describe your firm or the image you are aiming to portray. You know your limitations; don't take on what you can't do. In other words, if your design skills are lacking or there's not a team on-staff, consider outsourcing to a qualified team.

The most common mistake is the tendency to over design. Businesses tend to want to explain everything about their organization and procedures on their website. This makes it very difficult for visitors to find what they are looking for.

"People are like the Tasmanian Devil when searching for information, they want to get in and get out quickly," says Lindsay Hansen of LDH Consulting. "If your design is overwhelming and confusing they will click away and go to the next site in their search."

Another big mistake is bad navigation. It's very important to look at your site as the "user" would. Try to imagine what's important to them and design the navigation accordingly. Don't get too cleaver with how you name your links.

"People are accustomed to certain links, such as Contact Us, About Us, Location, and Patient Education Center," says Hansen. "Changing the name of these links just to be "different" can be damaging to your conversion rate."

Dynamic vs. Static Sites

Having a dynamic website means that the content is being changed in some way on a regular basis. Maybe you're adding articles, videos or photos or maybe it's more involved and you have a backend database that delivers up information based on exactly what the user is searching for.

"The benefit of having a dynamic site over a static site is that fresh content is better for search ranking," says Dorothy Wolden of Creative Intuition. "Search engines will rank your site as being more relevant and in turn put you closer to the top."

Dynamic sites will always out perform a static site. You may also want to add a blog to your existing site especially if you are already doing newsletters. You're writing articles for the newsletters, so why not post them on your website too?

Websites must-haves

A healthcare website should have a form people to inquire about appointments online. It should have a way for users to sign up for future communication, such as email newsletters or interact on social media sites.

It should be a resource for users who are looking for specific information about diagnoses and conditions.

"In today's world, people are seeking instant answers," says Wolden. "If they are experiencing symptoms in the middle of the night, they want to be able to access some information quickly and not wait until the office re-opens."

Wolden adds that it's also important to track activity on the site so you can see if your marketing efforts are producing the results you are looking for. "A successful website is producing leads that can be converted into new patients."

Daniel Casciato is a full-time freelance writer from Pittsburgh, PA. In addition to writing for Western Pennsylvania Healthcare News and Pittsburgh Healthcare Report, he's also a social media coach. For more information, visit www.danielcasciato.com, follow him on Twitter @danielcasciato, or friend him on Facebook (facebook.com/danielcasciato).

If Obesity is a Disease, Is It Also a Disability?

By Beth Slagle

Is obesity a disease, or merely a condition resulting from an unhealthy lifestyle?

The debate has raged for decades. Now the American Medical Association (AMA) finally put the question to rest in June when it voted in favor of Resolution 420, officially declaring obesity to be a disease, whether the cause is a physiological disorder or an unhealthy lifestyle choice. The AMA compared obesity to lung cancer, which is unquestionably considered a disease, whether the cause is harmful behavior like smoking or another factor.

While the resolution was intended to increase medical and community support for obese patients, it may have unintended consequences for employers. With the official classification of obesity as a disease, it may be easier for overweight employees to claim protection under the Americans with Disabilities Act Amendments Act (ADAAA).

In effect since 2009, the ADAAA expanded the 1990 Americans with Disabilities Act (ADA) which prohibits employers from discriminating against employees or applicants based on a real or perceived disability. The law requires employers to make reasonable accommodations for any employee or applicant that is otherwise qualified for a job.

Under the original ADA, it was typically very difficult to claim obesity as a disability unless the employee had a body mass index (BMI) greater than 40 and could prove that his or her obesity was a result of a physiological issue, such as a thyroid condition. Under the ADAAA, however, Congress broadened the definition of a disability, including for those who are simply "regarded as" disabled by their employers, whether or not the employee has an actual impairment. Since the ADAAA took effect, the Equal Employment Opportunity Commission (EEOC) has sued several companies for obesity-related discrimination under the ADAAA.

For example, the EEOC sued BAE Systems in 2011 because it fired an employee at its manufacturing division because of his weight. Although the employee had glowing performance reviews in past years, BAE Systems fired him two weeks after he requested a seat belt extender for the forklift, citing his weight as the reason.

The EEOC claimed that BAE Systems discriminated against the employee for a perceived disability and failed to make a reasonable accommodation as required by the ADAAA. The company ended up paying a $55,000 settlement to the employee.

EEOC v. BAE Systems should be a warning to employers that federal courts are taking obesity-related disability claims more seriously than before. While the AMA's new classification of obesity as a disease does not mean that it will be categorically protected as a disability under the ADAAA, it may strengthen employees' arguments for protection under the law.

Employers should be proactive in training supervisors and administrators to be sensitive to weight-related issues in the workplace. Before making any employment decisions because of perceived weight issues, employers should first consider whether a reasonable accommodation may be made. If no reasonable accommodations can be made without excessive expense to the company, the employer should clearly document job duties that the employee cannot perform.

The law surrounding obesity-related discrimination is changing rapidly. With the support of the AMA classification of obesity as a disease, it's likely that the ADAAA will include obesity as a protected disability in the future. Prudent employers should prepare now to make accommodations and ensure that the workplace is free of weight-related discrimination.

Beth Slagle is an attorney at Pittsburgh-based law firm Meyer, Unkovic & Scott. She can be reached at bas@muslaw.com.

Older Adults have Different Mindset

By Charlotte Wlodkowski

Within the next 10 years, the Pittsburgh region will see the population of those 65 years and older double. We know them as Boomers and they have a different mind-set than those who have retired before them.

Scott Wolovich, a physical therapist and graduate of the University of Pittsburgh with over 14 years' experience, sees his patients taking their physical and mental balance in a different way. He coordinates care by supporting the patient, their families and caregivers through education. Scott's primary role is in community based care in home health and he has served the older population for some time now. He is also the founder of Revel Pittsburgh, a regional initiative providing resources and tools to promote active, healthy lifestyles for older adults and those who love them.

Q. **What drew you to this field?**

Scott: After recovering from injuries, I was exposed to the field of physical therapy. I am now working to improve the health and quality of life for patients and get them back to doing the things they want to do. I stay in this field because helping other people is truly rewarding. You get as much from working with other people as they get from you.

Q. **How can the older adult population take better care of themselves?**

Scott: The single most important thing is staying active. There is a very clear correlation between physical movement, staying engaged in the community, and independence for the aging population. Studies increasingly point to social isolation as a strong predictor of declining health. Those older adults who continue to work tend to keep themselves informed and educated.

There is more information available today than has ever been in terms of ways to improve healthy lifestyle changes. There is greater access to more local resources. The challenge is, while information is available, people are not always finding it. Part of taking care of yourself is taking an active role in your health and getting the right resources.

Another challenge is changing people's eating habits. Everyone knows that we should eat healthier meals but old eating habits are hard to change. People need to be open to these changes for better health. Nutrition is a powerful and underutilized component to improving health.

Q. **What issues are older adults facing today that are more relevant than say, 10 years ago?**

Scott: The first issue is life expectancy. We are living longer which is a good thing. But, people who live longer have more health issues which challenge them to maintain independence and quality of life. Some people need to work longer even if their health is not at 100% due to their financial situation. Studies show that Boomers have saved less of their income than the previous generation which adds to the challenge of whether to continue to work or retire.

Senior housing is also an issue. There are a lot more options now. An older adult may think about adapting their own home or moving into a retirement community. There is a new movement known as

the 'Village' Movement. Communities create villages where older adults buy memberships into associations that provide services like transportation, help with things around the house and social interaction. This allows people to stay in their home with additional support as they get older, as opposed to moving into a senior care facility.

Villages help to keep older adults active, independent and safe. The Mount Lebanon Village is the first in the Pittsburgh region to provide this specific type of housing support. The movement started in Boston and revolves around the community pulling together to provide this type of care for the aging.

There are not enough appropriate senior living options at this stage, to meet the upcoming needs of the Boomers. The community is finding ways to help people stay in the community and connected to available support resources. Due to the sheer number of Boomers and their changing expectations, all cities and counties across the country are looking at ways to transform services and programs to the aging population. This is the work that I am doing with the RevelPittsburgh.com website and healthy living programs.

Q. **Are older adults viewed as more informed today?**

Scott: There is more information available today than even 5 years ago. But, this does not mean that people are getting the right information at the right time. That is a challenge. Physicians have less time to spend in educating people, and do not always have the time to access new information. We all know that hospitals are discharging patients much earlier and these people are going out into the community not fully recovered. Since there is less time spent in the hospital, patients and families have less time to learn about how to manage their condition.

I see community based care as a growing and vital part of healthcare for the older adult. By community based care, I don't mean just home health care, therapists, nurses, and social workers. It also includes the support system for the patient such as families, friends, and neighbors. We need to incorporate how to get the information to and from this informal support system as well. This is also a point of emphasis with health reform and the Affordable Care Act.

Nationally, 1 in 4 adults identifies themselves as caregivers for someone. That statistic is as of today and will increase as Boomers age and the older population increases. It is not just the role of the medical system to care for people. Society's role in caring for people and promoting healthy aging will continue to grow.

Q. **Where can older adults find current information?**

Scott: We need to provide local, comprehensive and trusted resources. The best place to start is the County Department of Human Services. They offer information from specialists and can connect people to the information they need. The United Way runs the dial 211 service, and can connect you to local information such as housing, transportation or utility assistance, not only health related support. There are disease specific organizations with local chapters, such as the Arthritis Foundation and the American Diabetes Foundation.

Online, I recommend Medline Plus which is a joint venture between the National Library of Medicine and National Institutes of Health. This site offers information from trusted sources ranging from simple to more advance. They have information on supplements, educational articles, and videos and they also have a specific section for older adults.

RevelPittsburgh.com is a new website that provides ways for older adults to stay active, healthy and connected to their local community. It offers more relevant information for the new mindset of the Boomers.

Many traditional organizations and senior centers tend to serve residents in their mid to late 70s and older. The Boomers are a new group of people reaching the age of 60 and 65 with different expectations of what it means to age successfully. Many Boomers are finding that the current senior center model does not meet their needs. They want to stay involved and engaged in their community. The RevelPittsburgh.com site is designed to support this initiative. It is focused on local areas, with dynamic interactive information on local branches of organizations. The site highlights what the Pittsburgh region has to offer older adults in the form of education and events.

Revel is valuable in helping residents avoid isolation by providing opportunities to become engaged in community events and programs. Registered members can also take advantage of free health tracking tools. People can track and manage their health information, such as medical contact, pharmacy and insurance company information. They can also track vital statistics, like blood pressure, blood sugar and body weight. Revel helps to organize and coordinate care by keeping their health information all in one place, allowing you to share the information with someone else if you choose.

Once a person creates an account, they can find others with the same interests, join groups and attend events. They will be able to also add their own groups and events to the site. Revelpittsburgh.com organizes events with partners such as Venture Outdoors, RSVP Pittsburgh Cares and New Life Kitchen. This healthy living series includes low impact walks through neighborhoods and parks, educates attendees on history of the area, and can include food tasting and healthy living education.

For example, earlier this spring we took a guided tour through the Friendship area, learned the history of the Victorian homes, and visited several art galleries. It ended at the Pittsburgh Glass Center with a food and organic cocktail tasting, as well as some interactive learning on healthy eating.

Most senior centers of today do not engage Boomers with innovative, community based programming. Boomers are more active. If you combine an active lifestyle with health education, you will have a more healthy community. Communities need to change the way they engage aging residents and promote a healthy lifestyle, and need new resources to make it happen. RevelPittsburgh.com is designed to take on this new role to help the local community organize, sponsor, and present a healthy new lifestyle to Boomers.

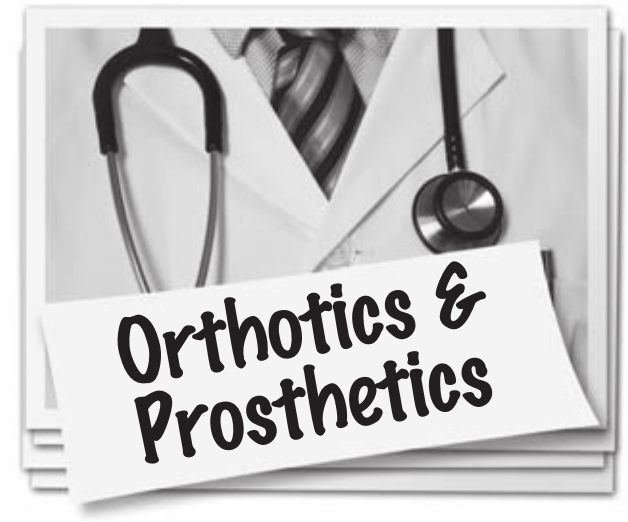
Q. **What advice would you give older adults?**

Scott: Actually, there are two pieces of advice I would like to convey. Stay active and be connected. I learned this through my interactions in the home care profession. People who continue to follow their passion for hobbies and interests look forward to the next day and find it fulfilling. It keeps them mentally and physically healthy.

I suggest older adults become involved with organizations and one in particular is RSVP (Retired and Senior Volunteer Program) Pittsburgh Cares which is the largest volunteer coordination group in the area. They match volunteers with their interests. Many older adults find using their skill based talents invigorating. Additionally, it benefits the organization with their mission of providing volunteer services and keeps older adults healthy through their interactions. This also keeps the community vibrant with activity.

For more information, visit www.revelpittsburgh.com

Orthotic Bracing for Treatment of Pectus Carinatum Deformities



Pectus Carinatum, also called pigeon chest, is a deformity of the chest with narrowing of the ribs and protrusion of the sternum bone. The deformity may be symmetrical or asymmetrical. Pectus carinatum usually has an onset in early adolescence and occurs more in males than females. When the body becomes skeletally mature, the deformity becomes rigid and potential for correction is minimal. Many individuals with pectus carinatum suffer decreased confidence and poor body image. While cosmesis is a primary concern for most individuals; shortness of breath, decreased endurance and pain may also be associated.

Pectus excavatum, or "hollowed chest" is another type of deformity of the chest in which the ribs and sternum indent into a concavity of the chest. This is more common than pectus carinatum. While this too may just have cosmetic implications, at times this can impinge on the internal structures of the heart, lungs and other organs. Depending on the severity, surgery may be indicated. There are several surgical techniques available to treat this deformity. Orthotic bracing may be an option but is far less effective that treating the pectus carinatum.

Orthotic (bracing) intervention for the treatment of pectus carinatum is a viable, conservative and cost effective approach. The orthosis is worn 23 hours per day for at least four months, possibly up to one year depending on age. Pectus carinatum orthoses are usually constructed of a front and back metal bar with adjustable attachments on the sides under the arms. There is a front panel and a back panel, which provides compression of the protrusion. The adjustable side attachments are gradually tightened until the chest has reached a flat position. The orthosis is worn directly on the skin and is contoured closely to the individual shape of each patient. The patient continues to wear the orthosis the full time until the deformity no longer rebounds when the orthosis is doffed. Through regular follow-ups with the orthotist, reductions in wear time are determined while ensuring the deformity does not recur. The wear time is gradually decreased and eventually the orthosis is only worn at night time until skeletal maturity. A team approach including the patient, caregivers, orthotist, physical therapist and doctor is necessary to ensure the best possible outcome.

For more information contact Laura at Union Orthotics & Prosthetics Co. at laura@unionoandp.com.

Undergrad & Grad Healthcare Programs

Cedarville University — Preparing Students for Collaborative Healthcare

By Elizabeth Pagel-Hogan

Cedarville University, a small Christian-centered university in Cedarville, Ohio, is preparing for big growth and changes in the healthcare terrain. Cedarville graduates across healthcare fields will be ready for collaborative healthcare and focused on better patient outcomes.

A physical sign of this emerging trend is the new nursing building on campus housing both the pharmacy and nursing programs.

"It was intentionally built it so we could have interdepartmental collaboration with high tech simulation," said Jan Conway, Dean of Cedarville University School of Nursing and Senior Professor. "There are labs to see patients at some point, but right now students are learning to work together in the delivery of care. A big focus in healthcare today in interdisciplinary care."

Conway has seen many changes in her 34 years at Cedarville. What she sees on the horizon, influenced by the Affordable Healthcare Act and reinforced by national studies, is a new focus on collaborative patient care.

"It's a national agenda with a major focus on collaborative practice rather than 'I'm the leader of the health team.' The goal is quality patient outcomes and cost effectiveness." said Conway.

"A wholisitc approach is cost effective, offers better resources for patient, helps patients understand their plan of care. Nurses, social workers, allied health professionals are coming together to say 'what piece can we contribute?' We're starting this approach with our new facility and in the high-tech simulation labs where students can work collaborative and contribute in their different roles."

Marc Sweeney, Dean of Cedarville University School of Pharmacy, feels the environment at Cedarville is unique when it comes to this new approach and preparing students to for professional careers grounded in collaboration.

"The attitude of collaboration, plus the technology and resources, it's very unique having it all at the same place," says Sweeney.

"When Cedarville built the nursing building and added the Master of Nursing and Doctor of Pharmacy programs they were built with collaboration in mind."

Evan Hellwig was a student at Cedarville and is now Chair of the Department of Kinesiology and Allied Health. Hellwig's excitement is contagious when he discusses the advantages for students enrolled in the athletic training program at Cedarville.

"The athletic training students have access to the simulation lab in the nursing department. The new technology available there includes a mannequin that you can program with a variety of scenarios. The students can act as clinicians while the mannequin responds," Hellwig says.

"The nursing department has worked wonderfully with our clinical educators to develop these scenarios. So now when our athletic training students are in their clinical rotations they have already experienced how to assess. Some literally crash and burn in a safe way in the lab. They feel so much more confident and prepared. "

Hellwig echoes Sweeney's assessment that Cedarville offers unique experiences for students pursuing healthcare careers. He estimates that out of 350 accredited athletic training program Cedarville students are in a select group of only a handful of athletic training programs that can give students access to this kind of technology.

Cedarville University, in northwest Ohio, just announced it's tenth president, Thomas White, Ph.D. Cedarville started as a liberal arts school but now offers the full gamut of programs many Christina colleges or universities do not. Currently Cedarville enrolls 3400 undergraduate students, but the university has a vision to enroll 10,000 students, 4000 undergraduates and 6000 online, adult and graduate students, by the year 2020.

"We are Christ-centered learning community and Biblically based. There's a strong emphasis that permeates the campus, from students to faculty," explains Mark Weinstein, Executive Director of Public Relations.

"We're not a huge campus, but when you have a smaller group the opportunities for collaboration are much greater than when you have huge institutions. That's something unique to Cedarville, we're at the table talking and discussing integrating at the faculty and student level," says Sweeney.

Conway described a example of this integration.

"This past year one of the pharmacy faculty and nursing faculty were teaching basic level research courses together. They planned classes together and taught classes together in a team approach, in the end the students had a research presentation and had to present the rationale from a nursing approach and a pharmacy approach. Students are recognizing each other and the need to work together," said Conway.

Cedarville students aren't stuck in labs all day. Melissa McNicol, a graduate student in the Doctor of Pharmacy program, is working in a retail pharmacy.

"We are given the opportunity to experience all types of pharmacy practice before we graduate, " says McNicol.

"We have already completed two rotations through retail pharmacies, both chain and independent. Next year we will do two rotations in hospitals, and then our last year of school will be all rotations. This will allow us to be able to have experiences in all types of pharmacy practice and determine which area is the best fit for us."

Students also get experiences at community health fairs and service learning projects. Here they get hands-on experience with interdisciplinary care.

"When we participate in community screening events, health fairs, it's interdisciplinary students and faculty doing this. They are just students taking care of patients, not looking at their disciplines," explained Sweeney.

"Also in nursing we are sharing with other disciplines some service learning projects where students work with outside agency or client project to work on problem, these kinds of projects can be handled in interdisciplinary ways," said Conway.

"Last year at an industrial business, students worked with the vendors for the snack machines and identified healthy foods. They got the vendor to bring in healthy foods for the workers. It is unheard of in years past to have students have an influence in care. A year ago they worked on blood pressure screening, this year it was nutrition. They are supporting the nurse at the facility, asking what are the problems, how can we help you?" said Conway.

For more information, visit www.cedarville.edu.

Pharmacy Revenue Integrity Solutions

During budget season, the C-suite is often challenged with the X factor. *How significant and accurate will the increases be in drug costs for the Pharmacy?* The dialogue regarding the growing influence of consumer-driven utilization of health care services and pricing transparency has taken on a life of its own as we enter this new era of healthcare delivery. Coupled with that challenge, is the reality that Pharmacy has become an increasingly important aspect of the overall revenue cycle on numerous levels, three of which are described below.

First, the recent media scrutiny of hospital pricing practices, together with the heightened importance of defensible and accurate pricing and charging practices for drugs, has resulted in increased demand for compliance and revenue integrity reviews focused on sorting through the complexities of these issues. The *TIME* magazine article by Steven Brill, "The Bitter Pill," which was a comprehensive outsider's analysis of The Charge Description Master (CDM), pinpointed pharmacy charging practices, which has increased interest by the C-suite and hospital boards.

Second, the Governmental Accountability Office (GAO) issued a report in September 2011 asserting that 340B covered entities were generating revenue through the 340B program and using the additional revenue to support or expand services for patients. They also found that the HRSA's oversight was "inadequate to provide reasonable assurance that covered entities and drug manufacturers are in compliance" especially critical of HRSA's failure to monitor hospital-based entities. As a result, HRSA 2013 goal is perform over 200 audits of 340B providers. HRSA also issued changes on February 7, 2013 not allowing GPO purchasing for 340B drugs effective August 7, 2013. The GPO limitation for 340B drug purchasing, in addition to ensuring each 340B drug claim can be accounted for during a HRSA audit, adds additional pressure to Pharmacy operations.

Finally, ensuring proper use of HCPCS and modifiers is essential to avoid compliance risks and obtain accurate and appropriate reimbursement for services rendered. Medicare Claim Processing Manual Chapter 17, *Drugs and Biologicals*, emphasizes the importance of assigning HCPCS and appropriate units for drug dosages. SunStone Consulting has found that in addition to ensuring appropriate charge capture for drugs administered, hospitals must dedicate time to compliance issues to include proper documentation for drug waste. Being compliant mitigates risk and assists with recovering costs related to services rendered.

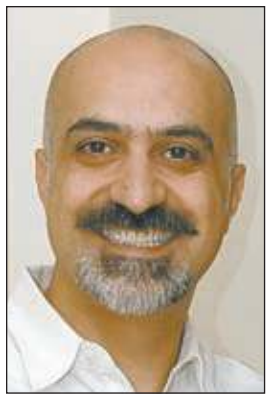
Because of the intricacies relating to the National Drug Codes (NDC), Wholesale Acquisition Costs (WACs) (formerly average wholesale prices (AWP)), HCPCS, revenue codes, units, and complex pricing mechanisms within Pharmacy information systems, *there are typically significant opportunities for improvement.* Due to the complexities surrounding the pharmacy revenue process from acquisition to payment, including billing compliance and minimization of lost revenue; *professional assistance and consultation is often required.*

SunStone Consulting has a solution geared specifically to addressing all of these issues and synthesizing the Pharmacy information system and Charge Description Master thus *ultimately improving the accuracy of Pharmacy pricing and billing.*

While many firms s offer advice in these areas, it is important to work with a firm with proven experience and expertise. Literally dozens of hospitals would be willing to endorse the work of one Pennsylvania d firm, SunStone Consulting.

For more information, please contact Vonda Moon (717) 676-6133 or vondamoon@sunstoneconsulting.com with questions or comments regarding this topic.

Converting from Paper to Electronic Patient Care Reporting (ePCR): Considerations and Challenges for EMS Industry



By Hadi Shavarini

The EMS industry for the most part operates on paper. When medics go to work, they save lives. They also produce a mountain of paperwork, all of which must be accurately managed, billed, sorted, reported to government agencies, and securely stored for a few years - a monumental and overwhelming task for any EMS operation.

Not too long ago, the adoption of electronic Patient Care Reporting (ePCR) system in EMS industry was just a thought. However, the HITECH Act, part of the 2009 economic stimulus package, changed all that.

The HITECH Act is trying to enforce and encourage the healthcare industry (EMS included) to adopt Electronic Health Records as a way to improve quality, safety, efficiencies and access. The Title IV of the act offers financial incentive for Medicaid to those organizations that adopt and use "certified" electronic patient care system beginning in 2011. Conversely, organizations that fail to implement convert to electronic operation by 2015 will be penalized by a reduction in Medicare payments.

In addition, the US-based National EMS Information Systems (NEMSIS) project has created pre-hospital information systems, standardizing data dictionary to represent key EMS data fields as well as a national database where states are required to send their EMS records for research and storage.

Set against the backdrop of government mandates (HITECH Act), national standards (NEMSIS), and evolving technologies, EMS industry struggles with implementing mobile technology that can enhance patient care, improve operational efficiency, and meet government requirements.

According to researchers at Robert Wood Johnson Foundation, complex technical, organizational, financial, and privacy/security factors make adoption of ePCR difficult and challenging for EMS agencies. Among these difficulties, the following are worthy to note:

Financial – Most, if not all, ePCR systems have a high start-up cost, and on-going maintenance fees, making them financially expensive to implement and keep.

Lack of Technical (IT) expertise – Most ePCR systems are difficult to implement, difficult to use, and most importantly difficult to maintain and keep operational. Most, vendors provide software solution that needs to be installed in portable computers. And adding to the technical complexities, all this has to happen in a mobile environment. As EMS agencies implement e-PCR systems, they recognize the need to build IT capacity to manage the highly complex infrastructure post implementation.

Security & Privacy - Concerns about privacy and keeping patient data secure is high on the list. Some of the well-known vendors fail to secure their database, while others use public Internet to email patient records to its final destination, leaving sensitive data open and vulnerable for all kinds of cyber attack and identity theft.

Increased run times due to ePCR system adoption – Most ePCR software are difficult to use and not user-friendly. EMS agencies express concerns that e-PCR systems would require greater time to complete than paper forms, resulting in increased ambulance run times.

Integration - ePCR systems should be electronically integrated with other information systems and equipment. Achieving this goal remains unsolved, mostly due to technical barriers such as lack of interfaces between ePCR systems and hospital EMR systems. The final step in the process resorts back to printing - hard copies of e-PCR report must be printed and provided as handoff documentation.

Conclusion

At a time when Health Information Technology is a national priority, EMS agencies are highly motivated to adopt ePCR systems to improve quality of care and enhance deficiencies.

The basic reality is that most EMS agencies do not have the resources (and/or the know-how) needed to implement an ePCR system. Most ePCR systems are difficult and expensive to implement and manage. Yet, to be eligible to receive the stimulus money, EMS providers must become electronically certified with "meaningful use" of the data.

The financial incentives, government mandates, and the rapid acceptance of communication technology is forcing EMS agencies to scramble to implement a "meaningful" ePCR system.

However, lack of IT know-how should not force EMS agencies to become geeks to save lives. They do not need to learn how to keep ePCR software operational using a portable PC in a mobile environment. What they need is to connect with a vendor that can provide them an easy-to-use, field-ready NEMSIS-complaint ePCR instrument. A maintenance-free mobile instrument is no different than any other equipment they use to save lives and provide care for their patients.

Hadi Shavarini is CEO of WebMedicPro (www.webmedicpro.com), a Greater Boston EMS technology company.

EMPLOYER MANDATE From **Page 1**

a subsidy.

It could prove challenging to pull employees out of the exchange in 2015.

There are several strategies business owners should consider for offering affordable coverage to their employees.

1. (MEC) Minimum Essential Coverage plans: MECs satisfy the individual mandate requirement for employees and are also designed to satisfy the affordability and essential benefit requirements in ACA, exempting the employer from the $2,000 penalty. Premiums are very affordable and the benefit levels are flexible and designed to cover the everyday expenses incurred by individuals.

2. Defined Contribution: This financial strategy can be combined with a number of plan design options. Employers fix the dollar amount that they contribute toward an employee's insurance plan. The amount is typically tiered, depending on the employee's status (individual, spouse, family, etc…). Employees select the insurance options that best fit their needs, and if their selections are more expensive than the employer's contribution, the employee pays the difference. This approach removes the owner from picking plans they think will work for the majority and empowers employees to choose the coverage they want and need. Importantly, this approach delivers more budgeting predictability.

3. Self-Funding: More organizations are moving to a self-funded insurance model to escape ACA's compressed 3:1 rating band, which is expected to impose significant rate increases on younger, healthier groups. In addition to avoiding this rating band, self-funded plans also avoid ACA's new Health Insurance Tax. Since self-funded plans provide any surplus claims funds back to the employer, they also provide significant incentives for groups that embrace health and wellness programs that work to reduce claims.

4. Smarter Wellness: On a positive note, ACA creates new flexibility to provide greater incentives and rewards for wellness program participation. Coupled with better tools to identify health risks, quantify costs and deliver targeted programs to reduce risks, SNFs have more reason than ever to invest in wellness programs, particularly if they are self-funding.

Conclusion

The individual mandate requires all Americans to have health coverage by January 1, 2014 or be penalized. Employers who would have provided credible coverage in 2014 can wait a year to offer coverage without penalty this year; however, they should understand and evaluate the financial impact this will have in 2015 if their employees choose to find coverage on the public exchange. SNF owners should consider offering affordable coverage in 2014 to avoid the pitfalls that will develop when the ACA employer mandate penalties for employees that have enrolled on the public exchange are enforced in 2015.

Matt Scott is Senior Vice President for HDH Group.

View from a Healthcare Insider

By Nick Jacobs

It's easy to be a remote dashboard video driver at a NASCAR race when someone else is assuming all of the pressure and risks behind the wheel. Oftentimes that's what my job feels like.

From my perspective I can observe the healthcare world and not personally be directly impacted by the fallout that others face on a daily basis. The good news for both of us, however, is that this neutral and objective viewpoint gives me valuable knowledge that is both significant and in many cases critical to those of you who are still doing the driving.

For example: Last week I heard about a hospital that had chosen to drop a clinical program that has been part of their service menu for years. The incredibly interesting aspect of this decision to lay off several highly skilled individuals was that over a year ago the Affordable Care Act had changed the reimbursement for this program in a manner that produces exponentially better financial benefits to the organization.

Consequently, that decision would appear to be an uninformed or at least a minimally informed decision; a potentially lucrative program is being eliminated while other health systems are currently initiating that very same program due to its value proposition in wellness, prevention and economic benefit.

Even the least informed of us in the field have determined that the only way to survive the onslaught of change that the industry is now facing is through a serious and concentrated effort in dealing with population health. Along with a half dozen other initiatives that include supply chain, attention to hospital acquired infections, quality, readmission rates and transparency; population health is a critical pathway to address the balancing of the teeter totter of healthcare finance so that we don't end up bankrupting this country.

With 45% of the newly insured falling into the Medicaid ranks and somewhere between 7000 and 10,000 Baby Boomers moving onto the Medicare ranks on a daily basis, our hospitals will be inundated with medical vs. surgical cases that would have, could have or should have either been prevented or at least ameliorated to some degree through public health efforts, education, and outreach.

For example, one medical issue that we don't regularly hear about in the non-medical-civilian world is the epidemic of inflammatory disease that is impacting our country.

Unless or until we move into our at-risk populations and address the urban food deserts, analyze the human impact created by the paragraphs of chemical additives to even our most basic foods, and deal with the endless consumption of sugar and salt in our manufactured diets; heart disease, cancer, and dozens of other inflammatory related afflictions will fill the hospital beds and lead to the $2,000,000 work-ups that take us down one diagnostic rabbit hole after another and into Detroit City-type deficits.

Coupons for fruits and vegetables, green pathways for walking, bike paths, other forms of diet, exercise, stress management and socializing activities, and integrative medicine education would have a significant impact on the general health of our population. So too would anti-bullying campaigns, anger management programs, and job creation.

Obviously, healthcare can't be the panacea for all 316,000,000 or so people in this country, but, by immersing ourselves into areas of population health we will contribute significantly to our collective future.

The old adage of "common sense being uncommon" hits heavily on this topic because we all know that even Superman had his vulnerabilities.

Our kryptonite has become our addiction to all of those things that common sense would tell us are absolutely not logical in terms of lifestyle, consumption, work-schedules, video-addictions, nutrition starved diets, sodium and sugar consumption.

Oh, and while we're at it, let's find a corner of a couch and plant ourselves firmly into that spot for eight or so hours at a time.

We must embrace ways to reach our populations and care about them before we end up spending every healthcare dollar ineffectively caring for them while never addressing the root cause of their problems.

Nick Jacobs, FACHE, International Director of SunStone Management Resources and an officer on the American Board of Integrative Holistic Physicians, is currently consulting in Integrative Medicine and Pharmacogenomics and writes the blog, healinghospitals.com.

INFECTION CONTROL From **Page 1**

The Highest Standards for Processing Linen and Garments

Healthcare laundries that pass their HLAC inspection receive a three-year accreditation. The principal benefit of accreditation to the healthcare customer is verification that their laundry provider meets the industry's highest standards for processing healthcare textiles, which translates into confidence that employees and end users — the patients — are receiving clean uniforms and bed linens.

During a recent interview with Paris Healthcare Linen, Pennsylvania's largest independent healthcare laundry, the benefits of HLAC accreditation were discussed with senior management who reinforced the value of accreditation. "Many hospitals and nursing homes take the accreditation very seriously, especially when evaluating a linen management partner," said David Stern, President and CEO of Paris Companies. "At Paris, we pride ourselves on taking the right steps to ensure that all our healthcare facilities have the best quality and safety measures in place, for both employees and our customers. For this reason, we make HLAC accreditation a regular part of our quality & safety systems." Paris Healthcare Linen Service has two plants that service the Pittsburgh area, and all Paris plants are HLAC accredited.

Accreditation: A Commitment to Exceed Expectations

Preparation for accreditation is not a quick and simple procedure. It takes several months and requires extensive coordination from numerous people within a company. "We have a cross-functional team that works diligently to secure and maintain the HLAC accreditation, including all plant managers, regional managers, and shift leaders," said Randy Rosetti, Vice President of Paris Healthcare Linen Services. "In order to succeed, everyone has to work together."

Paris has made it an ongoing operational goal to have all plants HLAC certified and has received the three-year accreditation for all processing facilities a second consecutive time, thus demonstrating the company's serious commitment to the healthcare industry, the quality expected by customers, and the overall contribution to creating a positive patient experience. "One of the key aspects of receiving accreditation is to have all quality, safety and training procedures written down and documented," says Rosetti. "Our division comptroller worked extensively to compile all the necessary information, so when we get inspected, we are able to demonstrate we have effectively communicated all the proper procedures to our hospital partners. It is always a team effort because the required procedures to operate as an accredited laundry are very strict, but in the end, always worth it for our partners and their peace of mind."

HLAC Accredited Launderers: A Preferred Healthcare Partner

"Any healthcare system or individual facility interested in outsourcing their laundry should demand a company with HLAC accreditation," said Joe Shough, Director of Business Development and Service Systems for Paris Healthcare Linen Services. "Outsourcing laundry operations has become the overwhelming trend for hospitals and nursing homes due to the associated savings it produces, not to mention the benefits it provides by allowing healthcare facilities to focus capital on their core competency, and free-up valuable space for revenue generation."

"Many healthcare facilities are seeking ways to help mitigate their exposure to Healthcare Acquired Infections (HAIs) while reducing operating expenses and outsourcing laundry operations often becomes an appealing option," explains Shough. "By choosing an accredited laundry, customers can rest assured their laundry is being processed according to the industry's highest available standards in safety and quality."

Shough adds, "One reason hospitals love using HLAC accredited laundry facilities is because it takes away some of the pressure associated with governmental regulatory inspections. Whenever a regulatory official finds out the laundry is HLAC accredited, inspections always seem to go more smoothly. If a facility is contracting with an accredited laundry, regulatory officials know that an unbiased third-party has provided inspections and independently found the healthcare laundry organization has strict operational guidelines in place and being followed to meet the highest standards for processing healthcare textiles.

Laundries located in healthcare facilities might find it more challenging to achieve HLAC accreditation because hospitals and nursing homes are designed primarily to address patient healthcare and not necessarily to process their own laundry. "An HLAC accredited facility is designed and operated to make sure it meets or exceeds HLAC requirements," Shough explains. "For example, each of the plants at Paris includes a barrier wall between soiled and clean linen areas. In addition, we look at airflow and make sure air doesn't flow from soiled to clean linen areas. This protects the integrity of the linen we send to our customers, and employees working in soiled linen areas always wear protective apparel."

More and more hospitals are experiencing the value and cost savings that occur as they outsource their laundry operations to an HLAC accredited laundry specialist. By doing so, hospitals are also able to mitigate their exposure to HAIs, divest themselves of activities that add little or no value to their operations, and concentrate on their core business — *saving lives and providing a positive patient experience.*

For more information on HLAC Accreditation, contact HLAC at 855.277.HLAC (4522) or online at www.hlacnet.org.

Peter Grundberg is a Principal at Strategic Marketing Professionals LLC, an independent marketing consultancy for healthcare textile providers and can be reached via email at pgrundberg.smpros@gmail.com. For more information on HLAC Accreditation, contact HLAC at 855.277.HLAC (4522) or online at www.hlacnet.org.

Paris Healthcare Linen Services is a full service HLAC accredited laundry partner with operations in Pennsylvania, Ohio, and New York. For more information, contact Paris at 800.832.2306 or online at www.parishealthcarelinen.com.

Bridging the Gaps

By Barbara Ivanko

Betty's room is on the east side of the building. Betty cherished the early daylight pouring through her window, remembering her first morning here at the long term care facility, eight years ago. The morning sun through her window that long-ago day assured her that this was meant to be her home.

As a morning person, most days Betty would rise with the sun. When the weather was nice, she ventured outside, crossed the small bridge that spanned the courtyard pond, and enjoy the morning rays in the patio that she had come to frequent.

The past several months have not been quite as bright for Betty. Diagnosed at the beginning the year with congestive heart failure, she had begun lately to take in the sunrise from her room. As her mobility declined, Betty talked with her children and engaged the services of Family Hospice and Palliative Care. Her quality of life has been the number one priority of Betty's family and her hospice care team. Morning sunrises are still on the to-do list.

Betty's decision to contact Family Hospice was an easy one, because she was so pleased with the care we provided to her husband several years ago. Now, thanks to a new regulation from the Centers for Medicare and Medicaid Services (CMS), that same decision should be just as easy for residents of any long term care community.

The new rules from CMS, which took effect August 26, govern how hospices and long term care facilities provide care for patients who choose hospice under the Hospice Medicare Benefit. The benefit is an entitlement to all Medicare Part A beneficiaries. The purpose of the changes is to improve coordination of care between hospices and long term care facilities, resulting in better quality of life and delivery of services for patients who select hospice care. It also contains a provision that ensures that long term care facilities honor the patient's right to choose hospice, and to receive care from the hospice of their choice. This is important because not every hospice is the same. Each has its own philosophy of care and range of services. Family Hospice offers expressive art and music, massage, and other services beyond the minimum requirements of Medicare.

Family Hospice embraces the new rule, as it assures more consistent communication among the long term care facility, patient, and the hospice chosen by the patient. CMS realized that nationwide, hospices and long term care facilities were not always on the same page. In some cases there was duplication of services – and in others, gaps in service and care.

Making the Most of Life

New rules from the Centers for Medicare and Medicaid Services will make it easier for those with loved ones in nursing facilities to choose hospice care.

As experts in end-of-life care, Family Hospice works with long term care providers to determine the best plan of care for those facing a life-limiting illness. In fact, Family Hospice recently offered free webinars on this topic to local nursing facilities with the intent to make the rule clear and ensure ease of implementation.

Family Hospice cherishes opportunities to serve families and help patients make the most of every day. Our hospice care teams work with patients and caregivers to develop the right plan of care for each individual. We want as many people as possible to have the chance to cross that bridge and enjoy the sunrise.

To change gears a bit, I am thrilled to become a member of Pittsburgh's health care community and look forward to sharing my experiences from Family Hospice with you every month. I gained my hospice experience in Florida – and that is where I developed my passion for end-of-life care. Western Pennsylvania's reputation for innovative health care is well-known, and I look forward to meeting and getting to know so many of you that make a difference in so many lives.

In the meantime, I'm happy to share with you that I am already falling in love with Pittsburgh. The hints of Autumn weather; the sidewalks that invite us to walk and meet our neighbors; and the friendly people I continue to meet are just some of the things that I'm already enjoying.

I look forward to sharing these and many more things with you.

Barbara Ivanko is President and CEO of Family Hospice and Palliative Care. She has more than 20 years experience in the health care and hospice and is an active member of the National Hospice and Palliative Care Organization. She may be reached at bivanko@familyhospice.com or (412) 572-8800. Family Hospice and Palliative Care is a non-profit organization serving nine counties in Western Pennsylvania. More information at www.FamilyHospice.com and www.facebook.com/FamilyHospicePA.

Gateway Hospice— Helping Families Embrace Life

By Kathleen Ganster

It was the feeling that all too many people face these days. In her own words, Phyllis Dominici felt like she "wasn't going to make it one more day. I was so exhausted."

Dominici and her sister, Patti Owens, were taking care of their mother, Francis Rozicky who had Alzheimer's disease. Although Mrs. Rozicky was in a nursing home, the two would visit every day, making sure all of her needs were met.

"We were both working full-time and I remember I was trying to pick up a gift for my grand-daughter's birthday, and I was trying to get to the home. It was just too much," Dominici said.

But despite their exhaustion and their mother's condition, hospice care never occurred to the sisters.

"When we spoke with Gateway, I said, 'On no. She doesn't have her mind, but the doctors have told us she will live at least a few more years," Dominici said.

Dominici learned from Gateway Hospice that a patient and her family can use their services to assist with patients needing hospice care in the final stage of their lives.

And the more she learned, the better Gateway Hospice services sounded to Dominici.

"My sister and I thought it sounded too good to be true," she laughed.

Even though Dominici was nervous, the sisters knew they could use the help and soon, Gateway was assisting the women.

"For my mother, they were just like having another daughter. They were our set of eyes when we couldn't be there," she said.

Gateway health care providers gave Dominici's mother the additional care that ensured she was comfortable during her remaining days.

"With Alzheimer's, they can't tell you how they feel or the last time someone gave them a bath. With Gateway, they were coming to us and telling us our mother's needs. We weren't going to them telling them what our mother needed," she said.

Also important to the sisters was the manner that the Gateway healthcare providers worked with them. When they thought her mother would benefit from additional or varied services, the healthcare providers would discuss the situation with them and see what the sisters wanted to do, then act as a liaison with the nursing home.

"It took a lot of stress off of us," Dominici said.

Dominici gave the example that her mother needed change in her diet, something the she and her sister never would have known.

"They told us our mother needed more fiber in her diet and addressed it with the home," she said.

Perhaps the most important factor to Dominici was the type of care that Gateway provided to her mother.

"They treated her as if she was their loved one. It wasn't like it was just a job to them," she said.

When her mother passed away, several of her healthcare workers came to the funeral.

"Like I said, they were like other daughters for my mother," Dominici said.

Mary Tobin, COO of Gateway said hospice isn't for every caregiver.

"I think hospice is a unique experience. It takes additional education and knowledge. It's not for everyone," said Tobin.

When Gateway is hiring hospice workers, they try to find someone that not only is an excellent caregiver, but one who fits the organization.

"We want them to fit into the culture of our Gateway family," Tobin said.

It is an aspect that Dominici agrees with. "It takes a special kind of person to be in hospice care," she said.

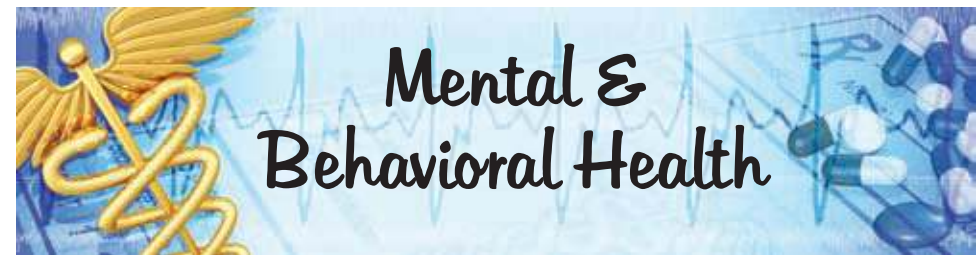
And for Dominici and her sister, Gateway Hospice caregivers made a world of difference to them in the last stage of their mother's life.

"Gateway gave us peace of mind. We knew our mother was getting wonderful care and we were able to rest easy," Dominici said.

For more information, visit www.gatewayhospice.com.

Preventing Depression in Older Adults

By Dr. Charles Reynolds



Brain Health

When people think about staying fit, they generally think from the neck down. But the health of your brain plays a critical role in almost everything you do: thinking, feeling, remembering, working, playing — and even sleeping. Recent research has shown that in the healthy aging brain, new synapses continue to form and nerve cells can regenerate. Aging is not a time of irreversible mental decline, and dementia is not universal and inevitable. Depression is not a normal part of the aging process. (Reference: www.alz.org)

A healthy brain is important to remain independent and vital.

- Older adults are at increased risk for depression.
- Depression is more common in people who also have other illnesses (such as heart disease or cancer) or whose function becomes limited.
- Older adults are often misdiagnosed and undertreated.
- Healthcare providers may mistake an older adult's symptoms of depression as just a natural reaction to illness or the life changes that may occur as we age, and therefore not see the depression as something to be treated.
- Older adults themselves often share this belief and do not seek help because they don't understand that they could feel better with appropriate treatment.

(Reference: CDC, 2012)

Older adults are at increased risk of developing a depression and research has shown that people with depression have an increased risk of developing a dementia.

Risks of depression in older adults

We know that depression is not a normal part of aging, and we know that while depression is treatable, it can be hard to overcome. Research has shown that about 15% of adults age 65 and older are depressed. Ideally, a person at risk of developing depression will never become depressed in the first place, but prevention of depression is something we know little about.

Older adults face unique challenges that may increase their risk of becoming depressed. Chronic pain and disease, death of family and friends, declining physical abilities, and financial strain are just some of the stressors faced by older adults.

Seniors who receive in-home services, such as a visiting nurse, home delivered meals, and personal care are considered to be at high risk for becoming depressed. This may be because they have mobility problems, decreased ability to care for themselves, are often lonely, and may be poor. About 10% of older adults with in-home services become depressed every year

Individuals with knee arthritis and the associated pain often find themselves reducing activities that they previously enjoyed. This change in activity may at times increase stress and could increase their risk of depression in the later years.

People with Mild Cognitive Impairment -- the state between no memory problems and dementia – are also at higher risk for becoming depressed. Some researchers think that it is the stress of losing one's memory and independence that increases the risk for depression. Another possible explanation is that changes in the brain contributing to memory loss may also increase the risk for depression. This is another reason why MAINTAINING BRAIN HEALTH is important to managing stress and preserving independence.

Can Depression in the Later Years of Life Be Prevented? That is the central question that the iManage (Independence, Managing Activities, No Matter What Age) research studies at the University of Pittsburgh is trying to answer.

The iManage Studies, funded by the National Institute of Mental Health, are designed to learn if new ways to solve problems and manage stress will help to improve sleep and quality of life, lower stress and pain, and help maintain independence.

Someone may be eligible for one of the studies if they are age 60 and older and experiencing one of the following:

- Stress or pain from knee arthritis
- Stress from mild memory changes
- Receive weekly home care services such as visiting nurses or assistance with personal care or daily activities

To learn more about the studies, please visit the iManage website (http://imanagestress.org) or call 412-246-6006 or email imanage@upmc.edu

Behavioral Health, Patient Centered Medical Home: Embed or Not to Embed...?

By Lee Reichbaum, Ph.D.

Don't look now, but the pendulum has swung again. The federal government, insurers, and physician practices are considering the newest rendition of what used to be known as preferred provider organizations, staff model HMO, and any number of other synonyms. The national push for new models of care is driven by the economics of medicine, the need to effectively manage healthcare by using evidenced-based protocols, and to establish coordinated quality of care based on establishing continuity in the doctor-patient relationship.

When reviewing Patient Centered Medical Homes [PCMH] and Accountable Care Organizations [ACO] "white papers" the responsibility for managing all aspects of a patients' care falls upon the primary care physician [PCP] selected by the patient or assigned by the insurer. This responsibility includes providing behavioral health services. Several approaches are being suggested to integrating behavioral health care: 1] embed care onsite with PCMH employed specialists [i.e. Psychiatrists, Psychologists, etc.]; 2] identify behavioral health specialists [BHS] in the community that provide excellence in both treatment and collaboration; and 3] a hybrid, with initial assessment onsite by an employed or consulting BHS followed by referral to established resources in the community if needed.

Embedding provides outstanding opportunities: familiarity with the expertise of the BHS working side by side, facilitate "warm hand-offs" among colleagues, seamless scheduling among practitioners, sharing records, and close management of the provision and levels of care. Among the major drawbacks to the onsite format are the relative costs: salaries, employee benefits, difficulties in having an in-house staff with expertise diverse enough to address the range of complexities a practice may encounter, as well as the return on investment value assigned to real estate within the office.

The second option is often favored because of efficacy and fiscal considerations. Physicians can serve more patients in same time in the consolidated space of a typically configured office than a behavioral health specialist who typically spends 20-55 minutes/appointment and generally requires a space larger than the typical examination room. This model maximizes office utilization.

Option 3, allows for combining onsite efficiency as well as utilizing broader expertise and resources in the community, with either an employee of practice or a consultant using space within the PCMH office.

In turn, PCPs/PCMHs/ACOs are urged to identify and affiliate with behavioral health specialists with demonstrated experience in evidenced-based treatment protocols. Physicians determine the breadth of behavioral care they personally feel competent to manage themselves and similarly identify markers requiring a higher level of expertise and referral. Which ever model is chosen, it must be patient-centered, efficacious, provider-to provider friendly, and increase the ability of a practice to meet benchmarks rewarding payment for performance schemas.

Close collaborative relationships between PCP and BHS help assure patients of coordinated continuity care, minimizes the sense of fragmentation or being abandon by the PCP referring to an estranged specialist. BHSs should be able to skillfully address the range of behavioral health problems by assessing patients' needs, providing direct treatment, or knowing the community of resources so as to make well-planned referrals. Remembering in a Consultative Model, the consultant serves two masters, the patient and PCP. BHSs should be available to PCPs by telephone, secure emails, or teleconsultations to provide "arm chair consultations" assisting PCPs to manage patients who are not ready to be referred or to coordinate the care of mutual patients.

The scope of expertise a BHS will vary, but ideally ought to include areas such as: caring for adults, couples, children, family; Axis I/II diagnoses, substance abuse of drugs, tobacco, eating habits; adaptation to health problems like diabetes, strokes, heart disease, pain; capable of running psychoeducation groups for stress management, smoking cessation, weight management, etc.

Recently Medscape (http://www.medscape.com/viewarticle/782624) published succinct "20 Things Psychiatrists Think Hospitalists Should Know", before requesting a behavioral health consultation. Using such a template guides when and how to refer, by doing so the referring physician assists the BHS's focus; preparation for the assessment; timeliness and efficacy of the evaluation; leading to a precise response to the Primary Care Physician/patient's needs.

Bottom-line, PCP identify a Behavioral Health Specialist who will provide expertise in helping care for your patients and with whom you develop a very collaborative trusted relationship.

Lee Reichbaum, Ph.D., Licensed Psychologist, is CEO, Allegheny Mental Health Associates. To learn more, visit http://amha4u.com/.

Lose – Lose: Doctors and Addiction

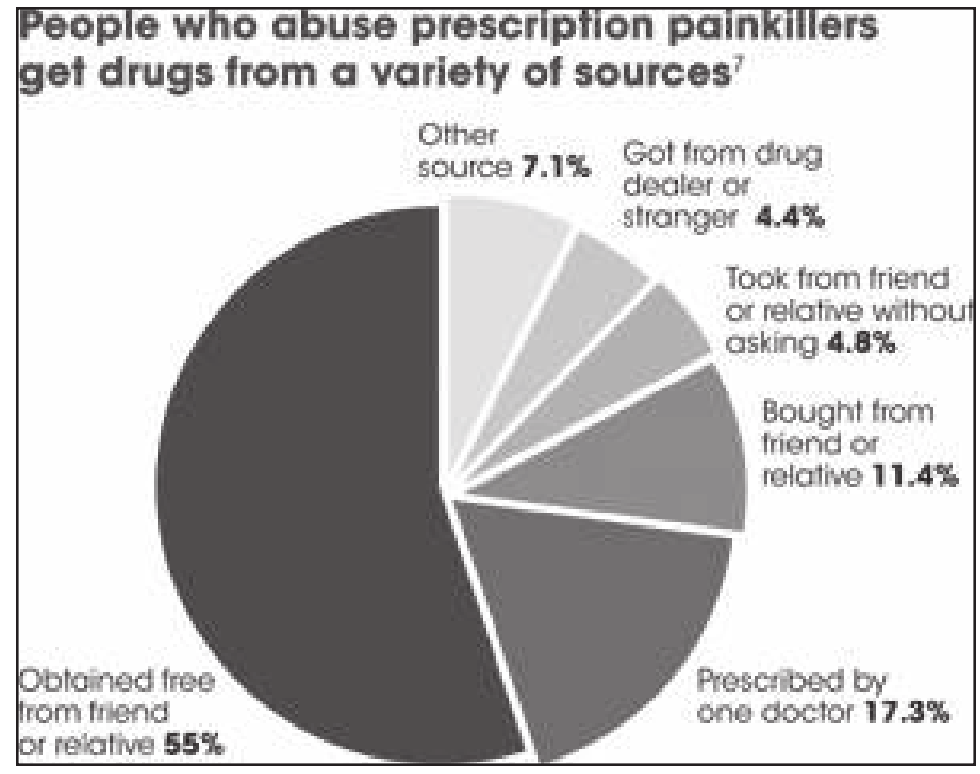
By Michael Campbell

Sit for a short time with a group of addicts discussing how their addiction began, how they sustained their habit, or the treatment approaches that have failed, and the discussion will probably include disparaging references to doctors. Increasingly, the medical profession is identified as part of the problem and the unabashed promoters of weak solutions. Few will go as far as Steven Tyler, the Aerosmith spokesman in recovery, who recently described doctors as the "new dealers." However, the consensus is that doctors too often end up on the wrong side of preventing and treating addiction.

Mary is a school teacher in her 50s who blames her doctor for her addiction to drugs. She was injured in a car accident and describes how her doctor gave her opiates to manage pain. He never discussed with her the addictive properties of her prescription, or the importance of transitioning as rapidly as possible to non-addictive approaches of pain management. "When I told him the pain was not going away, he just kept increasing my dosage. If I ran out of pills before it was time for a refill, the doctor at the pain clinic would write me a second 'scrip. By the end of the first year, I realized that I had become an addict."

In the effort to address acute and chronic pain, depression, anxiety, insomnia, and ADHD, doctors are constantly facing the risk that they may be prescribing the medication that begins the path to addiction. All too often they "awaken" an addiction that may be in recovery by prescribing a medication that has mood-altering characteristics. Give an addict or alcoholic a medication that changes the way they feel and you stimulate their disease. Addiction is often described as a "sleeping tiger," ready to strike at a moment of weakness. During the past year, we have treated a number of alcoholics at St. Joseph Institute who had been in recovery for many years and then relapsed following the use of prescribed opiates for injuries and minor surgery.

While doctors can be accused of over-prescribing, giving addictive medications to people with a history of addiction, or not carefully educating their patients on the dangers of addictive drugs, they are often the victims of carefully planned deception. "Mark" has spent hours reading WebMD and the online resources of the Mayo Clinic. He knows the symptoms that justify a prescription for an opiate or benzodiazepine. His ability to fake pain or emotional distress evokes comparison with a Broadway actor. Mark estimates that he has been to the emergency room almost 50 times, and has "never failed to score" the drug he was after.



Source: Centers for Disease Control and Prevention

A reality that must concern all of us is the amount of available prescription drugs that are not used by the patient. The CDC has documented how more than 50 percent of the drugs being abused come from a friend or relative.

Too often these drugs are from medications that are being over-prescribed. Dad gets a 10-day prescription of Percocet for a sprained ankle and stops using them after three days. The bottle sits in the medicine cabinet until his son sees it and shares the remainder with his friends. Addicts tell us how they like visiting grandma, because she often has left-over pills in her medicine cabinet that can be used or sold on the street. In the face of 500,000 emergency room visits each year for prescription drug overdoses, there is the need for great caution. When it comes to mood-altering and addictive medications, it may be better to prescribe too few than too many.

The other area in which doctors are vilified by addicts is prescribing medications to manage addiction. There are an estimated 500,000 opiate users taking Suboxone or anti-craving medications. For many, it keeps them away from drugs, but it does not help them establish the habits, and make the changes, necessary for sustained recovery. Rather than lead toward a drug-free life, too often these medications become the "fix" that works until someone stops the prescription, only to rapidly tumble back into addiction.

Users often describe Suboxone, Naltrexone, and Vivitrol as "Band-Aids" – an excuse to avoid the real work of recovery. Many Internet articles claim that a Suboxone doctor makes $15,000 a month treating 100 patients, fueling the perception that doctors are not concerned about addressing addiction, but only the potential money to be made.

When we pull together the pieces of the addiction puzzle, doctors do not get painted in a good light. Too many people are addicted to prescription medications, it is too easy to get a 'scrip for your drug of choice, there is too little patient education about addiction, and prevention is an unaddressed topic. However, I suggest it is unfair to paint the medical profession as the only bad guy. Blame can and should be widely shared.

In considering these issues there is a need for a new approach to addiction treatment and the development of new models for recovery. Too often doctors, treatment providers, and community groups work in isolation from one another. With more than 23 million Americans with an active addiction, and only 10 percent receiving treatment, we are all failing in some way to bring this epidemic under control. Now is the time to work together, engaging in dialogue to develop better solutions. We need better answers, and we need them now.

Michael Campbell is the President and Co-Founder of St. Joseph Institute for Addiction, a rehab program near State College, PA that is recognized for innovation and a personalized approach to treatment – www.stjosephinstitute.com.

Objectivity in Communication

By Jane Mock, CPHRM

No one argues that physicians have a lot on their plates. Regular challenges include providing quality care to each patient within a fully booked schedule; keeping up with medical record documentation; learning new systems; maintaining current awareness of regulations and laws; and navigating reimbursement issues. In addition, physicians spend a great deal of time educating patients and managing expectations for treatment, yet they still encounter the non-compliant, demanding or dissatisfied patient.

These circumstances can create a charged environment. Add into the mix a disagreement with a colleague, an unanticipated outcome in patient care, or a notice of a lawsuit, and the environment gets even hotter. Many providers have rushed to confess their shortcomings or criticize a colleague's care (which can appear to be self-serving), only to learn later that the outcome was unrelated to the care given or, in the case of criticizing a colleague, that there were additional factors that influenced treatment choices. In the tense environment after an adverse outcome, providers may say things to patients or document opinions in the chart that are not objective and do not serve to promote patient care.

Sometimes a subsequent treating physician (knowingly or unknowingly) acts as a trigger for the filing of a lawsuit when he or she makes a remark to the patient that is critical of a prior physician's care. In addition to a physician's verbalizing his or her subjective opinion to the patient, similar comments expressed in the medical record do not meet the patient's clinical needs. Some physicians have actually found themselves pulled into the litigation process when they make remarks to a patient about another provider's care, only to learn that there is an active suit in progress. The following scenario shows how disparaging remarks can help a plaintiff's case that is already underway.

A surgeon performed an angioplasty and stenting on a 55-year-old male patient who had suffered an acute myocardial infarction. One week later, the patient experienced a pulmonary embolism and a chest infection. He also developed an aortic aneurysm. He was then treated at a clinic over a two-week period. The physicians at the clinic were able to resolve the chest infection with a drain but did not address the aortic aneurysm. Following the patient's clinic stay, he returned to the surgeon, who performed a second procedure to address the aortic aneurysm. Because the patient had enjoyed a good rapport with the physicians at the clinic, he decided to see them for follow-up care. During one of these visits, his primary treating physician told him that he was "lucky to be alive" because the surgeon clearly did not perform the first procedure properly. The physician documented this conversation in the medical record. Unbeknownst to the physician, the patient and his family had recently filed a claim against the surgeon, alleging negligence resulting in his poor post-surgical course and need for additional surgery.

In addition to speaking negatively about another provider's care and documenting those comments, this physician—who did not know that the patient was entering into litigation with the surgeon—was soon subpoenaed for deposition by the patient's attorney.

A physician's ability to respond appropriately to patient-care situations involving other providers is crucial. Expressing oneself objectively in both written and oral communication is key to promoting continued patient care and, if applicable, defense of a malpractice claim.

Risk Management Recommendations

Communicating with the Patient

- Contact your insurance carrier's Risk Management Department for assistance with communicating with patients.
- If the patient asks you to comment on the treatment or role of other healthcare providers, only comment on your own care and interaction with the patient.
- When conveying to the patient and family what is known about an unanticipated outcome, avoid speculation and blaming anyone.
- If a patient asks a specific question about an unanticipated outcome, and the cause is not yet known, an honest answer might be, "I don't know" or "I don't know yet."

Communicating with a Colleague

- Access your Clinical Quality Committee or Medical Director/Medical leadership as appropriate for assistance with handling concerns regarding clinical patient care provided or with patient inquiries regarding a physician's care provided.
- Review the patient's record, previous studies, etc., to prepare for the discussion. The better prepared you are with the facts, the more likely you are to maintain a cool head; conversely, plunging into a conversation with little information and a lot of emotion pulls attention away from proper patient care and management of the event.
- Find a quiet place to have a discussion; this demonstrates respect for the work environment and also protects patient confidentiality.
- Discuss disagreements about care objectively; ask for clarification.

Documenting in the Medical Record

- Document in a timely fashion.
- Focus your chart documentation on your care of the patient.
- Document discrepancies using objective language.
- If addressing the contents of comparison reports, prepare a formal, written report for all studies that includes review of previous reports and, if indicated, comparison of previous images when possible. State if previous reports and images are not available and any attempts to obtain them.

DO NOT:

- Blame or disparage other providers or the patient in the chart
- Offer personal (other than medical) opinions
- Speculate on causes of poor outcomes
- Make observations, notes or entries unrelated to patient care
- Make derogatory statements or use language that blames another healthcare provider (e.g., "error," "mistake in judgment")
- Engage in professional disputes in the chart
- Include references to incident reports, legal actions, and attorney or risk management activities in the medical record **(These should be maintained in a separate, confidential file.)**

In the Event of a Claim or a Potential Claim

- **NEVER** alter the medical record in any way. **If you** are involved in an adverse or unanticipated outcome, contact your insurance carrier's Claims Department to report the medical incident. The claims specialist may ask you to prepare a legally privileged and confidential narrative summary to be used by Claims Department personnel and the defense attorney, as indicated. In the narrative, you can do the following:
  - Clarify chart entries
  - Elaborate on customs and practices
  - Recollect medical reasoning and reconstruct decision-making processes
  - Document discussions that were not included in the formal chart (e.g., those with the patient and family members, informal consultations with other healthcare practitioners and interactions with hospital personnel)
  - Engage in a preliminary retrospective analysis of your treatment and consider potential criticisms and appropriate explanations
- Keep a copy of the narrative summary in a confidential litigation file—separate from the medical record—so that the information remains personal and private.

Additional PMSLIC Risk Management Resources

Additional resources are available to PMSLIC policyholders regarding communications, documentation, the litigation process, etc. Here are a few examples:

- Disclosure of Unanticipated Outcomes
- Medical Records: Corrections and Alterations
- CME Course: Communication and Follow-Up
- CME Course: Responses to Litigation Stress
- Physician as Defendant: Understanding Your Role in the Litigation Process

Current PMSLIC policyholders can obtain courses or resources by contacting PMSLIC's Risk Management Department at (800) 492-7898. If you are not a current PMSLIC policyholder and would like to learn more about how to join PMSLIC, please call your agent or 800-445-1212 and ask to speak with a PMSLIC sales representative.

Jane Mock, CPHRM, is a Risk Management Specialist with PMSLIC Insurance Company and the NORCAL Group.

Personal Care Home Administrator Training at Penn State

This continuing education health care program is designed for those professionals who are preparing to become personal care home administrators and for health care workers who need to meet their continuing education requirements. These courses will address topics surrounding personal care homes as well as those issues related to patients who need home care assistance. For additional information contact Dr. Mary Sacavage at 570-385-6217 or mus53@psu.edu.

Who Should Attend:

- Administrators and aspiring Administrators
- Nurses, caregivers, and health care professionals who wish to fulfill continuing education requirements

Schedule

The entire 100 hours of training is offered in a Tuesday/Thursday format. September 24 to October 31, 2013, with the CPR/First Aid class to be arranged at each location.

(Lunch is on your own) Cost: $1395

**First Aid Training/Certification in CPR and Obstructed Airways Techniques (includes American Red Cross Certification). Cost: $172 (This fee includes a $32 fee that is charged by the American Red Cross for your certification)

Date/Time to be determined by each location

**If you are already CPR and First Aid certified, you are exempt from this session. Please provide a copy of your certificate along with your registration. Please note, no discount if you are already certified.

Classes will be held at the following locations via Video Learning Network

Campuses:

Penn State Altoona, Altoona, PA
Penn State Fayette, Uniontown, PA
Penn State Greater Allegheny, McKeesport, PA
Penn State Lehigh Valley, Center Valley, PA
Penn State Northern Tier, Towanda, PA
Penn State Schuylkill, Schuylkill Haven, PA
Penn State Worthington-Scranton, Dunmore, PA

Personal Care Home Administrator Training
Offered by Penn State Schuylkill via video conference
Held at the following Penn State campuses:
Altoona, Fayette, Greater Allegheny, Lehigh Valley, Northern Tier, Schuylkill, and Worthington-Scranton
Fall 2013

Course	Date		Time	Cost	Check to Register
Orientation Wednesday, October 16, 2013 9:00 a.m. to 4:00 p.m.	For additional orientation dates, visit the website: http://www.dpw.state.pa.us/provider/training/administratororientationprogramschedule/index.htm				
Complete 100 hours (includes exam)	All	All	All	$1,395	
Personal care services and personal hygiene	Tuesday	September 24	8:00 a.m. – 5:30 p.m.	$180	
**Care for residents with dementia, cognitive impairments, and other special needs	Thursday	September 26	8:00 a.m. – 4:30 p.m	$160	
**Nutrition, food handling, and sanitation	Tuesday	October 1	8:00 a.m. – 3:30 p.m.	$140	
**Care for residents with intellectual disabilities	Tuesday	October 1	3:30 p.m. – 5:30 p.m.	$40	
**Writing, completing, and implementing initial assessments; annual assessments; and support plans	Thursday	October 3	8:00 a.m. – 1:30 p.m	$100	
**Cultural competency	Thursday	October 3	1:30 p.m. – 4:30 p.m.	$60	
**Budgeting, financial record keeping and resident records	Tuesday	October 8	8:00 a.m. – noon	$80	
**Recreation	Tuesday	October 8	12:30 p.m. – 4:30 p.m.	$80	
**Staff supervision and staff person training including developing orientation and training guidelines for staff	Thursday	October 10	8:00 a.m. – 4:30 p.m.	$160	
**Care for residents with mental illness	Tuesday	October 15	8:00 a.m. – 5:30 p.m.	$180	
DPW Orientation	Wednesday	October 16	9:00 a.m. – 4:00 p.m.	FREE	
**Abuse and neglect prevention and reporting	Thursday	October 17	8:00 a.m. – 2:30 p.m.	$120	
**Resident rights	Thursday	October 17	2:30 p.m. – 5:30 p.m.	$60	
**Local, state, and federal laws and regulations pertaining to the operation of a home	Tuesday	October 22	8:00 a.m. – 10:00 a.m.	$40	
**Resident home contracts	Tuesday	October 22	10:00 a.m. – noon	$40	
**Community resources, social services, and activities in the community	Tuesday	October 22	12:30 p.m. – 4:30 p.m.	$80	
**Gerontology	Thursday	October 24	8:00 a.m. – 2:30 p.m.	$120	
**Medication procedures, medication effect and side effect, and universal precautions	Tuesday	October 29	8:00 a.m. – 4:00 p.m.	$140	
Fire Prevention and **emergency preparedness	Thursday	October 31	8:00 a.m. – noon	$80	
First Aid Training/Certification in CPR and Obstructed Airways Techniques* (This fee includes a $32 fee that is charged by the American Red Cross for your certification)	TBD	TBD	7 hours	$172	
PCHA exam (you must have completed all 100 hours of training to sit for this exam)	Thursday	October 31	1:00 p.m. – 3:00 p.m.	Exam only $100	

*If you are already CPR and First Aid Certified, you are exempt from the CPR and First Aid courses. Please send a copy of your certificate along with your registration.
**Course may apply toward Act 58 annual continuing education requirements for Registered Nurses.

PCHA Exam Schedule

Thursday, October 31, 2013 1:00 – 3:00 p.m.

Allow for two hours; this is the maximum time to complete the 100 question, multiple-choice exam.

Please note: Licensed nursing home administrators who wish to become certified as personal care home administrators must successfully complete the orientation and the exam. The fee for nursing home administrators to take the exam is $100.

Link for scholarship information

Scholarships may be available through the PA Department of Public Welfare. Please call 717-783-3670 for information or view the website at:

http://www.dpw.state.pa.us/provider/training/personalcarehometraining/administratorscholarshipforpersonalcarehomes/index.htm

Required Administrator Orientation

In addition to attendance in the 100 hour Administrator training program, participants must also attend the required PA Department of Public Welfare Administrator Orientation. The orientation is provided by the PA Department of Welfare at no cost.

Orientation will be available at the participating Penn State locations on October 16, 2013, from 9:00 a.m. to 4:00 p.m. Contact the Department of Public Welfare to register. Please call DPW with any questions at 1-888-322-3664 or visit the website at:

http://www.dpw.state.pa.us/provider/training/personalcarehometraining/administratororientationprogramschedule/index.htm

Attendance and Continuing Education Credit Hours

Accurate records of attendance will be maintained to verify and report the continuing education credit hours. Upon your completion of the program, a certificate of completion will be mailed to you.

Video Learning Network

The Video Learning Network (VLN) is a videoconferencing system that enables an instructor to be located in one classroom, while the students are located in multiple classrooms. In a VLN classroom, cameras and microphones are used to broadcast the instructor and students across all sites via TV monitors. Other equipment enables the instructor to share instructional materials, such as PowerPoint presentations, documents, and videos.

Accommodations

Penn State encourages qualified persons with disabilities to participate in its programs and activities. If you anticipate needing any type of accommodation or have questions about the physical access provided, please contact Mary Sacavage at 570-385-6217 in advance of your participation or visit.

Continuing Education Disclaimer

Penn State School of Nursing Outreach is an approved provider of continuing nursing education by the Pennsylvania State Nurses Association, and accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Planners, faculty, and presenters disclose no conflict of interest relative to this educational activity.

Cancellation Policy: Registration must be received one week prior to the beginning of the course. The University reserves the right to cancel or postpone any course because of insufficient enrollment or for other unforeseen circumstances. If a program is cancelled, registrants will be notified by phone and a refund will be processed. Otherwise, refunds will be made only if written cancellation is received at least ten business days prior to the first class. To cancel a registration, fax or email your notification to 570-385-6216 or mus53@psu.edu. The**re will be no refunds issued after September 10, 2013.**

The Bodiography Fitness and Strength Training System Offers a Ballet Workout for EveryBODY

By Christopher Cussat

The **Bodiography Fitness and Strength Training System** (BFSTS) is a new and challenging full-body workout that fuses the techniques and benefits of ballet conditioning with skeletal alignment, natural body weight, and the use of props (mats, weights, balls, and bands). Created by **Bodiography Contemporary Ballet**'s Artistic Director, **Maria Caruso**, the BFSTS is derived directly out of the fitness and strength training needs of professional ballet dancers. By combining the alignment principles of ballet, traditional training techniques, and specifically constructed exercise sequences, this workout is truly the "ballet workout for everyBODY."

Caruso acknowledges that she selfishly started the BFSTS a decade ago to keep herself conditioned for performance. "When I transitioned out of dancing full-time and into directing, I still performed cameo roles at each performance," she explains. "With a challenging schedule, I needed to design a fitness format for myself that would offer me the benefits of keeping my dancer physique without having to spend the countless hours in the studio." So Caruso introduced the system into her Pilates classes and found that participants were seeing similar results—long lean legs, a strong core, and muscular definition that normally took 10-12 hours of ballet class to maintain. "The program took off some time ago, but it took that passion and commitment of one of my artists, Kirstie Corso, to bring the training manual and program to life," she adds.

The BFSTS believes that overall strength stems from a strong center, and targets the core through intense and concentrated abdominal work. Working from the core and moving outwards, the Bodiography sequential format is designed to target all muscle groups from the abdominals, back, legs, arms, and glutes. In order to do this in an hour, exercises often work up to three muscle groups at one time. Muscle groups such as abdominals, inner thighs, and triceps are combined together in one exercise to allow for a more efficient and productive workout. The exercises are not only designed for the specific needs of dancers, but are simple and effective for any individual looking to obtain strong and lean muscles.

Such emphasis on overall health and fitness is nothing new to the operating philosophy of Bodiography, which has been focused on health and wellness since its inception. "I can't recall a day when I didn't work with an artist who was equally passionate about fitness, education, AND performance," notes Caruso. "Building a strong company brand has always meant that when you talk the talk, you must walk the walk." She explains that fitness and performance always work equally, and the BFSTS has been a critical component of Bodiography's success.

As a true proponent of the system, Caruso has applied this training system into the conditioning of her professional ballet company, Bodiography Contemporary Ballet. In fact, each company member participates in 3-4 BFSTS classes per week in addition to their ballet regimen. "But, that is part of their job," says Caruso. "BFSTS is a supplement to the critical training that keeps them on the stage—but it also does provide the average person with the benefits of that physique in as little as 60 minutes a week (with cardio training additional)." After years of personal training and conditioning, her dancers have also become the first certified "Bodiography Fitness and Strength" instructors!

Bodiography Contemporary Ballet also recently announced its Squirrel Hill Studio Expansion. Moving into Bodiography's 12th anniversary, Caruso is delighted to share the news of their facility expansion at the Bodiography Center for Movement. Opening on September 4, 2013, Caruso unveiled a complete building refacing which gave it a fresh look, a new 2000-square-foot storefront studio space, a second-floor tap studio, and the renovation of the third-floor studios. Plus, over the course of the year, Bodiography will look to take over additional space for offices and conference areas in their Squirrel Hill home. The new building is artfully decorated with photography of the company members by Eric Rosé.

According to Caruso, the Bodiography Center for Movement expansion began as an opportunity for them to develop and house programs beyond their conservatory. "The need for space to expand our conservatory was just as great as our desire to offer fitness and recreational programs, as well as electives for our conservatory students." In addition to building Bodiography's independent program, it has been a great desire of Caruso's to continue supporting young artists and companies with opportunities to have rehearsal and performance space at an affordable cost. "Thus, this expansion is just as important to Bodiography as it is to the community," she concludes.

Building on a strong foundation of social activism and artistic philanthropic endeavors, Caruso is thrilled to announce the company's 2013-2014 season while also offering a host of new fitness, recreational, conservatory, and community classes this coming year. Trainings are open to all fitness enthusiasts, with or without ballet backgrounds. For tickets or information about upcoming performances, visit: www.bodiographycbc.com or call: 412.456.6666.

For more information on the Bodiography Fitness and Strength Training System, instructor trainings, promotional classes, or licensing, please contact BFSTS Program Director, Kirstie Corso, at: kirstie@bodiographycbc.com.

Anova Home Health — Providing Compassionate Home Health Care

By Kathleen Ganster

When someone mentions "home health care" many may think of care for seniors. But home health care is for anyone of any age needing assistance with daily living and chronic conditions.

"We provide caregivers in the home to those in need and that includes children. We have had patients from newborn children to 104. We have a patient right now who is 104," Patty Knouse, branch director of the Anova Home Health Care Offices, Inc. Pittsburgh office said.

Home health care allows people to live at home for as long as possible, as comfortably as possible. For someone with chronic conditions, activities of daily living that are simple for most may be difficult or impossible without assistance.

Direct care givers from Anova assist with the tasks of daily living such as taking a shower safely, preparing meals, and needing assistance to walk or get in and out of a chair, shopping or doing the laundry, said Peggy Gursky, executive vice president.

"Help with these daily tasks can make all the difference in being able to remain independent," Gursky said.

Knouse added, "These are basic things that allow someone to feel normal. Everyone deserves that."

The advantage of having direct care workers from a service like Anova is that they can work in conjunction with their home health division for those who need more health care services. If someone moves into the hospice phase of care, they can continue to have the same home health care that the Anova private duty care has provided.

The caregiver may be the one main contact the patient has during a day and the socialization from the visit may be as important as the physical assistance. And in many cases, the caregiver becomes like a member of the family. That relationship is key to the patient's and family's well-being and peace of mind.

"Working many hours with a consumer allows them to know the consumer's needs and to fulfill those needs. Our caregivers become so attached that when their patient passes away, they attend the funeral. The death becomes a personal loss for the caregiver," Gursky said.

For parents of children with chronic conditions, the home health care may be essential for their health as well.

"It is exhausting caring for someone 24/7 and that can wear out the caregiver if they try to do it all themselves. If you don't have a substitute support system, you could really suffer yourself," Knouse said.

Another strength of Anova's care is their flexibility, said Gursky. One family who used both Anova's private duty and hospice care services told the staff that by allowing them the flexibility to get more care for their loved one when they needed it, they were able to continuing leading their own lives while still having the time to say good-bye to their mother.

After she passed, the family thanked the staff by hosting a luncheon in their honor.

"The caregivers and nurses were considered to be part of the family and were so appreciated," she said.

Another family wrote a letter of thanks stating that although it was difficult in turning over the care of a loved one to other caregivers, working with Anova was a wonderful experience.

"She wrote, 'The staff met all of the needs of our loved one, maintained the home, made grocery lists and made our lives easier just knowing that someone was there,'" said Gursky.

The care and training that go into the hiring and preparation for the caregivers by Anova is crucial to providing this quality care, according to Knouse.

"The caregivers are essential. We are nothing without are great caregivers and we realize their importance," Knouse said.

For more information bout Anova Home Healthcare Services, Inc. visit www.anovahomehealth.com.

Heads Up on Concussions!

By Dr. Steven T. Gough, PT, MS, DPT, OCS

Pittsburgh's star athletes Sidney Crosby and Troy Polamalu have increased awareness of concussions in sports. Head injuries are on the rise for athletes at all levels of play. An estimated 4 to 5 million concussions occur annually, with increases emerging among middle school athletes. The risk of injury increases when the athlete participates in contact sports (football, rugby, soccer, lacrosse and field or ice hockey).

What is a Concussion?

A concussion is a type of traumatic brain injury that is caused by a blow to the head or body. There may be no visible signs of a brain injury. Your brain is a soft organ that is surrounded by spinal fluid and protected by your hard skull. If your head or your body is hit hard, your brain can crash into your skull and be injured.

How can athletes prevent concussions?

Athletes in any sport can do several things to reduce their chance of concussion. Here are just a few:

Cross-train to maintain strength throughout the body, rather than only the muscles used for your sport. Working on lower body strength and balance could help avoid collisions on the field. Strengthening the muscles surrounding the neck can also help reduce head movement after a hit.

Wear the proper protective equipment. A helmet is essential to protecting your brain and can reduce your chance of serious injury by as much as 85%.

Follow the rules! Many of the rules put into play have been written specifically for the safety of the players. In an effort to reduce the type of hits that can cause concussions, the NFL has stepped up its enforcement of rules against helmet-to-helmet contact.

Coaches and trainers can also take steps to ensure their players are following the above guidelines, and they can also teach about concussions and the plays that can cause them. If a player sustains a head to head hit or collision, they should immediately be removed from play. Continuing an activity or returning to activity too soon may increase the damage done to the brain following a concussion.

What are the symptoms of a concussion?

Immediately following a hit or collision a player may appear to be dazed or stunned, forget plays, move clumsily, talk slowly, lose consciousness, forget events before the hit (retrograde amnesia), or forget events after the hit (anterograde amnesia).

Concussions can also be caused by multiple, minor blows, which is why players should be aware of the following symptoms of concussion: headache, nausea, balance problems or dizziness, double or fuzzy vision, sensitivity to light or noise, feeling sluggish or "foggy", changes in sleep pattern, and concentration or memory problems.

For more information visit www.AlleghenyChesapeake.com or call *1-800-NEW-SELF.*

Q & A: Impact Testing & Concussion Management

Q: What is ImPACT?

A: Immediate Post-Concussion Assessment and Cognitive Testing is the most-widely used and most scientifically validated computerized concussion evaluation system.

Q: When should an athlete be tested?

A: It is suggested that athletes 11(+) undergo baseline testing every two years and following a suspected concussion. The baseline test will act as a comparison to assess any changes or damage caused by a concussion.

Q: How should an athlete be treated?

A: Symptoms may decrease after hours, weeks or even months. If symptoms persist, a physical therapist can evaluate and treat many problems related to concussion. PT treatment can improve balance, stop dizziness, and reduce headaches.

A Key to Controlling Healthcare Costs and Inefficiencies — Reliable Patient Transportation

By John Chamberlin

As a healthcare provider or administrator, you understand how frustrating it can be to have patients arrive or depart for their appointment 30-60 minutes late due to the transportation vendor "running behind." Just as important, you understand the economics of these inefficiencies in your system down line:

- The delay and inconvenience caused to your other patients.
- If the patients cannot be seen, or seen on time, it can be difficult to design and maintain a proper care plan.
- The potential medical-legal issues of having the patients exposed to numerous liabilities while sitting in a wheelchair in your facility's hallway or lobby as they await to be picked up and returned to their home or facility.

And for facilities that currently coordinate their own transportation, are you providing your own drivers and vehicles simply because you believe outside vendors are less reliable? And, if so, are you absorbing and inordinate amount of insurance, vehicle maintenance costs and exposing the organization to transportation liabilities based on the assumption that there are no better alternatives for transportation?

When reviewing options for non-emergent transportation, there are few options that properly execute the sensitive mix between patient convenience and logistic efficiency.

However, a Pittsburgh-based healthcare transportation company has leveraged their understanding of these issues into rapid growth.

Transport U began operating in 2006 and has seen almost 100 percent growth year-over-year as its client base of long-term care and medical services facilities looking to secure efficient, dependable, high-touch, highly-skilled transportation to reduce their inefficiencies and improve patient outcomes.

And as Transport U has grown over the past seven years, one of the ways it has grown is by sticking to an individualized transportation service model versus the traditional shared ride service. When a patient is picked up for transport, they are the only trip that driver is focused on at that time.

The company's senior leadership has also been able to maintain consistency in its high level of service, individualized transport and reliability by requiring all staff members to undergo extensive training, including geriatric sensitivity training, according to Transport U's Vice President, Steve Simmonds. This training includes the staff being strapped in a wheelchair and transported as well as donning cataract glasses so that they have an understanding of the impairments and concerns their passengers regularly face.

Additionally, Transport U has made it a distinctive competency to provide what they call "door-through-door" service. Their staff does not just drop the patient off at the curb; they make sure they get to their destination, down to the office, and then back again direct into their home. For oncology appointments and cancer treatments, Transport U staff stay with the patient which, therefore, alleviates the issue of patients waiting for their ride to return, and allows the patient to continue recovery at home instead of the waiting room of a medical facility.

Currently, Transport U operates 24 hours per day, 7 days per week and has:

- 85 employees
- 100 vehicles from wheelchair-accessible Mini vans, mid-size vans and busses
- 500 trips daily

The company's steady growth, according to Simmonds, is attributed to economies of scale and great service but also being able to customize transportation solutions to their customers' needs. There is no single solution to every facility's transportation requirements. Long-term care facilities may need a mix of medical as well as social transportation services. Dialysis center staff requirements are different from those of hospital discharge staff. Transport U consultants work with each facility, individually, to assure highly reliable transportation service.

Al Allison is President and CEO of Baptist Homes Society, located in the South Hills area of Pittsburgh. "We have been utilizing Transport U for over 5 years now. They provide an extraordinary service experience. They really have a customer service orientation which is consistent with the customer values of our own organization. On a one-to-one level, the residents love the service and love the driver," said Allison.

As the healthcare industry continues to reform itself, along with noting that the Western Pennsylvania has the largest senior citizen population in the country, Transport U appears to be poised to maintain its position as a premier healthcare transportation company. But more importantly, Transport U is helping others to recognize that the concept of patient transportation coordination is a distinctive role within the healthcare continuum.

For more information on Transport U or for a quote, please contact Steve Simmonds at (412) 281-8350 or visit, www.TransportU.net.

Five TIPS for Integrating Vascular Into a Cardiac Continuum

By Kelly Neal Wilson

Vascular services represent a dynamic and progressively important component of the cardiovascular continuum in programs across the country.

Fueled by improved disease awareness, better patient accessibility and education, fiscal appeal, rapid technological advancement, and multidisciplinary physician interest, hospitals continue to actively pursue vascular services expansions…as they should!

Eroding procedural volumes both in the invasive and non-invasive departments within cardiovascular services persists, causing physicians and administrators to collaborate on ways to protect declining volumes. As a result, vascular has emerged as an attractive growth opportunity.

CORAZON RECOMMENDS THE FOLLOWING WHEN CONSIDERING THE INTEGRATION OF VASCULAR SERVICES INTO THE CARDIAC CONTINUUM:

1. Perform comprehensive analysis of current market capture for vascular medical and surgical procedures, and then compare utilization rates to state and national benchmarks.

This analysis will validate whether vascular services are, in fact, an underutilized service offering in your market, which will help with decision-making about the potential for expansion.

2. Engage both specialists and primary care physicians in discussions about expansion. Vascular screening and detection will require the support and diligence of practices across the continuum.

Meanwhile, focused attention on vascular disease must be incorporated in the day-to-day operations of referring physicians and PCPs. Involving podiatry rounds-out the multidisciplinary team to cover the varied referral sources to the program.

3. Use a vascular coordinator as an effective way to monitor/cultivate referrals

and ensure patient follow-up as a means to prevent fragmented longitudinal care. This role is constantly evolving and requires excellent communication skills and the ability to engage primary care and referring physicians.

4. Create a vascular quality metrics dashboard and track/report outcomes as part of the CV Service Line.

Ensure each specialty providing vascular care services is being measured by the same quality outcomes.

Include physician peer review as part of the quarterly quality process and use performance as component of re-credentialing.

5. Commit marketing dollars to increase vascular awareness in the community and direct patients to screening events.

Physician CME sessions with a focus on vascular detection and current therapeutic offerings available also raises awareness within a hospital's medical staff and helps promote referrals within the system.

Understanding the defined treatment strategies and developing cohesive and collaborative systems of care among providers and facilities will ensure future success and profitability — though these are not easy tasks to accomplish!

Untapped clinical and financial opportunity exists in almost every market, but requires creative strategies to capture.

Strong physician collaboration, from primary care through the vascular specialists, is an essential first step to meeting patient needs in a constantly changing healthcare environment.

From there, the possibilities are endless.

Corazon offers consulting, recruitment, interim management, and physician practice & alignment services to hospitals and practices in the heart, vascular, neuro, and orthopedics specialties. To learn more, call 412-364-8200 or visit www.corazoninc.com.

Copper as an Antimicrobial Touch Surface Fighting the Battle Against Healthcare Acquired Infections

By Jeri Steele, RN

If a person is hospitalized today, they have a 1 in 20 chance of acquiring an infection - of those who acquire an infection there is a 1 in 20 chance of dying from that infection. 4.5% of hospitalized patients develop healthcare acquired infections, annually. In the US, Healthcare Associated Infections (HAI's) claim the lives of 100,000 people each year. Resistant pathogens require expensive drugs, extended hospital stays and readmissions increasing healthcare costs by as much as $45 billion a year.

Copper is essential to the development of all forms of life and is naturally present in the earth's crust. It is the oldest metal used by man. Microbes were not understood until the 19th century, but copper's hygienic properties were well known through experience and tradition. The Egyptians, Romans, Aztecs and the Greeks (Hippocrates himself) used copper as a sterilization agent for drinking water, treatment of wounds, boils, eye infections and venereal ulcers. Today, copper is an active ingredient in many different types of antimicrobial products: fungicides, antifouling paints, antimicrobial medicines, oral hygiene products, hygienic medical devices, and antiseptics

In February 2008, the US Environmental Protection Agency (EPA) approved the registration of copper as an antimicrobial agent to reduce specific harmful bacteria linked to potentially deadly microbial infections. Surfaces made from copper and copper alloys, containing at least 65% copper, kill 99.9% of potentially harmful micro-organisms within 1 to 3 hours of exposure.

There are over 450 copper alloys which can be marketed in the U.S. as antimicrobial. Potential uses include door and furniture hardware, bed rails, intravenous (IV) poles, bedside tables, soap, hand-sanitizer and paper towel dispensers, faucets, sinks and work- stations. Can copper and copper alloys (brass and bronze) help curb the spread of bacteria that cause healthcare- acquired infections?

CASE STUDIES

The US Copper Development Association (CDA) is taking a lead role through research funded by the US Department of Defense. The study took place at Memorial Sloan-Kettering Cancer Center in New York, the Medical University of South Carolina and the Ralph H. Johnson VA Medical Center, in Charleston, SC. Intensive Care Units of each hospital took part. Three different patient populations were represented. Patients were randomly placed in available rooms with or without copper alloy surfaces, and the rates of HAIs were compared. A total of 650 patients and 16 rooms (8 copper and 8 standard) were studied between July 12, 2010 and June 14, 2011. The research showed that the most heavily contaminated objects were in close proximity to the patient including:

- Bedrail
- IV Pole
- Nurse Call Device
- Data Input Device (computer mouse)
- Visitor Chair Arms

Routine cleaning and sanitizing protocols were followed in all rooms. No additional cleaning measures were adopted or omitted.

Published data from the clinical trial found that the strategic placement of copper surfaces in the Intensive Care Unit reduced the number of patients who developed HAIs by 58%. The microbial burden on copper alloy surfaces was decreased by 83% as compared to non- copper surfaces.

A paper published by the CDA makes a "business case" for the use of antimicrobial copper touch surfaces based on this research. The paper states that at a typical 420 bed hospital, it is projected that treatment costs for HAI's will be $36 million annually. Using antimicrobial copper surfaces, on the items listed in the research, could cut total infections by 20% and translate to an annual savings of $7.2 million. Based on an initial one- time cost, of $3 to $6 million, to outfit the single patient

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rooms in a 420 bed hospital with antimicrobial copper touch surfaces would yield a payback in less than one year.

With the Center for Medicare & Medicaid Services (CMS) instituting policies to limit hospital reimbursement for HAIs (and private insurance providers expected to follow suit), the negative impact to a hospital's operating budget can be significant.

Antimicrobial Copper alloy touch surfaces will aid in the reduction of infectious bacteria throughout hospitals, while also helping to comply with federal mandates for improved patient safety.

Additionally, the copper alloy components are durable, may last for decades and are 100% recyclable.

"Copper alloy surfaces offer an alternative way to reduce the increasing number of HAIs, without having to worry about changing healthcare worker behavior," said Dr. Michael Schmidt, Vice Chairman of Microbiology and Immunology at the Medical University of South Carolina and one of the authors of the study.

"Because the antimicrobial effect is a continuous property of copper, the regrowth of deadly bacteria is significantly less on these surfaces, making a safer environment for hospital patients."

The EPA requires the following statement to be included when making public health claims related to the use of Antimicrobial Copper Alloys:

"The use of a Copper Alloy surface is a supplement to and not a substitute for standard infection control practices; users must continue to follow all current infection control practices, including those practices related to cleaning and disinfection of environmental surfaces. The Copper Alloy surface material has been shown to reduce microbial contamination, but it does not necessarily prevent cross-contamination."

Copper and copper alloys used as an antimicrobial touch surface is a step in a positive direction.

Jeri Steele does healthcare research and design at Stantec in Butler, Pennsylvania. Jeri can be reached at jeri.steele@stantec.com.

Population Health Portals Take Worksite Wellness to a New Level

By Pearson Talbert

Within corporate America, employee wellness programs have been popular solutions to the escalation of healthcare costs across all sectors of the economy. According to the most recent (2012) Employer Health Benefits Survey conducted by the Kaiser Family Foundation and the Health Research & Educational Trust, 63 percent of employers offering health benefits also offer at least one type of wellness activity, such as weight loss programs, gym membership discounts, biometric screenings or personal health coaching. Large firms – those with 200 or more workers – are even more likely to offer a wellness program than small firms; fully 94 percent offer one or more health-related activities. When asked about the effectiveness of wellness programs, 73 percent of employers offering at least one activity reported they were effective in improving the health of their firm's employees, while 52 percent said that wellness programs were reducing their company's healthcare costs. [1]

It is no wonder, then, that employers in western Pennsylvania and across the country are increasingly interested in ways to keep their workers healthy. The latest strategy to engage employees in health improvement is offering tools they can use on their own time, at their own pace, when they are at their most motivated. Population health portals customized for each company's employees give more than a passing nod to Americans' fascination with all things web-based. They empower employees to take charge of their health, and enable employers to incentivize them for doing so.

Although health portals have been around for a while, tying them in with employer wellness programming is new. Forward-thinking health organizations are seeing hospital-branded portals as a way to forge closer relationships with employers and their workers, as well as promote their services to a captive audience at the point when they are thinking about their health. It's a concept that is extremely timely, according to the Pew Research Center. According to the Pew's first study on health tracking, conducted in September 2012 as part of the Internet & American Life Project, 72 percent of Internet users say they looked online for health information within the past year. Even more significant, 60 percent of U.S. adults say they track their weight, diet or exercise routine; one-third track health indicators or symptoms like blood pressure, blood sugar, headaches or sleep patterns. [2]

This is the first national survey measuring health data tracking, which has been shown in clinical studies to improved outcomes, particularly among people trying to lose weight or manage a chronic condition. The Pew health tracking survey also found that:

- 46 percent of trackers state this activity has changed their overall approach to maintaining their health, or the health of someone for whom they provide care.
- 40 percent attest that tracking has led them to ask a doctor new questions or to get a second opinion from another doctor.
- 34 percent of trackers say it has affected a decision about how to treat an illness or condition.

Clearly, online health portals are the wave of the future as consumers increasingly turn to web-based tools to help them manage their health. Employers can capitalize on this trend by making portals available to their employees, allowing them to control content, incentivize employees to take better care of themselves and potentially mitigate future healthcare cost increases.

Hospitals who make their own branded health portals available to employers have distinct competitive advantages in the marketplace. These websites help employers lower their healthcare costs, which builds greater loyalty – critical when businesses make healthcare "buy" decisions. When it comes to the employees who use them, hospital-branded portals keep the organization's presence in front of the consumer 24/7 and allow them to promote programs and services, as well as maintain top-of-mind awareness. As employees are increasingly compelled to shoulder a bigger share of their healthcare costs, consumer preference is becoming even more important. And, of course, as the Affordable Care Act increases providers' accountability for preventing chronic conditions, these hospitals will already have the technological infrastructure and workforce health initiatives in place to help people better manage their health.

Pearson Talbert is president and CEO of Aegis Health Group. For more information, visit www.aegisgroup.com.

[1] http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8346-employer-health-benefits-annual-survey-summary-of-findings-0912.pdf

[2] http://www.pewinternet.org/Commentary/2011/November/Pew-Internet-Health.aspx

5 Ways Reality TV Can Improve Your Messaging

Solutions to help you grow…

By David M. Mastovich

I watch the Real Housewives of New Jersey. There. I said it.

I stumbled on the show when I zapped to Teresa Guidice overturning a table during an argument at a restaurant. Thinking this might be interesting, I pulled Darlene, my wife, in on it. Years later, I'm no longer embarrassed to admit watching the show. Apparently the 2.8 million other viewers of the most watched show in its time slot aren't either.

Some consider reality TV a guilty pleasure. Others criticize it as the lowest form of culture. Andy Denhart, journalist and TV critic, says Reality TV is important because it forces us to think of how we'd respond to what we're watching.

Whatever your view, you can benefit from applying Reality TV story telling techniques.

When you watch any of the Real Housewives series, you quickly realize the cast members, houses, clothes, cars and toys are actually far from the "reality" most of us know. Much of what the "real people" featured in these shows do isn't all that real.

Yet people still tune in. Why? Reality TV leverages these five fundamentals of story telling:

1. **Focus on The Big Idea.** Succinct messaging conveys the essence of the show. For example, *Survivor: Outwit. Outplay. Outlast.*

2. **Engage Your Audience.** American Idol, Dancing with the Stars, The Voice and other shows encourage the audience to vote. Viewers become attached to contestants in the way we used to connect with sitcom stars.

3. **Touch Emotions**. Teresa Guidice and other villains like Vienna Girardi from the Bachelor, The Apprentice's Omarosa and Scott Disick of Keeping Up With the Kardashians generate controversy to keep us interested and create a buzz.

4. **Concentrate on Key Target Markets**. Ever notice the shows feature a cross section of characters from multiple market segments that can buy stuff from sponsors? We relate to one or more of the characters and compare others to people we know. It leads to emotional buy-in among loyal viewers and allows sponsors to pitch us on their products and services.

5. **Make it Memorable.** The introductions, music, quick video cuts and editing combine to make a lasting impact. We remember the meltdowns and the dumb things people say or do. We feel bad for the jilted and those sent home. Even when someone loses, they often win from their "almost" celebrity status.

Enjoy your favorite show and improve your messaging by using the story telling techniques of Reality TV.

Vote Now: Post your favorite Reality TV Show Villian to Facebook.com/massolutions with #villain

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Happy Money: The Science of Smarter Spending by Elizabeth Dunn & Michael Norton

Book Information: c.2013, Simon & Schuster;

$25.00 U.S. & Canada; 199 pages

Your last paycheck was gone before you got it.

A good chunk of it was earmarked for housing. You had to pay for your new car, and gas. Everybody's favorite Uncle took his share, you have this nasty little habit called "eating," and there you go: a few dollars left for fun, which is no fun at all.

But what if stretching your meager wealth also stretched your well-being?

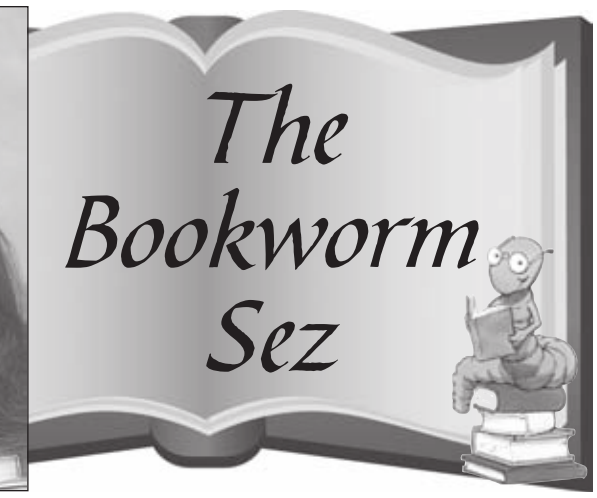
In the new book **"Happy Money: The Science of Smarter Spending" by Elizabeth Dunn & Michael Norton,** you'll find out how.

You have a love / hate relationship with money: you love getting it and hate when you don't have it. But as Dunn & Norton point out, you can utilize discretionary lucre to give you a better life, thus making you happier. In their research, they discovered five main Principles of Happy Money.

First of all, shift from buying *things* and spend your money on *events*. The vacation you took, the concert you attended, that dream fishing trip are etched in your mind far firmer than, say, last Tuesday's commute in your new car – especially if those special events were experienced with someone else.

Remember when an impulsive ice cream cone tasted like the best thing in the world? Reach back to those kinds of feelings by ending your spending and making indulgences into treats. When something is rare, it brings happiness because abundance "is the enemy of appreciation." Even the littlest treats don't have to cost a lot.

Use your money to buy time, especially when it comes to commuting, TV-watching, and socializing. Your fancy abode is no bargain if you have to commute for hours to pay for it. That big-screen TV is a commitment of *one-sixth* of your year. And socializing doesn't have to cost anything at all.



Learn to "pay now, consume later," since studies show that anticipation for an item is far more pleasurable than the item itself. That'll give you more time to imagine and savor – and besides, you'll be happier if you're debt-free.

Finally, invest in others. Research indicates that giving away money is "just as rewarding as getting more of it."

There's a reason why you've never seen a Happiness Store at the mall: turns out Mom was right when she said money can't buy happiness. It can, however, buy "Happy Money," which is a good start.

And here's more good news: most of the things inside this book are easy to do. You might already be following the Principles that authors Elizabeth Dunn & Michael Norton espouse – and if you're not, they won't be hard to embrace. The appeal of this book, therefore, is to change the way you think about what's in your wallet or pocket, whether it's meager or millions.

I liked this book, its gentle humor, and the sense it makes. I think that if you're tired of being dissatisfied with what you've got, you'll like it, too. "Happy Money" may not change your bankbook, but it will give you pennies for your thoughts.

The Bookworm is Terri Schlichenmeyer. Terri has been reading since she was 3 years old and she never goes anywhere without a book. She lives on a hill in Wisconsin with two dogs and 12,000 books.

Are You in Line with Physical Therapy Functional Reporting Requirements?

By Stephanie Barr, Esq.

In an effort to improve the therapy payment system, Medicare now requires that Functional Reporting be completed for all Part B outpatient therapy claims for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services regardless of practice setting. Section 3005 (g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833 (g) of the Social Security Act to require a claims-based collection system for outpatient therapy services. A six month testing period ran from January 1, 2013 to June 30, 2013. The July 1, 2013 deadline for Functional Reporting on claims has passed and if practitioners are not submitting G-codes with the respective severity modifiers they are or will begin seeing claim rejection letters.

Functional Limitation Reporting under Medicare presents a significant challenge to health care practitioners. The coding is complex and burdensome. However, for reimbursement purposes it is essential not only to include G-codes and severity modifiers on claims, but also to understand the complexities of coding.

For claims submission, practitioners must continue to report a nonpayable therapy code unless a beneficiary is under a home health plan of care (POC) (GP for a PT POC; GO for an OT POC; and GN for a SLP POC). Practitioners must also now report a G-code from 42 different Functional Limitation G-codes. These include six sets for PT and OT combined and eight sets for SLP services. The G-code sets contain the beneficiary's current status, projected goal status, and a discharge status. The practitioner selects the G-code set that most closely relates to the primary functional limitation being treated regardless of discipline. The practitioner should choose the G-code set that is most clinically relevant to a successful outcome; would yield the quickest / greatest functional progress; or reflects the greatest priority for the beneficiary. Finally, "Other PT/OT/SLP" code sets should be used when one of the other sets do not describe the functional limitation.

Along with these G-codes, reporting requires the inclusion of severity modifiers for the functional limitation. The severity modifiers must reflect the beneficiary's percentage of functional impairment. There are seven modifiers ranging from 0 percent impaired to 100 percent impaired (e.g., CH – 0 percent impaired; CN – 100 percent impaired). The practitioner should use a score from any functional assessment tool to assess severity, and clinical judgment should be used to assign the appropriate modifier. As an example, a practitioner may choose a CH modifier to indicate that the services are not intended to treat a functional limitation. The same modifier may be used for projected goal status and current status where the practitioner does not expect improvement (e.g., maintenance therapy).

G-codes and modifiers must be reported: 1) at the outset of a therapy episode of care; 2) at least once every ten (10) treatment days (coinciding with progress reporting period); 3) when an evaluative procedure is furnished and billed (e.g., billing of Current Procedural Terminology (CPT) codes 92506; 97001; 97002); 4) at the time of discharge from the therapy episode of care; 5) at the time where the reporting of a functional limitation is ended and need for further therapy is necessary; and 6) at the time reporting is begun on a different function limitation within the same episode of care. Generally, one functional limitation should be reported at a time, except where the beneficiary has reached the goal or progress set on the initially reported function limitation, but the need for treatment continues. A second functional limitation reporting would then be required using another set of G-codes, resulting in two or more functional limitations during one therapy episode of care.

Beyond these requirements, it is also imperative that practitioners document how a reporting decision was made so that the same decision making process can be used at the next assessment interval. As always, documentation to reflect accurate billing, coding and functional reporting is crucial to avoid claims being rejected and/or subsequent audits.

For more information on specific coding, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1307.pdf.

Stephanie Barr, Esq., is an attorney in the Health Care Department at civil defense litigation firm, Marshall Dennehey Warner Coleman & Goggin. A member of the American Health Lawyers Association, Ms. Barr focuses her practice on medical reimbursement, fraud and abuse, privacy and security, credentialing and licensing and anti-trust issues. She may be reached in Philadelphia at 215-575-2590 or smbarr@mdwcg.com.

When Hands are not Enough!

As Physical Therapists for **teli** (The Early Learning Institute), Physical Therapists, Mary Welage and Jeannine Moyer, have seen hundreds of infants and toddlers with special needs. Jeannine has worked for **teli** for 14 years. Mary Welage, PT, has worked for **teli** for over 6 years. Mary has worked in Early Intervention for 12 years, school age children for 12 and out patient therapy services for three. Through Early Intervention, children are referred due to a variety of conditions including prematurity, Torticollis, Down Syndrome, Cerebral Palsy, Spina Bifida (Myelomeningocele), Autism, limb deformities, Hypotonicity, and genetic disorders, among others.

Early Intervention services for children from birth to 3 years of age are provided in the child's natural environment, most often consisting of their home, daycare, or grandparent's home. Seeing how the children function in their most comfortable surroundings gives therapists an accurate picture of how children use their skills in their day to day life. These observations are used to develop a program that caregivers can more easily adapt into their daily routines.

To understand the specific needs of each individual child, physical therapists often assess strength, range of motion, posture, motor ability, and preferences of movement. Typically, the family or caregivers are the most important source of information. Parents and other caregivers share their concerns regarding the child's movements, often giving the therapist clues as to what may be causing a delay. At times the environment of the home is considered as well. Other information to consider is the child's medical history, cognitive function, behaviors, and possible sensory issues.

The therapists then develop a plan of treatment which might be comprised of hands on facilitation of movements, manipulation of the environment to encourage independent movement and/or the use of adaptive equipment to achieve optimal function. Parents and caregivers are encouraged to actively participate in the session, as well as carry out activities suggested by the therapist during the time between sessions. Sometimes, however, their hands are not enough. This is when therapists recommend equipment that can provide support when their hands are not available.

Some types of devices therapists may recommend are orthotics to manage lower extremity positioning which can improve stability in standing and walking, cranial molding helmets for plagiocephaly, specialized seating or garments to provide trunk support, standers when weightbearing is limited, and gait trainers, walkers or crutches for more independent mobility. Since the therapists see the child's home, they can take into consideration any space limitations or other challenges to the use of devices and work with the family to aid success.

For instance a child with low muscle tone may present with severely abducted hips which hinders their ability to crawl. Adaptations through the use of household items, such as elastic wraps, or a specialty item which can be purchased online are suggested and used. These adaptations help hold the legs together therefore allowing the child to progress in crawling. Also a child with Spina Bifida (Myelomeningocele) may require bracing for their legs and an adaptive walking device. The therapist is there to suggest appropriate interventions to best suit the child's ability as well as taking into consideration their natural living environment.

The goal is to provide families and children with information so that they can make educated decisions to create the best possibility for a child with challenges reach their optimal ability and function. Many of the children seen in Early Intervention do not require the use of adaptive equipment or may only need an adaptive item for a short time. When a therapist hands cannot provide the support required to help a child be successful then they look to the use of adaptive items and equipment. Ultimately the child's independence and family's ability to see the child function within their home and community is their success story.

Mary Welage

Jeannine Moyer

Gambling with Healthcare Payments

By Jean Hippert, PNC Healthcare

Payment collection has become a bit of a gamble today for hospitals and healthcare providers across the United States with high risks and large amounts of cash at stake. The winners will be those healthcare providers that maneuver successfully through the massive amounts of data, lack of standardized denial codes, diverse payor requirements and a mix of both paper and electronic patient accounting systems to ensure that no money is left on the table uncollected. But the odds against full payment just got tougher with the government-wide spending cuts known as the sequester and the across the board reduction in Medicare reimbursements.

Healthcare financial managers are already squeezing every penny from accounts receivable and accounts payable systems. To the lay person, a two percent reduction may not sound too painful. To already cash-strapped healthcare providers, however, the costs add up. The Office of Management and Budgets estimates the aggregate impact of the Medicare portion of the sequester to be nearly $11.4 billion in fiscal year 2013. That's just one of the impacts.

Payments arrive at hospital back-offices as one large dollar amount to reimburse for services rendered to a multitude of patients cared for at that hospital. On a good day, reconciling patient accounts to the single payment made by one insurance company is complex. With the Medicare reduction, the task is even more difficult. Some insurance companies are footnoting the reduction, while others are not. Some payors are using different codes, while other payments arrive with a lower dollar amount and no explanation. Additional resources – human and financial – needed for adjudication are simply not an option.

With over 1,200 healthcare customers and nearly 15 years of healthcare revenue cycle experience, PNC is offering the following tips to healthcare CFOs and other financial executives:

- **Digitize the Revenue Cycle** – The healthcare industry has been taking the lead from financial services in abandoning paper-based processes for electronic alternatives, but much work remains. Technology converts paper invoices and payments into an image and lifts information (through optical character recognition technology) from that image to populate patient accounting systems. When payments match the billing, the process is automated. Only exception items require human intervention to resolve, freeing up resources to address new exceptions due to the Medicare reduction.
- **Utilize Business Intelligence** – Hospital administrators are scrutinizing medical services, closing or terminating those viewed as marginal. Big data analytics and business intelligence helps financial executives to make fully informed decisions in determining demand and operational efficiencies today as well as for planning for the future.
- **Update Business Rules -** Work closely with your financial service provider to evaluate your current receivables to determine patterns in how the payors are accounting for reductions in their payments. Based on that research, adjustments can be made to your company's technology platform and business rules. While this solution will not eliminate exception items, it will at least put a dent in the stack of those requiring adjudication.
- **Utilization of Standardized Denial Reason Codes –** The lack of standardization in how payors are communicating lower payments as a result of the Medicare reduction and the impact on the accounts receivable department at hospitals and other healthcare providers makes a strong argument for standardized denial codes in general within the healthcare industry. Efforts to create standardized codes today would be prudent with more changes in healthcare reimbursement on the horizon with the Affordable Care Act.

Jean Hippert is senior vice president and managing director of PNC Healthcare, a part of The PNC Financial Services Group, Inc. Ms. Hippert may be contacted at Jean.Hippert@pnc.com or 410-561-9367.

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A Total Compensation Approach to Hospital Physician Integration

By Elliot N. Dinkin

Increasing physician-hospital employment is a hot topic in healthcare, even though it has been occurring for over 25 years.

Certain historical physician-hospital consolidation ended for many with divesture, as hospitals failed to integrate physicians into their organization and/or the acquisition costs and other on- going operating costs were too significant.

According to a survey released by Jackson Healthcare, 56% of the hospital executives who responded were involved in actual acquisitions of physician practices; additionally, 52% of the respondents were planning an acquisition in 2013.

This time things must be different as hospitals cannot afford to fail, as proper integration must occur with our changing healthcare landscape. The structural changes taking place in our health care system, mainly as a result of the delivery model modifications driven by the Affordable Care Act (ACA) that include initiatives such as avoidable readmissions, bundled payments, and value-based purchasing will mandate a much closer working relationship between hospitals and physicians.

On the other side, physicians' generational shifts regarding work-life balance combined with a loss of compensation due to reimbursement cuts would seem to push these relationships together. Simply stated, hospitals depend upon physicians for care delivery and patient volumes, while an increasing number of physicians depend upon hospitals for stable employment and income preservation.

From a Hospital's perspective, developing physician compensation models that align with organizational, quality, and financial goals will pave the way for success. Similarly, Physicians will look to be rewarded if they lead and implement cost initiatives and be the feeder for increasing patient volumes.

Alternately, hospitals may want to explore different partnerships or other relationship models, beyond straight employment. The wave of purchases that occurred during the 1990's taught valuable lessons on how not to accomplish these goals and this time, it must be structured to last.

From our perspective, creating a flexible Total Compensation Framework to accomplish this mutually beneficial relationship is a large part of successfully integrating these practices. A process would involve:

A due diligence analysis of existing compensation, benefit, and retirement plans sponsored by target practices

Review and design a fully-integrated approach, a partnership approach or other affiliation approach

Modeling all-in compensation plan costs under various designs and matching them with hospital goals/objectives

Developing appropriate variable pay programs with comprehensive benefit plans

Illustration of pro-forma impact on hospital and target group physicians and other employees

Elliot N. Dinkin is president/CEO of Cowden Associates, Inc. For more information, visit www.cowdenassociates.com.

Got Back Pain?

You're not alone! At any given time 25-30% of people in the United States report having low back pain in the past three months.

TRUE OR FALSE:

- 80-90% of adults in the US will experience back pain at some time in their lives. **TRUE**
- Fewer than 2% of people with low back pain have a herniated disk. **TRUE**
- Back pain is one of the most common reasons for missed work and the second most common reason for visits to the doctor's office. **TRUE**
- MRI, CT scan, and X-ray are the best tools to diagnose the cause of low back pain. **FALSE,** Most of the time imaging tests will not show a muscle spasm or ligament strain, which are the most common causes.
- Physical therapy can resolve your low back pain in as little as one visit. **TRUE**
- Sciatica is the medical term for severe low back pain. **FALSE,** Sciatica is leg pain caused by pressure on the sciatic nerve.
- Americans spend at least $50 billion each year on back pain. **TRUE**
- A week of bed rest is the best treatment for low back pain. **FALSE,** Bed rest can actually make back pain worse and even lead to other conditions.

What are the Symptoms?

The symptoms vary from person to person. You may experience a dull ache, burning sensation, or sharp pain. The pain may be located at a specific point or over a broad area. Sometimes, it might radiate into one or both legs.

Low back pain is categorized as acute, recurrent, or chronic. Acute pain lasts less than three months. Recurrent describes acute symptoms that come back. Chronic pain lasts longer than three months. Most of the time, low back pain will resolve within two weeks without medical intervention. However, 60-80% of patients with low back pain will have a recurrence within one year.

How Is It Diagnosed?

Your physical therapist will perform a thorough evaluation that includes:

- Complete health history to rule out metabolic, neurological, fractures, and cancer related causes.
- Questions about your specific symptoms
- Assessment of posture, flexibility, muscle strength, joint mobility, movement patterns, gait, and ergonomics

Will Physical Therapy Help?

Yes, and generally without surgery or medication. Your physical therapist will tailor your treatment to fit your symptoms, diagnosis, and lifestyle. Following evaluation, your physical therapist will identify the factors that have contributed to your specific back problem, and design an individualized treatment plan. At first, your therapist may use ice, heat, or electrical stimulation to help relieve pain. As you progress, your program may include:

- Manual therapy, including spinal mobilization
- Strengthening, with specific focus on the core musculature
- Flexibility exercises (Tip: tight hamstrings are often a culprit in low back pain)
- Education about how you can take better care of your back
- Training for proper lifting, bending, and sitting

Can this Injury or Condition be Prevented?

A physical therapist not only treats persistent or recurrent low back pain, but also plays an important role in preventing it.

Some of the preventative strategies include:

- Exercises to keep your back, stomach, and leg muscles strong and flexible
- Good body positioning at work, home, or during leisure activities
- Proper lifting techniques
- Maintain a regular physical fitness regimen—staying active can help to prevent injuries

For more information, visit www.alleghenychesapeake.com.

People and Awards

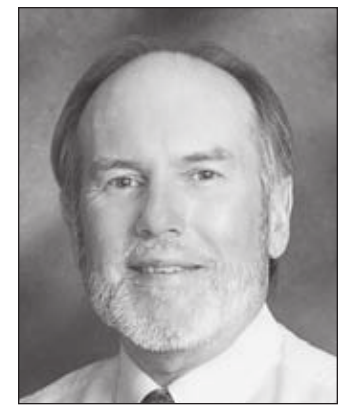
Winner Sed, Haynes join Sharon Regional Board of Directors

Karen Winner Sed

Two local community leaders with years of community involvement, **Karen Winner Sed** and **Larry Haynes,** recently joined Sharon Regional Health System's board of directors. Winner Sed is chief executive officer of the Winner Companies and Haynes is executive director of the Community Foundation of Western PA and Eastern OH and Sr. Pastor of Grace Chapel Community Church in Hermitage.

Larry Haynes

Winner Sed serves on the boards of Team Pennsylvania Foundation, the Community Foundation of Western PA and Eastern OH, the Winner Foundation, Shenango Valley Industrial Development Corporation, Subscribers Encouraging Economic Development (SEED), and WaterFire Sharon, She is also very active in a variety of community efforts including the revitalization of downtown Sharon and directing the newly formed Arts and Culture Center in Sharon.



John Gallagher

Haynes' community involvement includes serving on the boards of the Buhl Community Recreation Center and the Mercer County ARC Foundation, along with the steering committee for the Sharon Bidwell Center. He has been recognized as Boy Scout Person of the Year, Chamber of Commerce Person of the Year, Chamber of Commerce Volunteer of the Year, and Leadership Shenango Outstanding Mentor (six times).

John Gallagher, M.D., obstetrician/gynecologist, has also joined the SRHS board through his recent election as president of the Sharon Regional Medical Staff.

For more information, visit www.sharonregional.com.

Heritage Valley SportsCare Welcomes Medical Director

Piper Kilpatrick

Heritage Valley Health System is pleased to welcome **Piper Kilpatrick, MD,** as the Medical Director of Heritage Valley Sports*C*are, a collaboration between the Health System and Associates of Specialty Physicians (ASP) Orthopedics and Sports Medicine.

The highly trained and experienced sports medicine health care providers at Heritage Valley Sports*C*are provide care to athletes of all ages. They offer coordinated evaluation, treatment, and care management for medical conditions relating to musculoskeletal system, cardiac and pulmonary function, neurological conditions, concussion management and other sports-related injuries and illnesses. Additionally, Sports*C*are offers education to area athletic trainers, schools, and athletic organizations on a variety of sports training and injury prevention topics.

Dr. Kilpatrick received his undergraduate degree from Geneva Collage and obtained his medical degree from St. George's University School of Medicine in Grenada, West Indies. He went on to complete a Family Medicine Residency at UPMC St. Margaret and a Sports Medicine Fellowship at UPMC Shadyside. Dr. Kilpatrick is part of the ASP Orthopedics and Sports Medicine practice in Beaver, PA and is a member of the American Medical Society for Sports Medicine and the American Academy of Family Physicians.

"Heritage Valley Sports*C*are is a well established service that I'm proud to become a part of," said Dr. Kilpatrick. "Western Pennsylvania is well known for exceptional athletes and it's a privilege to be able to work the athletes and trainers deliver excellence on the playing fields of this region."

For more information, visit www.heritagevalley.org.

Family Hospice & Palliative Care Names Fundraising Veteran Lynn Helbling Sirinek Vice President of Development & Communications

Family Hospice and Palliative Care, Western Pennsylvania's largest non-profit hospice organization, has named **Lynn Helbling Sirinek** Vice President of Development and Communications. She joined Family Hospice on August 1.

In her new role, Sirinek has responsibility for the strategic development, implementation and advancement of endowment and capital development programs including major gifts, planned giving and the organization's ongoing philanthropic and fundraising endeavors. Additionally, she is responsible for Family Hospice and Palliative Care's marketing and communications efforts.

Sirinek comes to Family Hospice with more than 20 years of experience in fundraising and nonprofit management. Most recently, she served as Associate Director of Business Development and Planning at the RAND Corporation. Previously, she was President of the Ohio Grantmakers Forum, a membership organization serving foundations and corporate grantmakers. Additionally, Sirinek has worked as an independent consultant for a number of nonprofit organizations.

"Lynn's track record in non-profit management and successful fundraising efforts is exceptional," said Barbara Ivanko, President & CEO of Family Hospice. "She will be an important addition to Family Hospice as we continue to grow our service area and sphere of relationships with donors, foundations, grantors and volunteers."

"I am thrilled to join Family Hospice at a time when the organization is experiencing growth in response to the needs of its nine-county service area," Sirinek said. "Family Hospice holds a special place in the hearts of so many clients and families it serves, and I'm honored to have the opportunity to support and perpetuate its mission and story of compassionate care to Western Pennsylvanians."

For more information, visit www.FamilyHospice.com and www.Facebook.com/FamilyHospicePA.

Allegheny Valley Hospital Welcomes Swati Srivastava, MD

Swati Srivastava

Allegheny Valley Hospital (AVH) is pleased to announce that Family Medicine physician **Swati Srivastava, MD** has joined its medical staff.

Dr. Srivastava received her medical degree from Yerevan State Medical University after Mkhitar Heratsi, Yerevan, Armenia. She completed her residency through the West Penn Hospital-Allegheny General Hospital-Forbes Family Medicine Residency Program.

Dr. Srivastava takes care of patients in all age groups at all stages of life. Her medical interests include women's health and preventative care.

Dr. Srivastava is seeing patients in her office located at 356 Freeport Street, New Kensington. She is accepting new patients, accepts most insurances including Highmark Community Blue and can be reached for an appointment by calling 724-594-1140.

For more information, visit www.wpahs.org.

Western Pennsylvania Healthcare News wants to hear from you!

Email Daniel Casciato at writer@danielcasciato.com and we'll publish your story.

People and Awards

Physician Joins St. Clair Hospital Staff

Tera S. Conway

Tera S. Conway, M.D. has joined Zubritzky and Christy OB/GYN and is part of St. Clair Medical Services.

Dr. Conway earned her medical degree at Northeastern Ohio Universities College of Medicine and completed her residency in obstetrics and gynecology at The Western Pennsylvania Hospital, where she served as Administrative Chief Resident.

Dr. Conway resides in Morningside with her husband.

For more information, please visit www.stclair.org.

Submissions? Story Ideas? News Tips? Suggestions?

Contact Daniel Casciato at writer@danielcasciato.com

Pittsburgh Researcher to Speak at International Legionella Conference


Janet E. Stout

Legionella researcher **Janet E. Stout, PhD,** has been invited to speak at the 8th International Conference on Legionella in Melbourne, Australia.

Stout, who is director of the Pittsburgh-based Special Pathogens Laboratory (www.specialpathogenslab.com) and associate research professor at the University of Pittsburgh Swanson School of Engineering, will be speaking on the theme of prevention during the Legionella Control Measures in Hospitals session.

The conference, held in October, will provide an opportunity for scientists and professionals from across the globe to share information on *Legionella*, the waterborne bacteria that cause Legionnaires' disease. Topics to be discussed at scientific symposia include: global trends in Legionnaires' disease, infection, microbiology, control measures in hospitals, and diagnostics and detection.

A clinical and environmental microbiologist who has been researching Legionnaires' disease for more than 30 years, Stout is the author and co-author of numerous research articles and book chapters, including *Legionella* chapters in the *Manual of Clinical Microbiology (*American Society for Microbiology*)* and *Hospital Epidemiology and Infection Control*. Her expertise includes: *Legionella* detection, disinfection, remediation and control strategies for the prevention of Legionnaires' disease.

This will be the third time Stout has been honored to speak at the International Conference on Legionella. She spoke in 2009 (Paris) and 2005 (Chicago).

Special Pathogens Laboratory, The Legionella Experts®, specializes in the detection, control, and remediation of Legionella and other waterborne pathogens in building and utility water systems. Internationally recognized for clinical and environmental expertise in Legionnaires' disease prevention, SPL provides laboratory and consulting services to commercial and private industries especially: water treatment, healthcare and hospitality. SPL's laboratory is A2LA and NELAP accredited, and CDC-ELITE certified for Legionella testing.

People and Awards

Patrick White, M.D. Joins Family Hospice and Palliative Care


Patrick White

Patrick White, M.D., has joined Family Hospice and Palliative Care as the full-time team physician at The Center for Compassionate Care/Canterbury, Family Hospice's inpatient center on the campus of UPMC's Canterbury Place in Pittsburgh's Lawrenceville neighborhood.

In his role, Dr. White provides hands-on care for patients in Family Hospice's 14-room inpatient center. He completed his palliative care fellowship at the University of Pittsburgh and is board certified in hospice and palliative medicine. Currently, Dr. White is conducting research at The University of Pittsburgh to improve pain control in cancer patients and to enhance the way that physicians communicate with their patients.

Dr. White received his undergraduate degree from the University of Notre Dame and earned his M.D. from The Ohio State University College of Medicine and Public Health.

For more information, visit www.FamilyHospice.com and www.Facebook.com/FamilyHospicePA.

Conemaugh Health System Welcomes Chief Human Resources Officer

Brent J. Mallek

Conemaugh Health System welcomes **Brent J. Mallek** to its team as Vice President and Chief Human Resources Officer. With over 20 years in strategic human resource management, Mallek has extensive experience in human resources services, consulting, leadership development and teaching.

"I truly appreciate the opportunity to work with an organization that is known for high quality, high levels of patient satisfaction and a solid financial foundation," says Mallek about joining the Conemaugh Health System. "These achievements in today's healthcare environment do not happen by accident. They occur when great people commit to excellence and work hard to achieve and excel."

Mallek has previously held Vice President of Human Resources positions at a variety of healthcare systems including University Health Care System in Augusta, GA; University Health Systems Eastern Carolina in Greenville, NC; Riverside Healthcare in Kankakee, IL; and St. Francis Hospital in Chicago area. He holds a Bachelor of Science degree in Business and Human Resource Management from Michigan State University and a Masters in Business Administration - Human Resources from Edgewood College. Mallek is a member of the American Society for Healthcare Human Resources Administration.

At Conemaugh Health System, Mallek will be responsible for Human Resources strategic initiatives and goals for the System's 4,500 employees and 350 physicians. "We are very pleased to welcome Brent to our Conemaugh family," says Scott Becker, Chief Executive Officer of Conemaugh Health System. "His years of experience, innovative ideas and forward-thinking will enable us to continuously improve the ideal patient experience provided by our team."

Mallek and his wife, Kelly, come to Johnstown from Augusta, GA. In his spare time, Mallek enjoys golf, boating, skiing, SCUBA diving, and spending time with his family.

Learn more at www.conemaugh.org.

People and Awards

Allegheny Chesapeake Physical Therapy Adds Staff

Mandi Golden, PTA has joined the staff of Allegheny Chesapeake Physical Therapy. She received an Associate of Science degree in Physical Therapy from Mount Aloysius College. Mandi is also a licensed massage therapist.

Golden practices at Allegheny Chesapeake's Downtown Johnstown Office located at 237 Johns Street near the Inclined Plane (539-2050) and at the Portage Office, 711 Caldwell Avenue (736-9414).

"I am happy to be part of the extraordinary healthcare experience that ACPT provides and look forward to helping patients manage pain and regain mobility, strength and coordination after injury, illness or surgery," says Golden.

Allegheny Chesapeake Physical Therapy serves the physical and occupational therapy needs of a wide range of clients including patients, physicians, nursing facilities, hospitals, school districts, local companies and industry.

For more information, visit www.AlleghenyChesapeake.com.

Around the Region

Sharon Regional Health System Announces Plans for Strategic Affiliation

Sharon Regional Health System announced today that it plans to affiliate with Community Health Systems, Inc. in a strategic transaction that will result in capital investments and other resources to help position Sharon Regional for future long-term success. The Cleveland Clinic will participate in clinical program development, quality improvement, and branding through its alliance with Community Health Systems (CHS).

Following a year-long process and review of strategic options, Sharon Regional's Board of Directors has unanimously approved and executed a non-binding letter of intent for a sale of the Health System's assets to a subsidiary of Community Health Systems, Inc. Sharon Regional will now move forward through a period of due diligence and exclusive negotiations over the terms of the transaction.

"We engaged in a thorough and thoughtful process to ensure the best possible future for Sharon Regional and determined that affiliating with Community Health Systems, a highly regarded national healthcare organization, provides the greatest opportunity for building our future success," said William Strimbu, chairman of the board of Sharon Regional. "We will also benefit from the strategic alliance announced earlier this year between CHS and the Cleveland Clinic. The Cleveland Clinic will collaborate to advance quality and clinical programs, creating a true advantage for our medical staff, employees and, most importantly, our patients."

Other benefits of the proposed transaction include:

An infusion of capital for investments in facilities, services and medical technology;

Continuation and growth of the Health System's essential services (including medical/surgical, critical care, open heart and vascular surgery, emergency services, and obstetrics);

Hiring of employees in good standing at the time Sharon Regional closes on the transaction at the same rate of compensation with years of seniority recognized;

Maintaining Sharon Regional's current medical staff and strong efforts to recruit new physicians to the community;

Access to charity and indigent care; and,

A local board of trustees comprised of members of Sharon Regional's medical staff and local community leaders.

As part of the comprehensive planning and selection process, Sharon Regional's board of directors identified five Guiding Principles by which to evaluate potential partners. These included:

Community Choice in a Healthcare Provider – Patients, physicians, employers and their employees should have the right to choose the healthcare provider that best meets their needs.

Local Control of Healthcare Decisions – Decisions affecting the region's healthcare should be made locally by those who live, work, and raise their families in the area.

Perpetuation of Advanced Care within the Community – Patients and their families benefit by having tertiary or advanced-level services available in the local community.

Commitment to Improve, not Maintain Quality and Service to the Community – Recognition of the need to better the healthcare of the community by adopting innovative methods, modes, and models of medical services, best practice standards, and quality of care.

Economic Stability for the Community – A vibrant, growth-oriented and successful health system provides economic stability and opportunities to our region.

"Many hospitals and healthcare systems are aligning with partners that can support their operations with the significant resources and management expertise required to be successful in this dynamic period of change across our industry, especially as health care reform takes effect," said John R. "Jack" Janoso, Jr., president and CEO of Sharon Regional. "In CHS and the Cleveland Clinic we believe we've found partners that will support both our Guiding Principles and our values of integrity, caring, accountability, respect and excellence, and that this affiliation can advance our mission of providing comprehensive, convenient, high-quality health services close to home for the communities we serve."

A definitive agreement is expected later this year. The transaction will be subject to customary closing conditions and regulatory approvals.

Through its affiliates, Community Health Systems currently operates 135 hospitals in 29 states, including seventeen in Pennsylvania and four in Ohio. In March, Community Health Systems and Cleveland Clinic announced a strategic alliance to advance quality, cost-effective healthcare.

For more information visit www.sharonregional.com.

Forbes Regional Hospital Receives Accreditation to Become Pittsburgh's Newest Trauma Center

Forbes Regional Hospital, an affiliate hospital of the Allegheny Health Network, today announced that it has become accredited by from the Pennsylvania Trauma Systems Foundation as a Level II Trauma Center effective October 1, 2013. Forbes will become the 31st trauma center in Pennsylvania.

According to Christoph R. Kaufmann, MD, MPH, FACS, Forbes Regional's Trauma Medical Director, the designation represents an important milestone for the hospital and a critical new resource for the region.

"Trauma is the leading cause of death in the U.S. from ages one through 44. Having advanced treatment capabilities for traumatic injury will make a tremendous difference to this community for those who live here," Dr. Kaufmann said.

Dr. Kaufmann said significant investment was made in both the Forbes Regional medical staff and facilities to make trauma center accreditation possible.

"Our outstanding trauma team includes critical care trained surgeons and trauma physician assistants, who are in-house 24 hours-a-day, seven days-a-week, and a nursing staff specially trained in management of traumatic injuries. We have also invested more than $2.5 million in capital equipment and facility renovations to make sure our patients receive the highest level of care possible and have the absolute best chance of recovering from their injuries."

Trauma centers are specialized hospitals with resources immediately available to provide efficient and effective surgical intervention for life-threatening traumatic injuries to reduce the likelihood of death or permanent disability. Accredited trauma centers are regularly evaluated by the PA Trauma Systems Foundation to ensure they meet the highest of standards for patient care quality.

As a level II trauma center, Forbes expects to treat approximately 350 major trauma patients each year, said President and CEO Reese Jackson.

"This is a proud day for Forbes and the entire Allegheny Health Network. Our new trauma program is a wonderful resource for the community that will help decrease death rates in our region related to trauma by providing optimal care for those who suffer these kinds of injuries. And it's yet another example of Forbes' importance to this community as its only full service healthcare provider," said Jackson.

Level II trauma center accreditation is just the latest high-level service Forbes has added to secure its place as the leading specialized care facility in Pittsburgh's Eastern suburbs.

Other recent investments in the facility include a new, state-of-the-art Breast Care Center, a new liver disease clinic, expanded orthopaedic and neurosurgical capabilities and a state-of-the-art comprehensive robotic surgery program that now offers patient's advanced lung, gynecologic, esophageal and cardiovascular surgery options.

Forbes is now one of two Allegheny Health Network affiliated hospitals accredited by the State for trauma. Allegheny General Hospital in Pittsburgh has been a Level I Trauma Center since 1978.

Learn more at www.wpahs.org.

Around the Region

Around the Region

Washington Health System Deploys New Technology

Washington Health System (WHS) has been searching for an affordable, versatile, temperature monitoring system that would not only comply with regulations, but would eliminate the need for manual staff recording at various locations around its facilities - a system that would give real time alerts for appropriate corrective actions to prevent specimen and supply loss and keep surgical suites up and running. The solution WHS chose is TempVision™ - a remote, facility-wide temperature monitoring system developed by Mi-Jack Systems and Technology (MJST).

The TempVision™ System enables facilities to place wireless sensors at critical access points around the facility. The sensors then record activity around the clock tracking temperatures, humidity and door (open/close) security. If an event occurs, alerts are instantly generated and sent via text and/or email to the appropriate personnel, direct to Vocera badges when present.

Alerts can be viewed on any web enabled device, remote PC, Tablet or Smart Phone. The system also generates reports for trend analysis, historical data and documentation of corrective actions. The information can be retained indefinitely and is always at your fingertips, ready for regulatory and accreditation surveys and inspections.

WHS turned to MJST and implemented a 60-day trial of the TempVision™ System. Washington chose 5 high risk areas for the trial: Pharmacy, OR, Lab, Specimen Freezer and Nursery, since each of these areas would be adversely affected if temperature and/or humidity were out of range.

"The flexibility and helpfulness of the MJST team and the TempVision™ system made the decision to proceed with this partnership an easy one. We have been very impressed with the ease of the system and how helpful it has been for us at the Washington Health System" says Brook T. Ward, Executive Vice-President and Chief Operating Officer.

"Knowing that the humidity level and temperature is monitored at all times give me peace of mind that early morning surgeries will be on schedule," says Dorothy Zupancic, Manager of OR Central.

In addition to monitoring the temperature and humidity, the hospital was also concerned about the compatibility between TempVision™'s communication System and their internal Vocera (third party) System. The TempVision™ software is flexible enough to accommodate third party systems

The evaluation was completed in June, 2013. Review of the data proved that the TempVision™ System saved time on daily tasks and significantly reduced the amount of product loss.

The automated notifications dramatically decreased the amount of time that lapsed between an occurrence and the corrective action that was taken. Patient safety also improved by better preserving the integrity of medications and other refrigerated supplies as well as allowing staff to spend more time on patient care than making rounds manually recording temperatures.

"Having our temperature and humidity monitored at all times is extremely valuable to the Laboratory," says David Truxell, Director of Laboratory.

TempVision™ is a modular system that can be implemented in stages across the facility. The facility determines the level of monitoring that is needed and in which areas to place the sensors.

Learn more at www.mjst.com.

Robert Morris Seeks to Boost Access to Mental Health Care, Prepare Nurse Practitioners to Treat Chronic Illnesses

The facts are clear and grim: Suicide is the third leading cause of death in people ages 10 to 24. Four of the six leading causes of disability worldwide are due to psychiatric disorders. Mental illness increases the risk of a host of chronic illnesses, including diabetes, heart disease, and cancer.

"Mental health care in the United States, particularly for young people, is woefully inadequate," says Kirstyn M. Kameg, professor of nursing at Robert Morris University in Moon Township. In fact, only 25 percent of children and adolescents who need psychiatric care actually get help, according to the American Academy of Child and Adolescent Psychiatry.

To address this looming crisis, RMU is teaming with Heritage Valley Health System to educate nurse practitioners to provide mental health care to patients of all ages, including those suffering from multiple chronic illnesses. RMU has received a three-year, $923,000 grant from the federal Health Resources and Services Administration to support this initiative, formally known as the Access to Interprofessional Mental Health Education (AIME) project.

The grant will allow RMU to expand its existing Doctor of Nursing Practice (DNP) program for psychiatric mental health nurse practitioners, who have the ability to prescribe medications and provide psychotherapy. Since nurse practitioners work alongside primary care providers, including pediatricians, they can offer mental health services without having to refer patients elsewhere. Nurse practitioners can take into account a patient's overall health, including the chronic illnesses that both arise from and contribute to mental health disorders.

Grant funds also will be used to purchase distance-learning technology to allow students who live in rural areas an opportunity to return to school, graduate, and meet the mental health care needs of individuals in the under-served areas in which they reside.

"Patients with untreated mental illness often do not seek out preventative health care. They are at increased risk for developing drug and alcohol problems as well as smoking-related pathology. This lack of prevention increases health care costs and further burdens a stressed health care system," says Kameg, who coordinates the university's psychiatric mental health nurse practitioner program.

The School of Nursing and Health Sciences at RMU is one of only 72 nursing schools nationwide to offer a specialty in child/adolescent or family mental health. The goal of the grant is for RMU to expand enrollment in that program from 23 students at present to 72 by 2016.

Another objective for this project is for Robert Morris to enhance psychiatric mental health educational experiences through simulation scenarios, which will focus on multidisciplinary collaboration in the diagnosis and management of patients with multiple chronic health conditions. These interactive simulation experiences will be accessible to distance students in real time, thus maximizing the opportunity to practice diagnosis and treatment in a safe environment without risk of patient harm.

RMU will develop these simulations in collaboration with medical residents at Heritage Valley Health System through the university's Regional Research and Innovation in Simulation Education (RISE) Center. The RISE Center includes a standardized patient program, in which specially trained actors participate as patients in medical simulations. One of the goals of the simulations is to prepare future clinicians to collaborate as members of interprofessional teams, which will ultimately improve patient outcomes.

"Interdisciplinary simulation scenarios improve communication skills within the medical professions and lead to improved patient care and safety through a variety of hands-on learning experiences," says Dr. Stephen Hagberg, interim program director for Heritage Valley Family Medicine Residency.

For more information, visit www.rmu.edu.

Around the Region

21st Annual Mercy Parish Nurse and Health Ministry Symposium to be held October 26


Faith Roberts

The Mercy Parish Nurse and Health Ministry Program, part of the Pittsburgh Mercy Health System, invites clergy; faith community nurses; pastoral, health, and social ministers; nursing students; and laypersons who are interested in spirituality and wholistic health to attend the 21st Annual Mercy Parish Nurse and Health Ministry Symposium, "Weaving Prayer and Presence in Health Ministry," Saturday, October 26, 2013, from 8 a.m. to 1:30 p.m. in the Sister M. Ferdinand Clark Auditorium at UPMC Mercy, 1400 Locust Street, Pittsburgh, PA 15219.

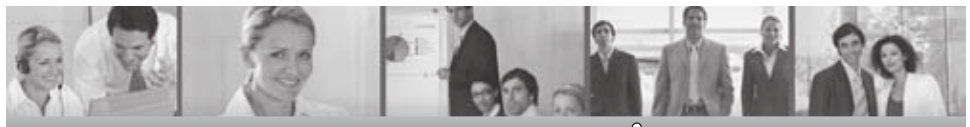
Ms. Faith Roberts, RN, MSN, FCN, director of Magnet/Professional Practice Program, Parish Nursing, and Obstetrical Services at Carle Foundation Hospital in Urbana, Illinois, will present the keynote address, "Weaving Prayer and Presence Together … Be Still and Know that I am God."

The cost, which includes brunch and free parking in the hospital parking garage, is $10 for ordained clergy/pastors, $30 for laypersons, and $40 for registered nurses, social workers, and licensed professional counselors who wish to receive continuing education credits. Ask about reduced pricing for first-time attendees and undergraduate nursing students.

Seating capacity is limited. Early registration is encouraged.

For more information or to register, visit http://www.pmhs.org/parish-nurse-program/education-and-resources.aspx, call 412.232.5815, or email Parish-Nurse@mercy.pmhs.org.

For more information about Faith Roberts, visit www.faithroberts.com. ✝



Resource Directory

Contact Harvey Kart to find out how your organization or business can be featured in the Western Pennsylvania Healthcare News Resource Directory. Call 412.475.9063, email harvey@wphealthcarenews.com or visit wphealthcarenews.com.

CHILDREN'S SERVICES

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Established in 1893, The Children's Home of Pittsburgh is an independent non-profit organization whose purpose is to promote the health and well-being of infants and children through services which establish and strengthen the family. The Children's Home has three programs: a licensed infant Adoption program, Child's Way® day care for medically fragile children, birth to age 8, and a 24-bed Pediatric Specialty Hospital, providing acute care for children ages birth to 21, transitioning from hospital to home. Additionally, our Family Living Area provides families with amenities to help make our hospital feel more like home, allowing them to stay overnight with their child. For more information, visit www.childrenshomepgh.org.

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EXTENDED CARE & ASSISTED LIVING

Asbury HEIGHTS

ASBURY HEIGHTS

For over a century, Asbury Heights, operated by United Methodist Services for the Aging, has been providing high-quality compassionate care to older adults in Southwestern Pennsylvania. Asbury Heights is a faith-based, non-profit charitable organization located in Mt. Lebanon. Through various accommodations, services and amenities, the needs of independent living residents can be met. For residents requiring more care, the continuing care community also offers personal care, nursing and rehabilitative care and memory support specialty care. Our Nursing and Rehabilitation Center has received a 5 Star Rating from the Centers for Medicare and Medicaid Services. The Health and Wellness Center is headed by a board certified, fellowship trained geriatrician. Two of our physicians were listed in 2012 Best Doctors by *Pittsburgh Magazine*. Residents may be treated by on-site specialists or retain their own physicians. Rehabilitative therapies are also available on-site. A variety of payment options are available to fit individual financial situations. The application process is very quick and easy and does not obligate the applicant in any way. For more information, please call 412-341-1030 and ask for Loretta Hoglund for independent living; Darla Cook for nursing admissions, or Lisa Powell for personal care. Visit our website at www.asbury-heights. org.

BAPTIST HOMES SOCIETY

Baptist Homes Society, a not-for-profit organization operating two continuing care retirement communities in Pittsburgh's South Hills region, has served older adults of all faiths for more than 100 years. Baptist Homes, nestled on a quiet hillside in Mt. Lebanon, serves nearly 300 seniors. Providence Point, a beautiful 32-acre site in Scott Township, has the capacity to serve more than 500 older adults. Each campus has a unique identity and environment yet both provide a full continuum of care, including independent living, personal care, memory support, rehabilitation therapies, skilled nursing, and hospice care. Baptist Homes Society is Medicare and Medicaid certified. Within our two communities, you'll find a the lifestyle and level of care to meet your senior living needs. To arrange a personal tour at either campus, contact: Sue Lauer, Community Liaison, 412-572-8308 or email slauer@ baptisthomes.org.

Or visit us at Baptist Homes
489 Castle Shannon Blvd., Mt. Lebanon.
(www.baptisthomes.org).
Providence Point:
500 Providence Point Blvd., Scott Twp
(www.providencepoint. org)

OAKLEAF PERSONAL CARE HOME

"It's great to be home!"

Nestled in a country setting in a residential area of Baldwin Borough, Oakleaf Personal Care Home provides quality, compassionate care to adults who need assistance with activities of daily living. As we strive to enhance the quality of life of our residents, our staff constantly assesses their strengths and needs as we help them strike that fine balance between dependence and independence. Oakleaf offers private and shared rooms, all located on one floor. Our home includes a spacious, sky-lighted dining room, library, television lounges, sitting areas and an activity room. Our fenced-in courtyard, which features a gazebo, provides our residents with a quiet place to enjoy the outdoors, socialize with family and friends, and participate in planned activities. Upon admission, the warmth of our surroundings and the caring attitude of our staff combine to make Oakleaf a place residents quickly call "home". Please call for additional information, stop by for a tour or visit us on our website. www.oakleafpersonalcarehome.com.

3800 Oakleaf Road,
Pittsburgh, PA 15227
Phone 412-881-8194, Fax 412-884-8298
Equal Housing Opportunity

Presbyterian SeniorCare
Positively Living

PRESBYTERIAN SENIORCARE

Presbyterian SeniorCare is the region's largest provider of living and care options for seniors (Pittsburgh Business Times, 2013), serving approximately 6,500 older adults annually. Established in 1928, the non-profit, faith-based organization is accredited by CARF-CCAC as an Aging Services Network. In addition, Presbyterian SeniorCare was awarded five-year accreditation in 2011 as "Person-Centered Long-Term Care Communities" for all of its nursing communities. Providing a continuum of options in 56 communities in 44 locations across 10 western Pennsylvania counties, Presbyterian SeniorCare offers independent and supportive apartments, personal care, world-renowned Alzheimer's care, rehabilitation services, skilled nursing care and home- and community-based services. For more information please call 1-877-PSC-6500 or visit www.SrCare.org.

ST. BARNABAS HEALTH SYSTEM

Regardless of what lifestyle option a senior needs, St. Barnabas Health System has a variety of choices to fulfill that need. Independent living options include The Village at St. Barnabas apartments, The Woodlands at St. Barnabas and White Tail Ridge carriage homes, and The Washington Place at St. Barnabas efficiency apartments. Living assistance is available at The Arbors at St. Barnabas in Gibsonia and Valencia. Twenty-four hour skilled care is provided at St. Barnabas Nursing Home and Valencia Woods at St. Barnabas. St. Barnabas Medical Center is an outpatient facility that includes physicians, chiropractors, general medicine, rehab therapy, a dental practice, home care, memory care and hospice. The system's charitable arm, St. Barnabas Charities, conducts extensive fundraising activities, including operating the Kean Theatre and Rudolph Auto Repair. St. Barnabas' campuses are located in Gibsonia, Allegheny County, and Valencia, Butler County. For more information, call 724-443-0700 or visit www.stbarnabashealthsystem. com.

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HOME HEALTH/HOME CARE/ HOSPICE

ANOVA HOME HEALTH AND HOSPICE

Anova Healthcare Services is a Medicare-certified agency that has specialized care in home health, hospice & palliative care, and private duty. Anova concentrates their care within seven counties in South Western PA. Through Anova's team approach, they have developed a patient-first focus that truly separates their service from other agencies in the area. Home Health care is short term acute care given by nurses and therapists in the home. Private duty offers care such as companionship, medication management and transportation services. Hospice is available for people facing life limiting conditions. With these three types of care, Anova is able to offer a continuum of care that allows a patient to find help with every condition or treatment that they may need. Anova's goal is to provide care to enable loved ones to remain independent wherever they call home. Anova Knows healthcare … Get to know Anova!

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www.bayada.com

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INTERIM HEALTHCARE HOME CARE AND HOSPICE

Interim HealthCare is a national comprehensive provider of health care personnel and services. Interim HealthCare has provided home nursing care to patients since 1966 and has grown to over 300 locations throughout America. Interim HealthCare of Pittsburgh began operations in 1972 to meet the home health needs of patients and families throughout southwestern Pennsylvania and northern West Virginia and now has offices in Pittsburgh, Johnstown, Somerset, Altoona, Erie, Meadville, Uniontown and Morgantown and Bridgeport WV. IHC of Pittsburgh has been a certified Medicare and Medicaid home health agency since 1982 and a certified Hospice since 2009. We provide a broad range of home health services to meet the individual patient's needs - from simple companionship to specialty IV care and ventilator dependent care to hospice care - from a single home visit to 24 hour a day care. IHC has extensive experience in working with facility discharge planners and health insurance case managers to effect the safe and successful discharge and maintenance of patients in their home.

For more information or patient referral, call
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1789 S. Braddock, Pittsburgh, PA 15218
www.interimhealthcare.com

MEDI HOME HEALTH AND HOSPICE

Medi Home Health and Hospice, a division of Medical Services of America, Inc., has a unique concept "total home health care." We provide a full-service healthcare solution to ensure the best patient care possible. Every area of service is managed and staffed by qualified professionals, trained and experienced in their respective fields. Surrounded by family, friends and things that turn a house into a home is what home care is all about. Our home health care manages numerous aspects of our patients' medical needs. Our Hospice care is about helping individuals and their families' share the best days possible as they deal with a life-limiting illness. Most benefits pay for hospice care with no cost to you or your family. Caring for people. Caring for you. For more information or for patient referral please call 1-866-273-6334.

PSA HEALTHCARE

At PSA Healthcare, we believe children are the best cared for in a nurturing environment, where they can be surrounded by loving family members. We are passionate about working with families and caregivers to facilitate keeping medically fragile children in their homes to receive care. PSA Healthcare is managed by the most experienced clinicians, nurses who put caring before all else. Our nurses are dedicated to treating each patient with the same care they would want their own loved ones to receive. PSA is a CHAP accredited, Medicare certified home health care agency providing pediatric private duty (RN/LPN) and skilled nursing visits in Pittsburgh and 10 surrounding counties. The Pittsburgh location has been providing trusted care since 1996, for more information call 412-322-4140 or email scoleman@psakids.com.

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The Children's Home of Pittsburgh &
Lemieux Family Center
5324 Penn Avenue
Pittsburgh, PA 15224.
www.childrenshomepgh.org
email: info@chomepgh.org

THE CHILDREN'S INSTITUTE

The Hospital at the Children's Institute, located in Squirrel Hill, provides inpatient and outpatient rehabilitation services for children and young adults. Outpatient services are also provided through satellite facilities in Bridgeville, Norwin Hills and Wexford. In addition, The Day School at The Children's Institute offers educational services to children, ages 2-21, who are challenged by autism, cerebral palsy or neurological impairment. Project STAR at The Children's Institute, a social services component, coordinates adoptions, foster care and intensive family support for children with special needs.

For more information, please call 412-420-2400
The Children's Institute
1405 Shady Avenue,
Pittsburgh, PA 15217-1350
www.amazingkids.org

PUBLIC HEALTH SERVICES

ALLEGHENY COUNTY HEALTH DEPARTMENT

The Allegheny County Health Department serves the 1.3 million residents of Allegheny County and is dedicated to promoting individual and community wellness; preventing injury, illness, disability and premature death; and protecting the public from the harmful effects of biological, chemical and physical hazards within the environment. Services are available through the following programs: Air Quality, Childhood Lead Poisoning Prevention; Chronic Disease Prevention; Environmental Toxins/ Pollution Prevention; Food Safety; Housing/ Community Environment; Infectious Disease Control; Injury Prevention; Maternal and Child Health; Women, Infants and Children (WIC) Nutrition; Plumbing; Public Drinking Water; Recycling; Sexually Transmitted Diseases/ AIDS/HIV; Three Rivers Wet Weather Demonstration Project; Tobacco Free Allegheny; Traffic Safety; Tuberculosis; and Waste Management. Ronald E. Voorhees, MD, MPH, Acting Director.

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Health Care Event & Meeting Guide

2013 HPNA 7th Annual Clinical Practice Forum Integration of Palliative Care Concepts: Neurological Conditions

October 3-5, 2013, Pittsburgh, PA.
Online Registration at www.HPNA.org for discount use promo code MAILE

Passion for Palliative Nursing

Friday October 4, 2013
6-8 PM
Sheraton Station Square, Fountain View Room
Cocktail Party to support the Hospice and Palliative Nurses Foundation (HPNF). Headquartered in Pittsburgh, HPNF is a national provider of grants, scholarships and leadership awards to hospice and palliative nurses.
Contact sharonk@hpnf.org or 412-787-930.

Advances in Pulmonary Medicine Symposium

Oct. 16, 7:30 a.m. to 2:30 p.m.
Monongahela Valley Hospital's Lombardi Conference Center
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To register, call 724-258-1145.

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21st Annual Parish Nurse and Health Ministry Symposium, "Weaving Prayer and Presence in Health Ministry"

Saturday, October 26
8 a.m. to 1:30 p.m.
Sister M. Ferdinand Clark Auditorium, Level 2 at UPMC Mercy
Register at www.pmhs.org/parish-nurse-program/education-and-resources.aspx.

The Magic of Mentoring

November 13th
3pm - 6:30pm
RMU Moon Township campus - Sewall Center
$40 if you register before 10/4. $45 after 10/4. Note: group discounts available.
3 Contact Hours and refreshments
Details at http://rtconnections.com/workshops/

UPMC Children's Ball

March 29, 2014, 6-9 PM
Carnegie Science Center
Call 412-802-8256 or visit www.upmc.com/childrensball.

Andy Russell Celebrity Classic

May 15-16, 2014
Heinz Field East Club Lounge, Allegheny Country Club
Call 412-802-8256 or visit andyrussell.org.

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Western Pennsylvania Healthcare News welcomes story ideas, etc. Call Daniel Casciato at 412.607.9808 or email riter@danielcasciato.com.

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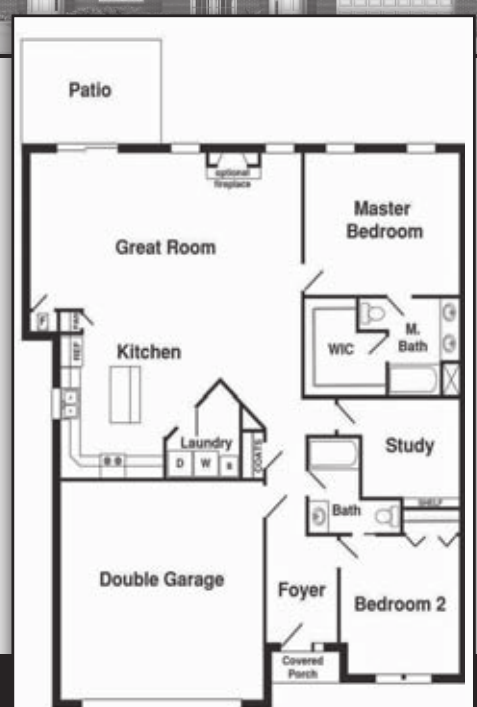

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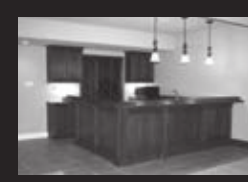

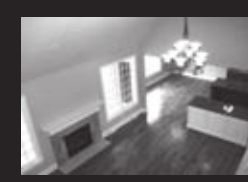

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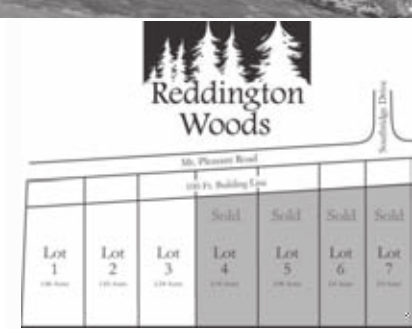

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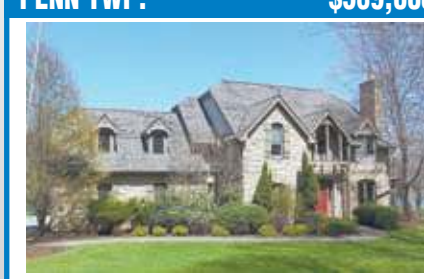
PENN TWP. $589,000



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