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Pharmacy IV Automation a Mature, Proven Technology

By Niels Erik Hansen, Ph.D.

As automation technologies enhance a growing number of hospital services — including imaging, surgery, radiotherapy and rehabilitation, among others — the hospital pharmacy remains largely *un*-automated.

Despite its central role in patient care, technicians in most hospital pharmacies still compound medications manually, in much the same way it's been done for generations.

Such a long history, combined with refinements in aseptic techniques and training, means manual IV compounding remains the accepted standard of care.

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Developing an Investment Strategy that Considers Enterprise Risks

By Craig Standen

Healthcare executives are facing an increasingly complex operating environment, where growing pressure on margins is resulting in greater reliance on investment performance of various asset pools to maintain a stable financial profile. Healthcare providers must take risks to grow and add value.

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Things to Consider When Outsourcing Leave Management

By Linda Croushore and Melissa Dunn

Employee absence can put a strain on any healthcare organization. Success in business demands high productivity as well as a lean and efficient staff. When an employee is absent on leave, it adds cost to a company's bottom line.

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Ten Tips for Implementing a Successful Worksite Wellness Program

By E.J. Heckert

An increasing number of employers are offering worksite wellness programs, but can these programs be effective?

The answer is "yes."

Successful worksite wellness programs help improve employees' health and productivity and reduce medical costs for employees and the company.

The Wellness Council of America states that workplace wellness

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At the same time, since the 2008 financial crisis, many organizations are focusing more time and attention on developing strategies to better withstand the impact of macro, systemic shocks, and respond appropriately should similar events occur in the future.

Risk is inherent in the pursuit of business objectives, and effective risk management is a key success factor in today's volatile market environment.

The traditional asset-only approach to portfolio decision-making does not take into account the correlation among and impact of risks present across the organization.

As such, the financial dynamics of healthcare systems and hospitals necessitate comprehensive, proactive and ongoing review of broader enterprise risks and more specifically the impact that asset allocation decisions and investment returns have on financial and operational performance.

As operating uncertainty has grown in the healthcare sector, management and boards are recognizing the benefits of closely linking strategy development with a better understanding of the associated risks.

An Enterprise Risk Management (ERM) framework provides a useful construct to identify, measure, monitor and respond to risks present across an organization. For healthcare providers, there are four main components of enterprise risk:

• **Unrestricted liquidity** provides operating and working capital, has long-term growth expectations, and supports strategic objectives, including capital spending requirements.

The unrestricted liquidity pools also carry risks associated with the allocation strategy.

• **Capital structures** of many providers are composed of various forms of debt, each of which has their own risk profiles and interest rate sensitivity.

In addition, financial covenants require providers to consistently meet defined financial performance thresholds or risk a potential default. And rating agency views on capital structure risks will factor into the credit rating and impact a provider's cost of or access to capital.

• **Operations/capital budgeting** risks encompass competitive positioning activities, execution of strategic initiatives, including spending needs and Affordable Care Act implementation, which drive financial performance and attainment of a desired rating level.

• **Defined benefit plans** have an additional set of risks for those that have them. Contribution requirements impact cash flow and plan funded status will directly impact the balance sheet. In addition, the discount rate used to determined benefit obligations, as well as earnings on plan assets, are subject to interest rate sensitivity.

ERM is a systematic and strategic process that closely links organizational strategy, operations, finance and treasury. It is designed to identify potential events/risks that may impact the organization and helps prioritize and appropriately manage identified risks within the organization's defined risk 'appetite.'

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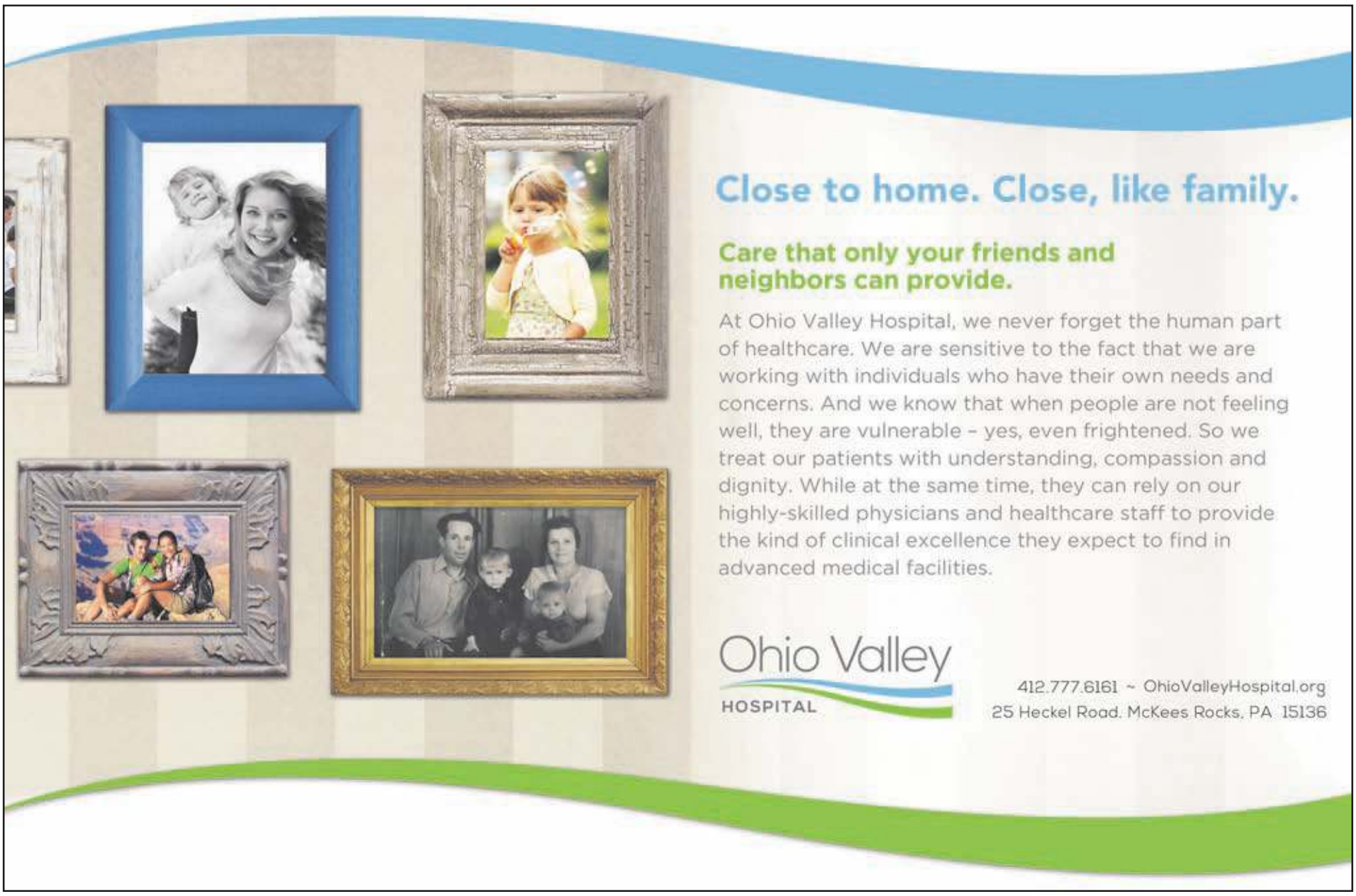

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But how much longer should it be?

Recent outbreaks of illness and adverse reactions linked to compounded medications, as well as numerous pharmacy product recalls, make the shortcomings of manual compounding increasingly hard to ignore.

Although pharmacy technicians are trained in the physical process of compounding, few understand the physics behind the process.

And, being human, even the most experienced technicians make mistakes; some studies have documented observed manual error rates of up to 10 percent in hospital pharmacies.

Being able to repeat a compounding technique is not the same as ensuring accurate repeatability.

Ongoing reliance on manual techniques would be understandable if there were no alternative.

But automated IV compounding systems have existed for more than a decade.

Moreover, the technology is proven to enhance the safety of compounded medications, reduce pharmacy costs and increase productivity. So why aren't more hospitals using it?

While pharmacists have generally welcomed technological innovation, many within the industry feel automated IV compounding technology is not yet sufficiently developed for widespread implementation. It's an unfortunate perception, and inaccurate.

At its most basic, the automation of medication compounding is simply the application of proven robotic technologies to well-understood processes and known physical parameters.

Available IV compounding technology can not only duplicate the manual process, but do so with substantially more accuracy, efficiency and repeatability.

Automation is the use of machines, control systems and technology to increase productivity and the quality of goods beyond what is possible through human labor.

The development of such technologies goes back more than three-quarters of a century — the first industrial robot was built in 1937 — and has undergone continuous enhancement and refinement ever since.

Today robotic automation is used to manufacture numerous products including cars, appliances, food, computers and mobile devices, among others.

Robots are particularly useful where a high degree of accuracy is required.

For example, silicon chip manufacturing often requires tolerances measured in microns, orders of magnitude smaller than the tenth-of-a-millimeter measurements necessary in pharmacy compounding.

But in order to successfully automate any manufacturing process, it is essential to fully understand the process — inputs, weights and measures, individual production steps, and desired outputs.

In other words, to automate medication compounding, you have to know how medication is compounded.

Fortunately, the process and physics of medication compounding are well documented.

In more than a decade of research, a team of engineers worked to measure and quantify virtually every aspect of IV compounding.

Their analysis included such variables as admixture fluid weight, surface tension, specific gravity and viscosity, differences in the diameter of 'standard' needle bore holes, the amount of force necessary for needles to puncture a vial stopper, and much more.

The resulting IV automation technology, called RIVA, can account for the various physical properties of inputs and also compensate for variation.

For those who might look to output quality as evidence of production efficacy, pharmacy automation has proven a resounding success.

Since RIVA technology was commercialized in 2008, systems have been installed at 35 sites worldwide and have cumulatively produced more than 2.5 million IV doses safely and accurately.

Further, installed units have performed nearly 200,000 routine growth media contamination tests with zero failures.

These numbers far exceed typical quality control validation measures for almost every type of manufacturing.

The bottom line is that pharmacy IV automation is a mature, well-established technology, with a solid record of quality control and output that is proven to be superior to manual processes.

As numerous hospital operations and healthcare procedures are improved with automation, it is past time for automated compounding to become the standard of care in pharmacies.

The benefits — reduced cost, increased efficiency and, most important, greatly enhanced medication and patient safety — make IV automation imperative. ✚

Dr. Niels Erik Hansen is president and CEO of Intelligent Hospital Systems in Winnipeg.

He holds a Ph.D. in control engineering and an M.S. in mechanical engineering from Technical University of Denmark, and has more than 30 years' experience in technology engineering and production with emphasis in motion control, fluid management and environmental engineering.

Organizational risk 'appetite' is a key consideration in setting objectives and developing strategy, including asset allocation decisions. There are several factors that can help providers determine their own unique risk appetite.

• **Current risk profile** is an inventory of the level and range of organizational risks across various categories; some examples include financial, operational, market, and/or reputational risks.

• **Capacity for risk** is the maximum amount of risk that an organization can sustain and remain in business.

• **Tolerance for risk** is the acceptable amount of variation around the desired outcome.

• **Desired level of risk** represents the 'desired' risk/return profile.

There is no standard or 'correct' risk appetite, just one that is deemed appropriate for a particular organization after evaluating the trade-offs associated with having a 'high', 'medium' or 'low' risk appetite.

Once a risk appetite has been determined, it is important to align strategy objective and expected outcomes appropriately.

A highly risk averse hospital would probably not feel comfortable with an 80 percent equity allocation; conversely, a health system with a tolerance for higher risk and volatility would probably not invest the lion's share of their investment assets in Treasury bills and money market funds.

With clear or better understanding of the type of risks present across their organization, how these risks are correlated, and the tolerance or 'appetite' for risk, providers will be in a better position to make more informed decisions about strategic asset allocation.

Stochastic modeling is an important tool SEI uses to evaluate more broadly the impact of asset allocation decisions on financial performance and key financial metrics — including bond covenants — and more closely aligns asset allocation decisions to organizational goals and objectives.

Using multi-year financial projections (ideally) and other data that covers each of the enterprise risk components noted above, stochastic modeling uses statistical analysis to generate probability distributions of expected outcomes under a range of economic environments, which helps highlight the risk/return profiles of potential asset allocation strategies.

Risk is inherent in the pursuit of business objectives and effective risk management is a key success factor for any organization, and ERM principles provide a model for identifying, measuring and monitoring enterprise risks to better enable you to achieve your organizational goals and objectives.

Finally, a siloed, asset-only approach to allocation decision making will give you one answer, but not necessarily the right answer without taking into account the risks present across your organization and linking those decisions to broader organizational goals and objectives. ✚

Craig Standen serves as the Director of Healthcare Advisory Services for SEI's Institutional Group. Based in Oaks, Pa., SEI is one of the largest investment outsourcing firms in the world. Craig can be reached at cstanden@seic.com.

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But equally draining for a company can be the issue of leave management. Leave management is a complex matter and what makes it more difficult is the fact that local, state, and federal regulations are all involved. Each company needs to decide whether it can afford to invest the time and effort required to enable its staff to stay current with those regulations.

An alternative that can make more sense — both in terms of time and money — is to outsource leave management. By outsourcing, Human Resources leaders can rely on experts that have experience with leave management, a service which includes intermittent leave, FML (family and medical leave), military, state and local leave laws, employer-sponsored leave, and compliance with the quickly growing issue of ADAAA (Americans with Disabilities Act Amendments Act).

Before making a decision, a company should study the various aspects of leave administration:

1. Understand what the scope of an employer's obligation actually is. The Family and Medical Leave Act of 1993 (FMLA) requires that covered employers provide employees with job-protected unpaid leave for certain medical and family reasons, including personal or family illness, military service, family military leave, pregnancy and the adoption or foster care placement of a child. However, the ADAAA has created additional obligations for an employer to evaluate leave as a reasonable accommodation.

2. Understand the administrative burden involved. Tracking and managing paperwork associated with leave requests creates an additional administrative burden for an employer. Employers generally need about 3-5 hours on average to effectively process each leave. An employer with 1,000 employees that averages 120 leaves per year has to spend the equivalent of nine weeks per year managing just the initial leave requests.

3. Understand the cost of compliance. According to the U.S. Department of Labor, Wage, and Hour Division, the average wrongful termination verdict for an FMLA case is $350,000, not including attorney fees. Consistent management of leave ensures compliance.

4. Understand that supervisors need support in this area. A supervisor can be individually liable for violating an employee's FMLA rights. Supervisor training is important. Outsourced vendors provide training and data to empower supervisors to better handle leave questions.

5. Understand what's required with intermittent leave management. Intermittent leave time needs to be fully reviewed to ensure that the leave meets the requirements of a serious health condition and that each increment of time away from work is appropriate and medically necessary. In addition, tracking and recertification ensures intermittent leave is being used appropriately and curbs potential abuse.

6. Understand the repercussions of changes in law. It is important to keep up-to-date on law changes, whether they are federal, state or local. This requires a staff commitment to remain abreast of all changes at all times.

7. Understand end of leave issues. The end of an employee's leave time is not necessarily the end of an employer's obligation. It is important that an employer discuss with the employee their ability to return to work after leave time has expired.

Outsourcing leave management can also relieve fears a company may have regarding privacy and being compliant with the Health Insurance Portability & Accountability Act (HIPAA). Outsourcing can ensure consistency in terms of meeting obligations.

Introducing an outside partner to handle leave management does not suit all companies. But if Human Resources departments are concerned with staff time commitments, liabilities associated with managing leave or have had issues in the past, they may welcome the expertise that a strategic leave management provider will bring to the process. ✚

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UPMC WorkPartners offers integrated health and productivity solutions for high-performing companies throughout the United States.

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programs are a wise investment to address rising health care costs and help improve employee's health and well-being.

HERE ARE 10 TIPS FOR EMPLOYERS ON IMPLEMENTING AN EFFECTIVE WELLNESS PROGRAM:

1. Understand Your Workforce — Review past insurance claims data, employee surveys and health assessments to select wellness programs that address your employees' most common health challenges.

2. Create a Plan — Develop a detailed plan that outlines short- and long-term objectives, budgets and expected outcomes.

3. Include rather than Exclude — Make wellness activities available for all employees and spouses/domestic partners.

4. Offer Biometric Screenings — Biometric screenings give employees a better snapshot of their current health.

Screenings held onsite at the workplace and at health fairs encourage more employees to participate.

5. Select Wellness Champions — Set up a wellness committee with "wellness champions" who will help drive your wellness program.

Choose leaders within the organization who are respected by their peers.

Make champion status an honor, and others will want to serve.

6. Communicate — Use email, promotional flyers and in-person meetings to communicate your wellness programs.

Messages from executives will demonstrate leadership support and likely improve participation in the wellness program.

7. Offer Incentives — Participation in wellness programs significantly increases when employers offer employees incentives.

Incentives can include gift cards, lower health insurance premiums, cash bonuses and discounts on various health products and services.

8. Provide Employees with Digital Tools — Digital tools (e.g. online, mobile, tablet) help employees keep track of their health care costs and become more-informed health care consumers.

9. Track Results — Evaluate your wellness program each year. Work with your health plan to measure the impact on employee engagement and medical costs.

10. Solicit Feedback — Be flexible and listen to your employees on how to improve the program for next year.

Following these tips can help employers and employees maximize the benefit they get out of employer-sponsored wellness programs — and improve the health of the company and its workforce. ✚

E.J. Heckert is vice president for UnitedHealthcare of Pennsylvania.

Securing Patient Data in the Mobile Era

By Dror Nadler

The healthcare industry is evolving from a private practice to network model, and technology needs to adapt to this trend. A growing number of physicians have joined healthcare practices to pool resources, raise the quality of care and achieve greater work-life balance. They often work in multiple clinics, and access to patient data — particularly on mobile devices — remains a dicey issue.

Physicians want to leverage their mobile devices to increase productivity and access relevant data wherever they go, but managing mobility across multiple organizations with strict data security policies is an immense challenge. This becomes even more challenging if physicians want to use their own smartphones or tablets. Most bring-your-own-device (BYOD) solutions would either restrict personal device usage to a bare minimum or wouldn't provide enough separation between physicians' work-related data and apps, and their private photos and information.

To address these challenges, healthcare practices can leverage a multi-persona approach. Dividing a single mobile device into *multiple* professional and personal personas will provide physicians with access to data residing in multiple clinics while maintaining access to their own personal data. Most importantly, the multi-persona solution will allow them to adhere to data privacy rules and regulations while staying productive.

Data Security

Mobile technology introduces new data security challenges when used in any business setting, in particular those that are highly regulated. A multi-persona BYOD solution is able to address most objections and effectively mitigate the main risks associated with accessing patient data on mobile devices.

Healthcare executives worry that allowing physicians to use personal mobiles devices could lead to compliance violations and increased risks of data leaks because healthcare data would reside within the same space as personal data and apps. With a multi-persona solution, however, physicians could install professional personas that segregate personal data from patient data at the operating system level. A malicious application on the personal persona, for instance, will not have access to the healthcare network persona containing sensitive patient data.

IT departments could manage the professional persona and ensure compliance without exercising any authority over the personal persona. Physicians would be able to switch between personas with one tap on the screen.

Attending Multiple Healthcare Practices

Physicians need to be able to access various patients' health histories in multiple locations and from multiple networks while dealing with different IT departments that follow different standards and policies. Rather than forcing physicians to use different mobile devices for each network, healthcare organizations can use a multi-persona approach to operate their particular policies without overlap.

This could also prevent headaches and reduce costs when patients are being treated within multiple healthcare networks and locations. In such cases, accessing patient data can be a lengthy process for physicians. Instead of asking other clinics to send images and tests, they often re-order the same x-rays and tests in the interest of time. A multi-persona BYOD approach may allow multiple health organizations, in a city or given geographical area, to provide all physicians with access to patient data through multiple mobile personas. Unlike the typical processes that involves paper forms, faxes and long delays, using a multi-persona approach could allow physicians to look at patient health histories from the examination room in just seconds. Dr. Jones at Hospital A could get a patient who received an x-ray at Hospital B and then use Hospital B's persona to pull up the image, all while respecting Hospital B's management of that data.

With multi-persona BYOD, physicians could leverage a persona for each clinic they attend, and perhaps even get limited access to patient data at other clinics. This would eliminate the issue of overlapping IT jurisdictions — each healthcare organization could be confident that physicians are accessing patient data according to their policies.

Work-Life Balance

The multi-persona solution could also introduce additional flexibility that will allow physicians to minimize time spent in the office, tethered to an in-network computer.

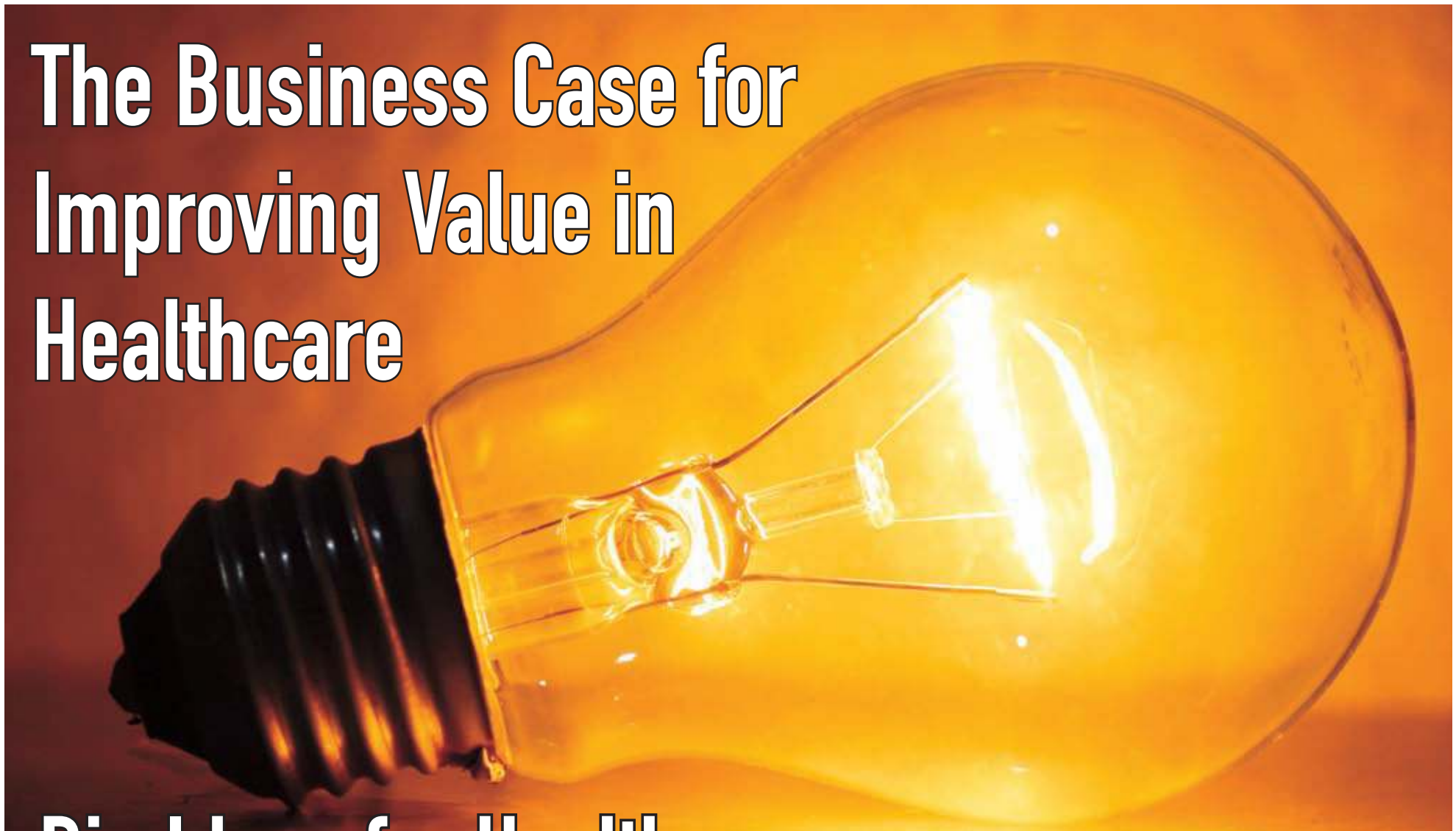
Having a single mobile device with multiple professional personas would allow physicians to knockout small tasks they'd normally have to complete while in the office such as emailing, typing notes or reviewing tests. Physicians would be able to do this securely from their mobile device while on the train or bus ride home — or from the couch after their kid's little league game. Having mobile access to patient data without introducing additional risk means physicians are less tethered to their workplace and therefore able to maintain a healthier work-life balance.

BYOD doesn't have to be a threat to healthcare organizations. With a multi-persona solution, organizations can give physicians the flexibility and work-life balance they want without introducing additional risk to sensitive patient information. As mobile technology is adopted in a growing number of healthcare organizations, multi-persona BYOD will play a key role in preserving patient privacy, increasing physicians' productivity and enabling faster access to life-saving information. ✚

Dror Nadler is SVP Sales & Strategic Alliance for Cellrox. He brings 20 years of global leadership experience in driving adoption of emerging technologies in the marketplace, building strategic partnerships and deploying sales strategies resulting in accelerated revenue growth.

For more information, visit www.cellrox.com.

The Business Case for Improving Value in Healthcare



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mHealth: Using Mobile Technology to Reduce Readmissions

By Robert Oscar, R.Ph.

A growing number of top hospitals and healthcare providers have begun to utilize mHealth platforms, including mobile technology devices, smartphones and remote monitoring, to connect patients and clinicians, extend care outside of hospital walls and reduce avoidable hospital readmissions.

In 2013, 2,225 hospitals paid penalties for high hospital readmission rates, with penalties costing them up to two percent of their Medicare reimbursements — a total of $227 million, according to Kaiser Health News.

According to one survey of clinicians reported by Qualcomm, 52 percent believe the use of mobile technology will substantially impact the delivery of healthcare in the future, with another 16 percent noted that the use of mobile technology will dramatically change the way that healthcare is delivered in the future.

The Rise of mHealth

One key reason for avoidable hospital readmissions is that patients do not always hear, or remember, what is communicated to them during the discharge process, fueling a non-compliance issue that costs the U.S. healthcare system $300 billion a year, according to FierceHealth.

mHealth directly addresses gaps in communication across the healthcare delivery system, impacting outcomes in chronic disease management, improving care coordination and gathering data for population health management.

Forging a strong connection with patients and aiding the post-discharge process is critical for improving outcomes. Healthcare apps offer patients easy access to essential medical and pharmacy benefit–related information, including:

- Reminders and alerts for prescription drug compliance
- In-network provider directories and directions to offices
- Pharmacy and medical benefit summaries and claims history
- Drug formularies and drug prior authorization status
- Deductible summaries and cost-sharing requirements
- Drug prices of nearby pharmacies and expected out-of-pocket costs with generic and therapeutic alternatives
- Self-diagnosis tools with symptom and disease lookup features
- Daily wellness tracking tools for achieving health-related goals
- Health-related symptom checkers
- Options for in-home monitoring and in-home care

Currently, health-related apps are used primarily for information retrieval, with some mobile devices providing more one-on-one interaction.

For example, RxManager, which is offered by Physician's Plus, provides personal drug utilization information for each patient, including specific money saving suggestions for better pharmacy benefit use.

The app also offers patients a number of features, including:

- Records immunizations and health screenings, and those recommended based on the individual's profile
- Tracks health and wellness, including weight, HgA1c, headache log, blood pressure, cholesterol, and more (the date and time selector supports multiple tracker measurements per day)
- Creates a list of questions to ask the doctor

The most effective Web-based platforms:

- Gather, integrate and access drug claim histories and formulary data
- Deliver personal notifications to patients regarding drugs that require prior authorization
- Contain personalized messaging to increase the effectiveness of consumer engagement communications
- Include reporting applications that measure changes in pharmacy utilization and prescription drug adherence for chronically ill patient populations

Ultimately, the widespread use of mHealth will save time and money across the healthcare delivery system, simplify pharmacy understanding and utilization, and enhance the effectiveness of medication therapy management.

As more hospitals and hospital systems begin to develop networked apps for their providers, physicians will be able to extend their clinical tools — and reach — to more people.

Along these same lines, apps designed for physicians are expected to become increasingly better connected to patients' clinical records so that information can be easily shared between healthcare providers.

With apps designed to support patient care and enable clinicians, pharmacists and hospital staff to encourage adherence to medications for chronic health conditions, such as diabetes and asthma, hospitals can cut costs and work collaboratively with individuals who are at risk for adverse drug events that lead to hospital readmissions.

Given that 60 percent of a healthcare provider's cost is for human resources, according to Qualcomm, mobile technology, including smartphone apps and Web platforms, offers significant promise for creating a more efficient system at the point of care, and an ecosystem of web applications and services that work in collaboration to connect and support patients, caregivers and providers.

Robert Oscar is President and CEO of RxEOB. Throughout his 25 years in healthcare, Robert has developed and implemented successful programs to effectively manage pharmacy benefit risk including pioneering work in the Medicare HMO market.

Before founding RxEOB more than a decade ago, Oscar worked in the medical information systems industry, designing, developing and implementing several different claims analysis tools.

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Interpreting the FY15 Proposed Medicare IPPS

By Kristin Truesdell

On April 30, 2014, the Centers for Medicare and Medicaid Services (CMS) released the FY2015 Proposed Inpatient Prospective Payment System (IPPS) rule. In addition to the customary annual payment updates, provider facilities can continue to expect to work harder to achieve payment rewards and/or avoid payment penalties associated with performance such as re-admissions, value-based purchasing, hospital acquired conditions, and select inpatient quality measures.

Below are some tips for understanding the components of the IPPS for the coming year:

Standard Operating Payment Rates — Under the proposed FY2015 rule, the standard operating payment rate increased 2.1%, equating to $5,401. After adding the increased federal capital rate of $433, the national operating standardized amount with wage indexes greater than one totals $5,835, which is a net increase of 0.6% from the FY2014 rate of $5,800. In addition to the payment rate increase, the relative weight averages included in Cardiovascular service line have increased 5%, Orthopedics have increased 0.2%, and Neurosciences have increased 1%. All three of these service lines have significant revenue and volume potential; Corazon recommends a thorough review in these areas in order to understand how the proposed changes will affect your hospital, both operationally and financially.

Readmissions — The Hospital Readmissions Reduction Program requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. The maximum reduction increased to 3% in FY15 versus 2% in FY14. In addition to the three existing conditions measured (acute myocardial infarction, heart failure, and pneumonia), CMS has included Chronic Obstructive Pulmonary Disease (COPD) and Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) to be used starting in FY15. CMS has also made revisions to the FY14 algorithm to exclude planned readmissions within 30 days of discharge.

Value-Based Purchasing — The estimated amount of base operating DRG payment amount reductions for FY15 (a 1.5% reduction) is the same amount available for value-based incentive payments, which is approximately $1.4 billion. The measures for FY15 were finalized in previous rulings to include 17 measures. CMS also made final and proposed rulings for future VBP program in FY17 and beyond.

Hospital Acquired Conditions (HACs) — As part of the Affordable Care Act, a 1% reduction in payment is made to hospitals whose ranking is in the top quartile (top quartile = worst rankings). CMS estimates that approximately 753 hospitals will be subject to the reduction, which equates to $330 million.

Two-Midnight Rule — Under the two-midnight rule, a patient qualifies as an inpatient admission if in the hospital for at least two midnights. Although finalized in the FY14 IPPS ruling, the two-midnight rule was initially delayed until October 2014 due to extreme resistance. However, on April 1 the President signed into law an extension to delay Recovery Audit Contractor enforcement of the two-midnight rule through March 31, 2015. CMS is inviting feedback on this issue and welcomes suggestions via written correspondence or emailed to SuggestedExceptions@cms.hhs.gov with ''Suggested Exceptions to the 2-Midnight Benchmark'' in the subject line.

Although changes will likely be made in the final ruling due later this year, hospitals should be prepared for what's to come by

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Physicians and the Cloud: Optimizing Security and Efficiency

By Bahman Saless

This year marks Meaningful Use Stage 2 of the Centers for Medicare and Medicaid Services' (CMS) Medicare and Medicaid EHR (electronic health record) Incentive Program — and physicians and administrators have quickly discovered the value inherent in the data they create every day. Technology is becoming increasingly vital to the practice of medicine as organizations adopt EHRs and attempt to extract data from those records to analyze, but even as technology evolves to keep pace with the changing demands of the workplace, it can cause new and unforeseen headaches for users.

Cloud storage has been a boon for many medical practices and integrated delivery systems that use EHRs. The ability to connect to a cloud and access medical records or practice management systems (PMSs) from anywhere, even outside of a clinic or hospital setting, has facilitated the spread of telemedicine and given rural or other underserved patient populations better access to practitioners and specialists. Some EHR and PMS vendors offer cloud storage with their software products and guarantee HIPAA-compliant, encrypted products that secure the safety of that valuable data.

However, the question of who owns the data in a vendor's cloud isn't completely clear, which has led to some concern in the medical industry — particularly because of the strict but sometimes murky laws surrounding medical records storage.

Health care providers are required to keep their patients' medical records for a certain number of years (the number varies according to state and specialty), and legally, medical records are the property of the patient to whom they refer.

If a patient requests his or her medical record within the time constraint mandated by the state, a care provider must be able to produce that record.

And as physicians and administrators know, sometimes the current EHR you're using isn't the best fit for your practice or organization; many physicians' offices and hospitals have gone through several rounds of EHR software before finding a good fit. Moving data from one EHR system to another has proven difficult at best, and if the organization is using an EHR vendor's cloud, they might be forced to pay for two different software licenses in order to maintain access to their old data.

A new technology solution to the data problem is emerging, though. Often called the "private cloud," this option gives medical organizations full control over their data — with all the accessibility of a vendor-owned cloud. Dr. Tom Lally, who runs his practice Physician Housecalls in Denver, notes that his private cloud provider has allowed him to maintain access to his data — from his EHR and PMS alike — even while changing EHR vendors.

"If you use a vendor's cloud — they give you a website and you log in — they own 100 percent of the data," he notes. "Everything. You don't even have it on your server, so you can't even hit 'print' and print out your demographics — and then there are charges and fees and big barriers to exiting contracts with that vendor. So physicians can get signed in with a vendor who quasi-owns their data; and then they can't get it back themselves. It's a big risk, and we won't even consider it."

Lally's practice gives critically ill patients an alternative to urgent care or an emergency room visit; they deliver primary care as well as urgent, transitional and palliative care — and they do it all over the city, making the private cloud provider an important part of the practice.

"Years ago, our providers took notes on their laptops," he explains. "We'd get all the laptops together and synchronize them onto a central server, so at the very best, I'd be seven days behind on a chart. We just couldn't get those databases together."

Lally says that his practice had always used a personal cloud, but hosting it off-site with his private cloud provider allowed Physician Housecalls more support and professional-level service for a similar cost. Providers were given tablet computers they can use to log on to the private cloud; they can view appointments, medical records and more from that tablet, as if they were working in the office, and it's secure and HIPAA-compliant.

"Everybody is now working in one environment," he says, "so we can share documents and protocols so much faster and more securely than anybody else could do that. For every provider, there's at least one support person in the background doing faxing and billing — and those folks are also logging on to the private cloud.

"It's much more efficient for us; it gives us a lot of flexibility; and if we decide to change software vendors, it's no big deal for us," he adds. "So we can adapt moving forward." ✚

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analyzing the potential affects published in the proposed rule. With such as strong focus on achieving positive care and patient satisfaction measures, hospitals must put a constant and concentrated effort on current outcomes and ongoing improvement initiatives. Indeed, monitoring and improving quality can have a lasting impact on financial performance. Quality must be the foundation of all clinical services, and can propel a hospital into great position to be a provider of choice in a given marketplace. ✚

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4 Steps to Building and Managing Your Online Reputation

By Lea Chatham

Whether you know it or not, you have an online presence. And it may be growing without any input from you. Your current and future patients are online, and they are listening to what others have to say. One in five Internet users has consulted online reviews and rankings of healthcare service providers and treatments. Staying competitive means being online, listening to what people are saying, and engaging in the conversation. It is a key piece of marketing your practice in today's digital environment.

Follow these four steps to successfully build and manage your online presence and reputation:

1. Create a Website: The days of static websites are over, and you can no longer get away with having no website. You need a useful, dynamic site that engages patients and provides the tools and information they want. Your best bet is to use a website design firm that specializes in medical practice sites. Look for one that offers an affordable base package with add-ons like patient education or blog articles. Link to your patient portal from the site. Ideally, your portal should be integrated with your EHR and practice management system and offer access to medical records, secure messaging with providers, and the ability to see their billing history and make online payments. Other great features include the ability to make appointments or link to online reviews.

2. Engage with Patients on Social Media: It's time to allay any fears you have about social media. Two thirds of U.S. adults use social media and it is a great way to stay connected to your patients and keep them engaged. Go where your audience is — Facebook, Twitter, and YouTube most likely. Create your pages and encourage patients and staff to "like" and "follow" you. Promote your social channels through email, your website, a direct mailer, and in all your interactions in the office. Post regularly, be friendly but stay professional, and respond to comments. If a patient brings up a health concern or shares something that could pose a potential HIPAA violation, direct the conversation to a private chat or take it offline quickly.

3. Own and Monitor Your Online Listings: Many practices aren't even aware that they have online listings on physician search and rating sites. These sites use the physician blue book and other sources to populate their pages. Most will allow you to own your information and make updates. Many also allow consumers to leave reviews or ratings. It's important to make sure that these and other listings like Google are up to date and to monitor those reviews. The easiest way is to conduct a series of online searches for your practice and providers by name. Set up a spreadsheet to list all the sites and keep track of reviews. It can take some time to get them all up to date but it's worth it.

4. Be Responsive to Comments and Reviews: Whether it is a comment on your own social media page or on a third-party site, you need to be aware of what people are saying and be responsive. Thank patients for the positive things they say and respond to the negative. If someone has a complaint, apologize and let them know what you are going to do to fix it. Showing that you care and want to resolve the problem goes a long way and reflects well on you. It can also help keep that patient and show potential patients that what your patients think matters.

Patients are increasingly looking for healthcare services online, and they expect you to be there and to be actively engaged. More than two-thirds of patients used online search prior to booking an appointment and over 40% of consumers say that information found via social media affects the way they deal with their health. If you're not there, then you are missing an opportunity to build your practice. ✚

Lea Chatham is the Content Marketing Manager at Kareo, responsible for developing educational resources to help small medical practices improve their businesses. She specializes in simplifying information about healthcare and healthcare technology for physicians, practice staff, and patients.

Defense Investigations — An Ounce of Prevention Just Might Keep You Out of Jail

By Anthony C. Vitale

Just about every day there's at least one story published in a newspaper somewhere in the U.S. about healthcare fraud. It might be about an individual provider who has been arrested, a hospital that is under investigation, or an office employee in a healthcare setting who has been sentenced to jail for their role in defrauding Medicare, Medicaid or some other payor.

How do these cases come to the attention of investigators? And, what can a provider do once they become the target of an investigation?

Investigations can be initiated in a number of ways: Disgruntled employees, ex-spouses who feel slighted, or a jealous competitor can serve as a whistleblower.

Or, your practice might become the target of computer surveillance — i.e. a provider's billing practices show up as an outlier for performing too many procedures or making more money than others.

Some providers and suppliers that historically have had a greater risk of fraud also end up targets of increased scrutiny.

So, what do you do once you become aware that you or your practice has become the target of an investigation?

One of the single most important decisions a healthcare provider or organization can make is to determine when to conduct a defense investigation.

A defense investigation is a confidential internal investigation conducted by counsel when there is a suspicion of a government investigation, government subpoena, employee hotline complaints, whistleblower allegations, aberrant data trends or direct allegations of fraud and abuse.

Defense investigations apply not only to criminal matters but also to civil, administrative and licensure liability.

The purpose of a defense investigation is to reduce or eliminate criminal, civil, licensure or administrative liability for the organization's management and employees.

The need, and in some instances the duty to investigate, stems from several sources: state law, OIG regulatory guidance, Sarbanes-Oxley Act, and federal and state civil False Claims acts.

A defense investigation consists of four distinct components:

The factual investigation: At this stage your legal counsel should be conducting a shadow investigation of the government or enforcement agency's actions.

This should include a complete investigation of the facts surrounding the allegations of fraud, abuse or regulatory noncompliance.

Sometimes investigators identify a provider as a suspect and then attempt to build a case around them based on little more than suspicion.

Other times a factual investigation can reveal inconsistencies or gaps in the investigator's report that can prove favorable to the defense.

The legal investigation: This will take place at the same time as the factual investigation.

At this point it's important to identify what laws, rules or policies are alleged to have been violated.

The lifeblood of any investigation is evidence.

If there isn't enough evidence then an investigation can die on the vine.

You want to bring in your own private investigator to conduct interviews and bring in billing and coding experts to crunch numbers.

Whatever the issues demand, it's imperative that you match the government's resources.

Defense development: At this stage legal counsel develops defenses and explanations to the violations identified by the investigating agency and begins to create corrective action plans.

A corrective action plan should include an analysis of the investigation's findings, recommendations for corrective action, a timetable to implement the corrective action and the procedure for monitoring the effectiveness of the corrective action plan.

Judgments must be made on how to present a case to the prosecutor and what you want to accomplish.

The important thing to remember is that you can't fight everything.

You have to pick and choose your battles.

Defense case presentation to enforcement authorities: A defense attorney will meet with the prosecutor early on in an effort to protect your interests.

This is why it's imperative that a healthcare provider bring in counsel as soon as he or she suspects they have become the target of an investigation.

The bottom line for anyone facing an investigation: The quicker you get a lawyer involved the better off you are. ✚

Anthony C. Vitale is the president of the Health Law Offices of Anthony C. Vitale in Miami, Fla.

The firm concentrates in criminal, civil, regulatory, Qui Tam/Whistleblower, administrative and licensure representation of healthcare providers.

Think Twice About "Maximum Medical Leave" Employee Policies

By Antoinette Oliver and Elaina Smiley

The recent $1.35 million settlement that Princeton HealthCare System must pay to former employees should cause all health care employers to consider re-examining their employee medical leave policies.

Princeton HealthCare System (PHCS) had a maximum leave policy that allowed employees to take no more than 12 weeks of leave for medical reasons within a 12 month period.

The PHCS policy was in line with the Family Medical Leave Act (FMLA), which allows qualified employees to take unpaid, job-protected leave for specific family or medical reasons, such as the birth of a child, a serious health condition or to care for a sick family member.

Employees who qualify for FMLA leave can take up to 12 weeks of leave within a 12-month period, either intermittently or all at one time.

PHCS fired any FMLA eligible employee who took more than 12 weeks of medical leave.

It also fired those employees who were not eligible for FMLA leave after their being absent for only a short time.

The EEOC filed suit on behalf of the 23 affected employees, arguing that PHCS' policy failed to consider leave as a reasonable accommodation under the Americans with Disabilities Act (ADA).

The ADA requires employers to make reasonable accommodations for any employee who has a qualifying disability.

A disability is defined as a physical or mental impairment that substantially limits one or more major life activities.

Under the ADA, employers must work with employees on a case-by-case basis to determine what reasonable accommodations are necessary, depending on the employee's specific disability and the particular circumstances of the job.

In some cases, unpaid medical leave in excess of the 12 week FMLA leave period may be a reasonable accommodation.

The ADA does not define the amount of time that is considered a reasonable accommodation for a medical leave. Instead, employers need to assess each case on an individual basis to determine the amount of leave that would be a reasonable accommodation.

Employers should consider factors such as whether the employee will be able to perform necessary job duties after the leave period with or without an accommodation and whether the accommodation would cause an undue hardship on the company.

In the PHCS case, the hospital applied its 12-week limit on medical leave uniformly, without regard to whether an employee may have been covered under the ADA.

Thus, the hospital violated the provision of the ADA that requires employers to work with each individual to determine a reasonable accommodation based on the specific circumstances.

Many health care employers enforce a standard maximum leave policy among all employees to avoid showing favoritism or discrimination.

But an inflexible policy may be a violation of the ADA because it fails to make reasonable accommodations for employees' disabilities on an individual basis.

Small health care employers should take note that the ADA applies to all companies with 15 or more employees.

The FMLA, however, only applies to employers with 50 or more employees.

While a small health care employer may not have to provide medical leave for employees under the FMLA, it may have to allow

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A Trip to the Mall for Some Shopping, Dining, and Healthcare

By Scott A. Huff

As healthcare design professionals we often partner with clients who are on the leading edge of defining rapidly changing models of healthcare delivery. Healthcare providers strive to provide efficient, convenient, patient-centered care for their communities. Sometimes, a change in scenery can help them achieve that objective.

One-stop shopping takes on a new meaning as healthcare organizations explore new concepts of retail healthcare. Earlier this year, Main Line Health's (MLH) new, 32,000-sq.-ft. outpatient medical center opened at the Exton Square Mall, 30 miles northwest of Philadelphia. We worked with MLH to transform former multiple tenant spaces into a brand new kind of mall tenant. This retail/healthcare hybrid takes advantage of the mall's visibility, location, ample parking and extended hours, plus the convenience of combining a doctor visit with shopping and dining.

The idea of combining mall retail with medical services might seem unusual at first, but for people trying to make efficient use of their time, the Main Line Health Center at Exton Square brings healthcare to a convenient location featuring other amenities that big box retail store conversions do not have. As an ambulatory care facility, it is distinct from convenience care centers now popping up in pharmacies and supermarkets, which offer treatment for uncomplicated minor illnesses and injuries, primarily through nurse practitioners.

Come on in

What's inside? The health center offers traditional physician practice space combined with urgent care, and such services as chemotherapy and infusion, laboratory, neurodiagnostic and vascular testing, physical rehabilitation, and radiology (CT scan, DEXA Scan, Mammography, MRI, Ultrasound, and X-Ray). This combination offers another level of the one-stop shopping concept within the medical field. Imagine seeing your doctor for a routine visit and having same day access to onsite specialists or diagnostic imaging services which would normally require multiple follow-up appointments.

With both interior and exterior mall entrances, access is a snap even when the mall is closed during late evening or early weekend hours. Once inside, the concept is to create an innovative concierge experience focused on the consumer and patient-centered care. Think Apple® Store for healthcare.

Most services at the health center are unified by a centrally located registration desk which functions as a hub of integration. In lieu of multiple check-ins with separate practices, patients at this facility can centrally register for all services at one time in one location. A public concourse is designed to feel like a comforting "stroll through the park" as it connects the exterior entry, central registration, and mall entry. Each service entry along the interior concourse is defined with monumental wood panels creating portals that resemble the hollow of a tree.

In collaboration with MLH, the mall owner PREIT worked to bring similar warmth to the more than 300 linear feet of store front which encloses the health center. Local artist Jeff Schaller was commissioned to create monumental "art pop" panels that incorporated clinical images as well as icons of the local Chester County landscape, representing the combined vision of community and care.

Form follows flexibility and function

Behind the public façade, our modular floor plan comprised of standard room types allowed for greater adaptability to both current and future services. Based on a 10 foot by 10 foot room module, this "kit of parts" planning process reduced design time and increased our ability to interchange program elements and functions during planning and construction with relative ease. The flexibility also allowed Main Line Health more time to determine their response to the changes in the delivery model and uncertainty of the market.

The existing structure of the mall space is exposed in the public spaces, highlighting the generous ceiling height. Above the ceiling of the clinical spaces, the ample height is used for multiple utility transitions for plumbing distribution to exam rooms and a ducted return air system which are not normally required by retail tenants in a mall setting. Mechanically, the units designed to deliver consistent air to each retail space are modified to allow for greater temperature and humidity control required for the new occupants and the equipment.

What the future holds

The Main Line Health Center at Exton Square consolidates services previously provided at two nearby ambulatory care centers in Chester County. Maria Flannery, director of physician practices/ambulatory care center for Main Line Health told the *Philadelphia Business Journal*, "Those centers didn't have great visibility; there

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Do I Really Have to Go Downtown?

By Dr. Brian J. Schiro

This is a question that is often asked by patients when a doctor tells them that they need specialized care. This question has a wide array of implications for patients. For those who are elderly or have advanced diseases with significant morbidities, the requirement to travel out of their rural or community healthcare networks can be arduous.

Traveling for thirty minutes or an hour by car into the hustle and bustle of the urban streets and finding one's way into a tertiary care facility is daunting and leads to undue stress and anxiety. In addition to travel, significant monetary costs are borne by the patients or caregivers who miss work in order to bring their friend or family member in for advanced care. This is compounded by the need to return to the tertiary care hospital for the initial visit, procedure (if needed), and follow-up care.

While many rural and community hospitals have the needed resources to offer patients advanced care, out-dated referral patterns and unfounded biases exist that sway primary care providers and specialists to transfer care to the urban centers. For instance, oncology patients who fail standard therapies in the community setting are often referred to Cancer Centers where they are evaluated for advanced treatment.

In the case of patients with primary or metastatic liver malignancies, patients are often referred for targeted liver therapies (e.g., percutaneous ablation, chemoembolization, and radioembolization, etc). These techniques of Interventional Oncology are now ubiquitous in Interventional Radiology fellowship training programs and are intensely reviewed in standard continuing medical education in Interventional Radiology. Thus, these services can and should be offered to patients at hospitals which have a clinically robust Interventional Radiology department whether at urban centers or in the community.

Another example is in the field of vascular disease. Patients with peripheral vascular disease or aortic aneurysms require initial evaluation, treatment, and routine life-time follow-up. In the case of abdominal aortic aneurysms (AAA), these patients typically have significant comorbidities (e.g. COPD, CAD, PAD, etc.) limiting their physical activity. A long walk through an urban hospital environment after an exhaustive search for parking can be prohibitive and may limit appropriate and necessary follow-up.

Today, endovascular aneurysm repair (EVAR) by endovascular specialists, including Interventional Radiologists among others, can be performed safely in the hands of experienced operators in the community with technical success rates approaching 98%. This is detailed in an abstract published by Schiro et al. in the Journal of Vascular and Interventional Radiology in 2012. In practices with routine clinical follow-up programs, the required yearly CT angiogram and clinical visit can be performed at any rural or community center.

In today's technologically advanced society, medical knowledge and techniques are rapidly disseminated. Cutting-edge, advanced care and treatments once coveted only by urban tertiary care centers can now be safely and effectively managed by subspecialists in the rural and community settings.

Gone should be the days of sending patients on unnecessary odysseys for healthcare.

When patients ask, "do I really have to go downtown," the answer should be, "No — we can offer you world-class treatment right here at home." ✚

Dr. Brian J. Schiro trained in diagnostic radiology at the University of Pittsburgh Medical Center and completed fellowship training in vascular and interventional radiology at Baptist Cardiac and Vascular Institute in Miami, FL.

He is certified in Vascular and Interventional Radiology by the American Board of Radiology and is a partner of Interventional Radiology Specialists, Inc., at Washington Health Systems, Washington, PA. For more information, visit www.ivrspecialists.com.

Asbury Heights Collaborates on *Positive Approach to Care* for Individuals with Dementia

By Cara Todhunter

Asbury Heights prides itself on being a leader in maximizing function and wellbeing in older adults. It's an achievement that involves ongoing training for staff at all levels and having senior leadership stay abreast of the most current and effective approaches to the care of older adults.

Our focus on wellbeing extends to all of our residents from independent living to personal care, nursing care, rehabilitation and memory support.

In the area of memory support, Asbury has partnered with dementia care expert Teepa Snow, MS, OTR, to implement and expand on her techniques and teachings known as *Positive Approach to Care*.

This approach focuses more on physical cues rather than verbal cues when communicating with residents with cognitive impairments and how our brain controls our body and our behaviors. It's an attempt to look at the world from the perspective of an individual with dementia.

When we use the *Positive Approach to Care* and approach a resident at Asbury who has cognitive impairment, we are using strategies that are scientific, based on the aging process. While the *Positive Approach to Care* is tailored for individuals with dementia or other cognitive impairments, it really is a natural progression of how to communicate with anybody.

The *Positive Approach to Care* may have been designed specifically for individuals with dementia or other cognitive impairments, but the methods involved in the training are reflective of excellent overall customer service and a common sense approach.

For example, instead of just walking into a resident's room, we knock on the door or a table to get their attention. We call them by name. We move slowly. We approach them from the front. We get on their level to talk — sitting, squatting or kneeling. This approach minimizes the chance of startling the resident and gives them more control, which is in keeping with our resident-centered approach to care.

There are four levels of achievement and a coaching level involved in *Positive Approach to Care* training. All employees at Asbury are required to complete level one of training, and employees working on any memory support community are required to complete levels one and two — level one within the first 90 days of employment and level two within the first year.

Because the *Positive Approach to Care* represents a culture change, it needs to be reinforced regularly to become habit forming and a standard practice of care, and that's where peer coaches are effective.

We have four or five peer coaches who have advanced skill and training. They've completed level three or level four of training. Peer coaches meet up with staff for 15-20 minutes each week. They demonstrate techniques and make sure staff is practicing everyday. Our peer coaches are helping us to achieve culture change in a positive way.

Asbury activity directors have also completed a similar advanced level of training as peer coaches. The services that activity directors provide to residents are centered around engagement and programming. Their expanded level of training provides them with additional knowledge about dementia and makes it easier for them to identify an individual's abilities for social engagement. By having an expanded base of knowledge, activities directors can manage the social setting and develop opportunities for all residents to be active and involved.

For example, some residents are able to play bingo, but there are some who can't but would still like to be involved. By understanding the abilities of each resident, we can have everyone involved. Some may play bingo, one may stack the cards in a neat pile and another may have another task. We want everyone to be engaged socially, and through *Positive Approach to Care* our staff is being given the training so that can happen.

Asbury will soon be the site of a *Positive Approach to Care* College where individuals from around the country will come to learn these innovative techniques.

Teepa Snow and Asbury staff members will train and demonstrate elements of the *Positive Approach to Care* so that professionals caring for individuals with dementia can meet their needs through a more caring, thoughtful approach.

More details about the *Positive Approach to Care* College at Asbury Heights will be announced soon. ✚

Cara Todhunter is senior administrative director, Health Care Services, for Asbury Heights. For more information, visit www.asburyheights.org.

TGIF: Making Fridays More Productive for Your Office

By Dr. Brent Shealer

When I was again presented with an opportunity to pen another column here, I was asked if I could write something about practice management.

My first thought was, "Sure, that's easy."

I mean I've run my own private office for over 10 years, so sharing some tidbits and tips that I do around here shouldn't be a problem.

Boy was I wrong! Here I am, a solo-practitioner Chiropractor, and I'm going to offer practice management advice to larger volume offices, multi-disciplinary clinics, and other clinical specialties? No way! What works for me on a daily basis couldn't possibly be expected to work across that broad of a spectrum. We're all in the medical field, but how we function from a practice management standpoint in our respective offices often is so very different.

But then it hit me, I can share one simple little thing that I do, and have done for years, that really does help in running my office.

So TGIF right? We've all heard it. I mean of course everybody loves Friday because for most of us it's the end of the work week and the beginning of the weekend. Because of that though, too often Friday can tend to become a very unproductive day for both us as a provider and/or business owner and our various staff as it's too easy for us all to slack a bit and have our eyes on the weekend. I completely understand that, but there is one simple little trick you can do that can make Friday more productive in your business, professional, and clinical life.

If you keep any sort of weekly business or clinical stats, figures, cycles, ordering, insurance posting, billing, filing, record keeping, etc., use Friday as the beginning of your week, not Monday. That's it! That little simple shift in thought will change your mindset. Making Friday the beginning of your week for these types of things will have the effect of making it a more productive day because we all should want to "start the work week off well".

In my office, I use Friday as the beginning of the week when I tabulate all of my weekly numbers. Weekly patient visits, weekly profits, weekly billing and collection, expenses, etc. are all done on a Friday-Thursday basis.

To expand, this can work well for any business regarding any sort of weekly stat, calculation, or figure.

It also can work well for your personal life. Do you try to go to the gym x amount of days/week? Well if so, use Friday as the beginning of that count. Do you count calories? Use Friday as the start.

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Homeopathy for the Pain in You

By Michelle S. Fielding, WHE

As a morning runner with my 10-year old Australian Shepherd, Hines, I look forward to getting out the door for a good run in the fresh air on any given day, it's a great way to start the day! Hines and I love running to the park where he sees other dogs and we run freely without the worry of traffic. Hines particularly loves to run up-hill, which was initially a new challenge for me, but one I adapted to and now its part of our routine.

However, one Saturday morning in April, I woke and stepped out of bed, and had a terrible sharp pain in my right knee. I could barely put weight on it and I didn't know what I had done. I had stabbing pain that made it very difficult to get down the steps, and my knee was stiff with inflammation. Once I hobbled downstairs, it was apparent we would not be running. I felt bad for Hines for this was the high point of his day!

Needless to say, I got on the Internet and checked my symptoms and self diagnosed, Iliotibial Band Syndrome. The iliotibial band is a band of fibrous tissue that runs down the lateral side of the thigh. It provides stability to the knee and hip and helps prevent dislocation of those joints. The band may overdevelop, tighten, and rub across the hipbone or the outer part of the knee.

Each time the knee is bent or the hip flexed, the band rubs against bone. IT Band Syndrome is particularly common in runners, cyclists, and people who participate in other aerobic activities. While I've heard other runners complain of their IT Band, this was my first experience with it. My pain was so excruciating that Saturday evening. As I changed clothes for bed, I actually fainted as I tried to straighten my knee. That night I decided I was more comfortable sleeping in the recliner chair with my knee slightly bent.

On Monday morning, I decided to call the physical therapy office at my gym. I informed the physical therapist that I really had tremendous pain when putting weight on my knee, and that the knee was quite stiff and inflamed, particularly on the lateral side, and I was concerned that I would not be able to drive. The physical therapist advised me not to schedule an appointment at this time for he felt it was too severe to work on, but that he would call me on Wednesday, to see if there is any improvement in my condition. By Monday evening, I called my homeopath, and told her my chief complaint of a stiff right knee and inflammation on the lateral side of the knee, and sharp pain upon standing or any attempt of bending or fully straightening the knee.

Then, after a few questions, my homeopath asked if I had any Bryonia at home, and I did not, then she asked about Rhus tox, which I had. Rhus tox is good for painful, swelling joints and stiff limbs, and affects fibrous tissue markedly, but after two doses that evening, it had no affect on my knee. My homeopath advised if I had no improvement to get Bryonia which I did. That Tuesday I took two doses and later that night, I was feeling some relief. This was the first time in three days that I had moved from the recliner chair back into bed. Bryonia matched my whole state—physically, emotionally, and mentally, much better than Rhus tox. Yet it still has a strong affinity for joints and right sided ailments, that are worse with motion and on first movement. My homeopath understood me and recommended Bryonia because it correlated with all my characteristic symptoms the best.

When the physical therapist called back on Wednesday, I schedule to see him later that morning. The knee was still quite swollen, but I was at least able to ambulate to my appointment. The physical therapist confirmed the IT Band Syndrome diagnosis and stated that I had the worse case of it he had ever seen. He provided some treatment and then gave me some exercises to do to start stretching the IT band. He saw me again the next day, and I continued to improve. Then he did not see me until Monday, and I was much better by then, walking nearly normal and bending my knee much better. He asked what I did, and I explained it was the homeopathic remedy. He was so impressed with my accomplishments that he dismissed me from his service, I was well on my way to healing.

This was an ideal example of how homeopathy works. You find the remedy that best matches the unique characteristic symptoms of a client, then you take a minimal dose of the remedy and it works on the entire person, affecting their physical, emotional and mental state. Homeopathic remedies are natural remedies from the earth, and they complement our bodies natural defense system, enabling the body to more effectively heal itself. As our body is an ecosystem, the homeopathic remedies coordinate so well that they never initiate a side effect and all the remedies are regulated by the FDA.

Michelle S. Fielding, WHE, is certified, whole health educator/coach, nutrition educator, and homeopathic student. For more information, visit www.michellesfielding.com.

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were tucked into business plazas. Here, we are in a place where people can see us, easily find us, get in and out quickly and do some shopping or grab something to eat if they want."

Early results show evidence of increased patient through-put with quicker turnaround times and improved patient satisfaction. The facility has allowed Main Line Health to be more responsive to their clients. With multiple modalities and specialties on site, impromptu consultations and same day scheduling can occur, improving collaborative care and strengthening the bond between patients and physicians.

And the collateral benefit is the creation of a new kind of anchor tenant that has exceeded health center expectations and has driven customers to the mall, benefiting other tenants. A true win-win. ✚

Scott Huff is a project manager and senior associate with Stantec architecture and engineering in Philadelphia.

Making Care Affordable for Patients: Financing Options For Providers

By Ann Garnier

High-deductible plans and rising out-of-pocket expenses and premiums have precipitated a major shift in medical financial responsibility to patients.

While it may have helped slow healthcare cost increases in recent years, having patients shoulder a growing share of medical costs is leading to unhealthy outcomes for both individuals and providers.

Patient liability was 24% of allowed charges in 2013, according to CarePayment, which offers patient financing through hospitals, physician groups and other providers.

Tellingly, the liabilities were split almost evenly between those without insurance, at 13%, and those who owed a balance after insurance, at 11%.

But these medical services are increasingly unaffordable for both the uninsured and the insured:

• 30% of U.S. adults say they, or a family member, deferred medical treatment in 2013 because of the cost, according to Gallup.

• Unpaid medical bills are the leading cause of personal bankruptcy, NerdWallet found in 2013.

• Patients with higher co-payments were 70 percent more likely to stop taking their cancer medications, according to a 2014 study by the University of North Carolina.

One consequence is that providers end up treating sicker patients who put off care as long as possible, undercutting population health management efforts.

Moreover, providers face an increasing financial burden from bad debt.

They collected just 17% of patient liabilities in 2013, according to CarePayment, with a rate of only 5% for uninsured patients and 30% for self-pay after insurance.

In fact, Moody's Investors Service recently warned that bad debt is becoming a hot spot for hospitals, in part because of the proliferation of high-deductible health plans that make consumers foot a greater portion of their health-care bills. "Today's high deductibles are tomorrow's bad debt," the report states.

This situation prompted a recent commentary, "First, Do No (Financial) Harm", in the Journal of the American Medical Association, which called for doctors to address financial concerns with patients. For a growing number of providers, one strategy is to offer patient financing:

"Patients with financial hardships may be delaying treatment because they're concerned about these costs and their ability to pay. The people in this region want to pay their bills — they're responsible and have a strong work ethic," says Lisa Johnson, Vice President Public Relations and Marketing for Blue Mountain Health System in Lehighton.

Blue Mountain recently added affordable financing options for patients. "When patients come to the hospital they already feel bad," Johnson said. "Now we can alleviate their anxiety over affording the care they need."

Currently, there are four main financing options for patients:

1. Medical Credit Cards

They are generally used for elective procedures, such as cosmetic plastic surgery and LASIK, but some cover medically necessary treatment. They often come with a "teaser" rate that puts interest on hold for a designated period of time. But if the full payment is not made during that period or if a payment is missed, the interest charged can jump overnight as high as 26.99% and even apply retroactively. Medical credit cards require an application with a credit check, so patients who don't make the minimum monthly payment could hurt their credit score and hear from a collection agency.

2. Installment Loans

They are usually available only for elective treatment. They require a credit application, so not everyone will qualify. Interest rates can be significantly above market rates — reaching more than 30% APR for those with poor credit history and thus substantially increasing the total cost of treatment. An installment loan is made for a single procedure or package of procedures, and new services can't be added without amending the contract.

3. Internal or Vendor-Managed Payment Plans

Some providers offer this option for medical services but not elective procedures. Generally, patients are not charged interest and are eligible regardless of credit history or employment. There's no credit application, so these plans don't impact a patient's credit report. However, many healthcare organizations do not offer financing. And those that do can be putting themselves at substantial regulatory risk unless they follow consistent policies and terms for offering financing to patients and comply with numerous consumer credit laws and regulations.

4. Credit Lines

A growing patient-friendly option for financing medical care (although not typically elective care) is a line of credit. As a rule, all patients are eligible and there's no application fee or credit check. Interest rates can be as low as 0%, and some programs extend payments up to 72 months, making them budget-friendly. For example, a $500 balance may require a monthly payment of only $25.

How to choose? A patient-friendly financing solution is one that most closely addresses the needs and expectations of the patient while removing financial obstacles to obtaining care. For providers who want to help patients get the care they need — and get paid for the medical services they deliver — patient financing can be the key. ✚

Ann Garnier is Chief Operating Officer of CarePayment. Ann has more than 25 years of experience in health care strategy, product and market development, operations and marketing. For more information, visit www.carepayment.com.

This little shift in your mindset can be used in many different applications, but they all have the same end result of making Friday a more productive day and thus allowing you to accomplish more in whatever it is that you choose to do.

And to all of you weekend warriors out there who usually just trudge through Friday, think of it like this, if you work to make Friday more productive it will tend to go faster and then the weekend is here sooner! So as you can see, this shift in thought has nothing but great outcomes.

After attending Penn State University, Dr. Brent Shealer graduated from Sherman College of Chiropractic in 2001. Upon receiving his Doctor of Chiropractic (D.C.), Dr. Brent associated with Newman Chiropractic in Pittsburgh. He then opened Shealer Chiropractic, P.C. near the suburbs of Monroeville and Penn Hills in June of 2003. For more information, visit http://drbrentchiro.com/ and https://www.facebook.com/DrBrentChiro.

Innovation in Healthcare's New Normal

By David Schmahl

Prompted by incentives in the Affordable Care Act, healthcare associations are introducing innovative new practices and resources for their members with the following results:

• Improvements in performance and quality care

• More access to information and data

• Record numbers of certification applicants

These organizations, with members ranging from cardiovascular health professionals to gastroenterology nurses, are mining new data sets, conducting research and developing new tools to collect information with the goal of providing powerful benchmarking and performance-gap data to support individual members' purposes. Following are examples of such innovation successes, drawn from SmithBucklin client organizations.

• The American Association of Cardiovascular & Pulmonary Rehabilitation (AACVPR), a multidisciplinary professional association composed of health professionals in the field of cardiac and pulmonary rehabilitation, launched two outpatient data registries.

The two registries – one focused on outpatient cardiac rehabilitation and the other on outpatient pulmonary rehabilitation – track patient outcomes and program performance in meeting evidence-based guidelines for secondary prevention of heart and vascular disease or pulmonary disease. The registries are providing their respective programs with national outcomes data for benchmarking and demonstrate the positive impact of rehabilitation on the morbidity, mortality, physical function and quality of life of heart and pulmonary patients across the United States.

By assisting in the collection, management and interpretation of outcomes data, the registries assist AACVPR members by comparing outcomes and processes to evidence-based goals and national benchmarks; implementing quality improvement projects based on real data; enhancing documentation and communication with the program's key audiences, such as hospital administrators, referring physicians, insurers and case managers; and promoting the role and effectiveness of rehabilitation in the management of chronic heart and lung diseases.

In addition, the registries are providing support to physicians while improving third-party payer coverage.

• The Society of Gastroenterology Nurses and Associates, Inc. (SGNA), a professional organization dedicated to the safe and effective practice of gastroenterology and endoscopy nursing, began the Nurse Fellowship Program, collaborating with commercial supporters and Texas Christian University's Center for Evidence-based Practice and Research.

The purpose of the program is to educate and train GI/endoscopy nurses on evidence-based research that can be then applied to their day-to-day practice. Fellows receive in-person training using curriculum developed by SGNA and TCU.

• The National Association Medical Staff Services (NAMSS), dedicated to the professional development and advancement of practitioner credentialing, privileging, professional practice evaluation and provider enrollment, created NAMSS PASS™, a national database of practitioner affiliation histories.

NAMSS PASS provides members with the first-ever means to ensure accurate and efficient credentialing of physicians in their hospital system, and it is the only universal resource for tracking practitioner affiliation history.

It serves as a centralized data repository of primary source practitioner affiliation information. In fact, NAMSS PASS has recently introduced the Electronic Connectivity Program which is designed to help healthcare entities and vendors connect their credentialing-related software systems to the NAMSS PASS database.

• Innovations in technology have led to a record amount of certification applicants for the National Association of Healthcare Access Management (NAHAM).

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Enhancing Client Brand Identity: Do Design and Construction have a Role?

By Bob Bailey, AIA

A medical office building with a striking design can go a long way towards helping a healthcare services provider looking to expand their market, by becoming a recognizable landmark. For anxious parents bringing children for treatment, a strong design statement can help to reinforce the mission of the healthcare provider.

At the South Fayette, Pennsylvania, medical office building for Children's Hospital of Pittsburgh of the University of Pittsburgh Medical Center (UPMC), the architects at IKM created a design solution that provides striking and memorable imagery consistent with the client's goals for the project.

Communicating the Brand with the Design

Anna Klingmann, an architect and academic who specializes in branding, states, "A brand is something that brings out the identity of a particular place." IKM's concept dealt with two overarching ideas. First was to capitalize on a site selected for its high visibility from an interstate highway that could present the Children's Hospital brand firmly in the area south of Pittsburgh. Second was to create a building with a memorable similarity to the main hospital to emphasize the brand. As Children's first stand-alone outpatient facility in well over a dozen years, the building design needed to communicate their successful brand. The client wanted a similar aesthetic to their main hospital but not a replica.

The simple organization of the building is reflected in its massing. Waiting areas and public circulation are placed at the front of the building. Behind them, exam rooms and treatment spaces are contained in a large 4-story volume with brick veneer. The upper floor public functions are contained in a metal panel-clad three story "tube" element that rests on a tile-clad one-story podium. The end of the "tube" becomes a glazed lantern visible from the highway. The "tube" is canted at an angle from the rectilinear brick volume. Additionally, a glazed portion of the waiting space on each floor juts out from the "tube."

Photo courtesy: Rycon Construction, Inc.

Choosing Building Materials to Convey the Brand

As the major design element, the "tube" was used to convey the branding message and concept. At the main hospital, one of the most memorable features of the building are those portions that are clad in variegated copper panels. The juxtaposition of the expanses of copper against brick masonry and curtainwall give the main building a very strong visual that contributes to the institution's brand identification. Due to cost concerns that ruled out actual copper cladding, IKM decided on an integrally-insulated metal wall panel system as the basis of design. Project designer and manager, IKM's Douglas Lieb, AIA, carefully selected a palette of 3 colors for the panels with the tonal values of copper. Approaching the building, you notice the interplay of panel sizes and colors, the depth that the reveals lend, and the five different sizes of windows within the system, seemingly in random locations yet each placed in a very studied position.

Construction as a Reflection of the Design Process

IKM and its project engineers developed the design utilizing Building Information Modeling (BIM) software, analyzing the architecture, structure, and building systems 3-dimensionally. This resulted in significantly fewer conflicts during construction.

The client retained a construction management entity to advise on cost and constructability during design. The benefit was an ongoing dialog about design and construction choices relative to the quality level of the building.

As a net result of this process, the project ultimately came in more than 16% under budget. This savings afforded the client the opportunity to purchase all new equipment (which they had not originally intended) as well as major items of equipment that they had also not intended.

The greatest benefit of the savings was that it enabled the client to build out the MRI suite on the 4th floor two years ahead of schedule, thereby expanding patient care as well as bringing a significant revenue stream online.

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DRSarchitects Vital Signs

Less is More

By Scott Hazlett, AIA, ACHA, EDAC

Is less really more? Or can only more be more? This aphorism, "Less is More", surfaced in the 1855 poem *Andrea del Sarto* by Robert Browning, but was later attributed to Ludwig Mies van der Rohe, a German/American architect of the modern era, as his motto due to repeated use by him and his followers. He used this simple concept as a way of expressing the spirit of twentieth-century architectural style and adopted it as a precept for minimalist design, or in layman's terms, "keep it simple".

How does this "less is more" concept apply to healthcare in the twenty-first century? From an architectural and facility perspective, "less is more" describes where the hospital of the future is going, or has been going for the last 10 years. Many of us just didn't notice this evolution. Driven by changes in insurance reimbursement, escalating healthcare costs, fierce competition for the healthcare dollar and the wants and desires of the healthcare consumer, the hospital facility is shrinking and outpatient locations and homecare offerings are growing. The winner in this race is going to be the healthcare systems that downsize their hospital-based facilities and grow their outpatient and homecare facilities as quickly as possible. The large hospital building that housed all services in one location used to be thought of as an asset, but now, in these changing times, it has become a liability.

Hospital construction is one of the most expensive square footages to build, maintain, heat, cool and constantly meet the highest level of regulations and scrutiny by authorities having jurisdiction. The new model of healthcare delivery will reduce the size of a hospital to its smallest possible functional size to house the 24-hours-a-day critical care and inpatient care components only. All other outpatient care, administrative and support services will be housed elsewhere in construction that is less costly to build, maintain, heat, cool and has much less stringent regulations to meet. And, these non-hospital facilities will be located closer to healthcare consumers' homes, which will increase patient satisfaction. Sounds like a win-win situation for everyone involved.

A smaller hospital, with less square footage to heat, cool, clean, supply, staff, secure, light and maintain 24-hours-a-day, 365 days a year, every year, will save many dollars and FTEs. The hospital's chief financial officer will be smiling from ear to ear. But to realize these savings, there are only two ways to achieve this size reduction. The first option is to build a newer, smaller, more efficient and flexible hospital and abandon the old facility. The second is to consolidate services into existing areas that are the newest and most efficient and tear down the inefficient and more costly wings. Simply closing or abandoning some of the existing space is not a solution. "Less is more" in this case means having space that is only in use generating income and eliminating the rest.

Allowing the hospital facility and campus to be smaller and more compact provides a number of benefits including: less parking required, improved circulation simplicity and clarity, lower energy and maintenance costs, reduced distances between departments and services, fewer staff members required to run the facility and the option to have windows in most spaces to promote healing. By reducing the 24- hours-a-day portion of the healthcare system to the minimum square footage and increasing the 8am-5pm portion to the maximum, major cost savings should be realized. This is a 180º turnabout in the healthcare delivery model after spending the last 50-100 years making hospitals bigger so that they can be everything to every person in one location. This new model may now result in a hospital that is only about 25% of a health system's area and the other 75% is non-hospital space for outpatient services, administration and support.

The "Lean Design and Operation" concept that has been adopted by many hospitals nationwide in the last 5-10 years has had the goal of trying to reduce healthcare costs, improve efficiency, shorten steps for staff members, improve patient and staff safety and make facilities more user-friendly. Many institutions have been pleased with their efforts and results to make their facilities and processes leaner and more efficient. But, like most good things, "Lean" is not a new concept, it is just a validation that "Less is More." ✚

Scott Hazlett is a Senior Architect and Medical Designer at DRS Architects in Pittsburgh, PA. As one of Pennsylvania's leading architectural, planning and interior design firms, DRS Architects has experience and expertise in a wide variety of healthcare specialties. We pursue quality, technology and innovation in creating facilities that enhance the designed and natural environment. Scott can be reached at shazlett@drsarchitects.com.

Build Pest Control into Your Construction Plans

By Jennifer Brumfield

Breaking ground on a new building or renovating an old building can be an exciting time. But if the right precautions aren't taken, new construction can also attract unwanted attention from pests.

To help prevent pest issues during construction and ensure your facility does not become home to pests once construction is complete, build pest management into your construction plans.

There are a variety of proactive measures your facility can take before, during and after the construction process to accomplish this.

Before

Before construction even begins, it's important to get two people on board: your pest management provider and your contractor.

An experienced pest management provider can do more than prevent and manage pest infestations that pop up during construction.

When involved from day one, he/she can also provide feedback on building materials and locations that will be the least attractive to pests, and help you build measures into your construction plan that will lead to a successful pest management program when the doors to your new facility finally open.

Several tips your pest management professional may provide include:

• Use non-cellulose building materials to deter termites.

Consider applying a preventive termite barrier to the property.

• Use pest monitors to assess pest populations in the surrounding area.

Understanding which pest species will be a threat will help you determine what steps you need to take to deter them.

• Understand geographic conditions.

Selecting a location for your facility near a water source might create additional pest pressures.

• Sufficiently grade the property to prevent puddles from forming around the foundation.

Remember, moisture attracts pests like mosquitoes and termites.

Even though your management team may be the ultimate decision maker, it will be up to your contractor to take the lead on pest management during his/her work.

With that said, meet with your pest management professional and contractor to discuss why pest management is important during the process and make sure everyone is on the same page about how it will be carried out.

During

Construction can be the cause of pest issues for a number of reasons.

When construction begins, it can disrupt a pest's current habitat.

This disruption can force them to find shelter elsewhere, including within or around building materials such as wood, or at neighboring buildings.

To prevent your construction from being the source of pest infestations for neighboring properties, and, not to mention, to be a responsible builder, work with your pest management professional to set out baits and traps around the property's exterior.

This tactic will also help prevent pests from returning once construction is complete.

Construction can also disrupt the sanitation and maintenance programs that are already in place at your facility, which is why it's important to keep the construction site as clean as possible throughout the entire process.

Make sure all workers are aware that food and trash left behind can attract pests, and should be disposed of daily.

In addition to keeping the site debris-free, work with your pest management professional to inspect all incoming raw materials for signs of pests before bringing them onto the site.

After

When construction starts to wrap-up, don't forget about these finishing touches that can play a role in pest prevention:

• Work with an HVAC professional to ensure you have positive airflow in the building, so pests are pushed out of entrances instead of pulled in.

• Install air curtains at entrances to deter flying insects from entering.

• Use sodium vapor lights on the exterior of your building, which are less attractive than fluorescent or incandescent lights.

• Make sure trees and shrubs do not touch the side of your building.

Trim branches back at least two feet from the building exterior.

• When landscaping, also keep in mind that certain plants are more attractive to pests than others.

For example, flowering shrubs are most attractive to stinging insects, while ivy, pachysandra and similar ground covers will attract rodents.

Once construction is complete, continue to work with your pest management professional on a regular basis.

An ongoing Integrated Pest Management program will help keep pests and the threats they pose from building a home in your facility. ✚

Jennifer Brumfield in an entomologist and Training and Technical Specialist for Western Pest Services, a New-Jersey based pest management company serving residential and commercial customers throughout the Northeast and Mid-Atlantic.

Learn more about Western by visiting www.westernpest.com.

Send story ideas to Daniel Casciato at writer@danielcasciato.com

Negotiating Tenant Allowance Dollars on your Commercial Lease

By Dale Willerton and Jeff Grandfield

When it comes to negotiating your commercial lease for a healthcare tenant there are many factors to consider.

Among these factors is the leasehold allowance (defined as the amount of money a landlord may provide to a tenant for improvements).

Commercial tenants may improve the property in whatever manner they wish, with the landlord's permission.

It is the allowance which is negotiable ... the landlord provides the allowance and may recover a portion in the rental rate during the tenant's lease term).

Tenants must also consider whether they will be provided a tenant allowance (also known as Tenant Inducement/Tenant Incentive or TI money) from the landlord.

Building out a healthcare practice can be costly for the tenant and there are a number of valuable leasing incentives that these tenants should negotiate on when they are entering into a new lease agreement and even a lease renewal.

Here are some of the points to consider:

1. Tenant Allowance — A tenant allowance is inducement money paid by the landlord to the tenant.

The tenant uses this money to offset the cost of building walls, painting, and any leasehold improvements that need to be done to the premises.

This does not, typically, include any money the tenant spends on fixtures or equipment.

The tenant's allowance money typically does not need to be repaid to the landlord (it is an inducement).

2. Landlord's Work — Rather than accept a tenant allowance from a Landlord it is not uncommon for the landlord to use his own money to at least partially turnkey the premises for the healthcare tenant.

This is especially common if the landlord owns a construction company and has staff on salary that can do that type of work.

When negotiating for either a tenant allowance or landlord's work these are some points well worth considering:

a) The more money you want the landlord to kick in, the more prepared you need to be. At The Lease Coach, we will frequently have a healthcare tenant get a preliminary design and construction cost prepared so we can show this to the landlord and negotiate for the maximum allowance we can get. As seeing is believing for the landlord legitimate quotes on contractor letterhead go a long way.

b) The leasehold improvements always cost more than initially expected. You do not want to come up $30K short because you did not get your ducks in a row. It pays to get multiple quotes starting from a single design plan.

c) Before you get three or four weeks into the leasing process with a particular landlord, it makes sense to ask the landlord or their leasing rep. what their inducement package includes. Some landlords have standard allowance that they give to almost any tenant. The Lease Coach utilizes several strategies and can frequently, effectively, double that allowance for a tenant — the key is to try to keep the rental rate down while increasing the allowance.

d) There are many types of landlords; some of them are flush with money and can contribute 100% of your leasehold improvements while others may provide a tenant with a more limited amount of tenant allowance money. If you are not afraid of a slightly higher rental rate, The Lease Coach can often persuade the landlord to pay totally for your leasehold improvements.

Keep in mind that negotiating for the maximum lease inducement package can make all the difference in the world to a start-up business or tenant.

Far too often, doctors approach the leasing process timidly, almost as if applying for the privilege of paying the landlord rent. Consequently, they leave a lot of inducements and incentives on the bargaining table.

It's also important to understand how the landlord pays you the tenant allowance.

Tenants often mistakenly assume the landlord pays that money as soon as the deal is signed and before construction is started.

This, however, is rarely the case! In most cases, you are reimbursed after you meet a number of conditions, including opening for business and proving that you have paid the contractors.

To play things safe, have some short-term financing in place to carry you through if you're relying on the landlord's contribution to your build out.

It's also possible to negotiate for some of the allowance up front in certain cases.

Remember, you're not going to get more than you ask for.

The Lease Coach frequently negotiates for lower rental rates and additional perks and incentives than the tenant expects.

Landlords (and their leasing agents) often allow some "wiggle room" and can settle for less.

For a copy of our free CD, *Leasing Do's & Don'ts for Commercial Tenants*, please e-mail your request to DaleWillerton@TheLeaseCoach.com. ✚

Dale Willerton and Jeff Grandfield — The Lease Coach are Commercial Lease Consultants who work exclusively for tenants.

Dale and Jeff are professional speakers and co-authors of Negotiating Commercial Leases & Renewals For Dummies (Wiley, 2013).

Got a leasing question? Need help with your new lease or renewal? Call 1-800-738-9202, e-mail DaleWillerton@TheLeaseCoach.com or visit www.TheLeaseCoach.com.

Providing a Good, Healthy and Happy Culture for Employees

By Kathleen Ganster

There may be no other career field where the care and understanding of employees is as important as it is in the health care field.

These are the people who are taking direct care of loved ones and family members and what job could possibly be more important than that?

So helping health care workers know what is happening in the overall industry and helping them do their jobs as best as they can is imperative.

Celtic Healthcare knows and understands the importance of this role. And with ever-changing health care policies and regulations, keeping employees abreast of these changes and knowing that they are satisfied can be a challenge.

"With health care changes happening at such a rapid pace, we feel this focus is even more important – we want our team to know what is happening, but also take the temperature of what they feel about the changes and how to implement them," said Bill Gammie, Vice President of Value Based Care at Celtic Healthcare.

While team meetings are important and can be valuable ways to share information, they are not the only method Celtic uses to assist their employees.

"So many times there may be a meeting and no one says anything. Just because no one says anything, doesn't mean all is well," he said.

That is why Celtic uses tools to measure the individual and cultural satisfaction levels. Taking it even one step further, they use personality profiles to assist in working with each individual to provide new information in the best format for each employee.

"These assessments look at how each individual is going to best accept changes and the best methods to communicate with that individual," Gammie explained.

The tests are part of the normal application process for employees and then they are readministered on a periodic basis.

"We use a very popular program called Peoplekeys.com that provides information on how different people need to be guided. Everyone is different," he said.

Bill Gammie

The Celtic cultural assessment includes looking at "each level, each location and each role," according to Gammie.

"We want to see how each one is doing, how they are feeling and how they are working together," he said.

Gammie gave the example of when Celtic discovered employees want to know more about what was happening in the healthcare industry as a whole, then how that effected Celtic.

"We then implemented Town Hall Meetings where we explain different issues in the industry and our employees can ask questions," he said.

Front line supervisors are well trained in assisting their employees in learning new policies and procedures, and work hard in communicating with their staff.

"Ongoing communication is a key component to our environment," Gammie said.

Online tools also help provide training and assistance, so every member of the Celtic team is able to easily keep up-to-date on changes and new techniques.

"We love saying, 'Culture eats strategies for breakfast.' We feel that you can't leave change to chance, you have to manage it," he said.

Admitting that it is a new twist on a new cliché, Gammie said, "A good, working culture is a journey, not a destination. We are always working at keeping a good, healthy and happy culture at Celtic."

To learn more about Celtic Healthcare visit www.celtichealthcare.com. ✚

Multi-Functional Anti-Inflammatory Drugs: A Potential Alternative to Steroids

By Gur Roshwalb, M.D.

Atopic dermatitis, also known as eczema, is a common condition.

According to the National Institute of Arthritis and Musculoskeletal and Skin Diseases, it occurs equally in males and females and affects an estimated nine to 30 percent of people in the United States today.

According to the American Academy of Dermatology, the condition is much more prevalent than it was 30 years ago.

Traditionally, steroids have been prescribed to treat the symptoms of atopic dermatitis.

Unfortunately, prolonged use of steroids can lead to undesirable side effects such as tachyphylaxis (tolerance to vasoconstriction), rosacea, stretch marks and skin atrophy.

In addition, short stature and suppression of the hypothalamic-pituitary-adrenal axis in children remain concerns for both physicians and patients.

Long-term steroid use can also promote the development of infections.

To counter the limitations of steroid treatment, some physicians have prescribed topical calcineurin inhibitors, which in turn carry a cancer risk and can suppress the immune system.

These concerns are echoed by the National Eczema Association, which notes that frequent and prolonged application of a topical corticosteroid to the eyelids, for example, can cause glaucoma and even cataracts; acne around the mouth; and redness around hair follicles.

There is also concern that topical steroids are absorbed and may have systemic effects.

As a result of the lack of effective alternatives to steroids, there is a serious unmet need for treatment of atopic dermatitis.

For this reason, Celsus Therapeutics, based in New York City and London, is focusing on the development of novel non-steroidal anti-inflammatory, first-in-class synthetic drugs termed Multi-Functional Anti-Inflammatory Drugs (MFAIDs).

MFAIDs are designed to block a key enzyme, SPLA2, that triggers the inflammatory process and is also a target of the currently available steroids.

Due to its different chemistry, however, side effects like steroids are not expected. Celsus' lead drug candidate, MRX-6, is a topical cream currently being tested in a Phase II trial in atopic dermatitis, with results expected during the fourth quarter of 2014.

A previous trial of MRX-6 showed significant improvement in patients with contact dermatitis.

Thirty patients were topically administered MRX-6 twice daily for 21 days in a double-blind, placebo-controlled multi-center study. MRX-6-treated subjects showed a 56 percent improvement using the physician visual assessment score compared to 24 percent improvement in placebo-treated subjects.

There were no observed adverse effects.

We believe MRX-6 and other MFAIDs we are developing might offer effective treatment for a wide range of inflammatory diseases — including conditions with pulmonary inflammation like cystic fibrosis; inflammatory skin diseases such as eczema; inflammatory bowel disease (IBD); and opthalmic inflammatory conditions such as conjunctivitis and dry eye.

For example, Celsus' MFAIDs have shown preclinical safety and efficacy for treating conjunctivitis and dry eye in animals in studies.

The company's OPX-1 compound is a topical treatment in eye drop form, targeting inflammation affecting the surface of the eye (conjunctiva) such as Dry Eye Syndrome and allergic conjunctivitis, both seasonal and perennial.

Positive data on guinea pig conjunctivitis as well as a safe ocular toxicology profile have been obtained.

MFAIDs have a structure that is particularly attractive for ophthalmological formulation.

Additionally, Celsus has published data in the standard industry animal model in asthma — the rat ovalbumin allergic bronchitis model — showing amelioration in symptoms, histology and inflammatory mediators.

Further, a preclinical program in cystic fibrosis (CF) generated positive data in CF cell lines.

A preclinical program in IBD has demonstrated the efficacy of Celsus' MFAIDs orally administered in both in vitro and in vivo in both the Dextran Sulfate Sodium (DSS) and Trinitrobenzene sulfonate-based IBD animal models.

Both injection and oral administration were effective in animal models.

Finally, MFAID's have produced promising results in the standard cellular assays for CF, demonstrating inhibition of IL-8 production, a key inflammatory mediatior in CF.

CFX-1 will target the underlying inflammatory causes of CF pathophysiology and aims to provide a safe, chronic treatment to CF patients that will reduce pulmonary inflammation and mucus secretion and provide for improved breathing and quality of life.

If the work being done at Celsus comes to fruition, it could be the beginning of a new set of options for patients experiencing various types of inflammation — and one that avoids the very real risks presented by today's steroids. ✚

Gur Roshwalb, M.D. is Chief Executive Officer of Celsus Therapeutics, a biotech company focused on the development of a new class of non-steroidal, synthetic anti-inflammatory drugs termed Multi-Functional Anti-Inflammatory Drugs or MFAIDs.

Understanding Pseudo-Addiction

By Ben Brafman

Diagnosing a genuine addiction can be challenging, even for a medical professional. This is particularly true in the event of prescription drug addiction, because a patient may display many addictive behaviors without actually qualifying as having an addiction. The question we must ask ourselves concerns the intention behind these behavioral patterns, as the answer may reveal whether a patient is dealing with an addiction or a pseudo-addiction.

In 2010, the Centers for Disease Control reported that nearly 5,500 people were using prescription painkillers for non-medical reasons for the first time each day. That is an astronomical number that is expected to continue rising, as prescription medications can be highly addictive substances. However, they can be highly effective at doing what they are intended to do — reduce pain. Therein lies the difficulty in separating true addiction from pseudo-addiction.

Identifying Pseudo-Addiction

Pseudo-addiction often occurs when an individual is faced with serious or chronic pain. A patient struggling with intense pain may be desperate for relief, which can lead to symptoms such as anxiety, mood swings, and even requests for additional dosages. When undertreated, severe pain can influence a person's actions, as reducing the pain becomes a priority. Someone may exaggerate the pain they are feeling, lie about how often they are taking their medication, or watch the clock, counting down until the next dose. All of these activities can mirror some of the symptoms of addiction.

Addiction, on the other hand, is motivated by a very different factor. Drug abuse and addiction affect the body and the mind, so true addiction includes physical symptoms like constipation, profuse sweating, dehydration, and fluctuating blood pressure. Opiates, in particular, wreak havoc on the body, displaying these symptoms and more. Feelings of euphoria, drowsiness, or unexplained food cravings are strongly associated with genuine addiction.

The defining characteristic, then, between addiction and pseudo-addiction, is understanding whether the patient is trying to reduce their pain or obtain more drugs to abuse. If someone ultimately wishes to manage their pain, they are likely experiencing pseudo-addiction. If they are attempting to get their hands on more drugs, it is probably a case of addiction.

Treating Pseudo-Addiction

Although pseudo-addiction could eventually lead to addiction, the two should not be treated in the same way. A person with pseudo-addictive symptoms could benefit from detailed consultations regarding their treatment plan. Pseudo-addiction can be eased when a patient thoroughly understands their treatment and medication schedule. It's important that they have confidence in their medical team and trust that their pain will be attended to.

Addiction is not simply a case of explaining the treatment plan, because addiction is not about isolated pain. It runs much deeper than that, and any abrupt changes to the medication schedule could result in serious complications. If a patient has developed an addiction, the addiction should be treated in a way that complements the initial treatment for pain or trauma.

Understanding pseudo-addiction can help physicians to take precautions to avoid it, and the same goes for addiction. Medical professionals should assess their patients before administering any medication. This is imperative not just from a physical standpoint, but for identifying if a patient is at a higher risk of developing true addiction. Then, when symptoms for pseudo-addiction or addiction begin to manifest themselves, medical staff can be in a better position to act in the patient's best interest. ✚

Ben Brafman is the clinical director, president and CEO of Destination Hope, a nationally recognized substance abuse and dual diagnosis treatment facility in Fort Lauderdale, FL. With more than two decades of hands-on experience in the field of substance abuse and addiction, Brafman is a leading authority on substance abuse, addiction and treatment protocols.

For more information, visit www.drugrehabfl.net.

Non-profit Wins Environmental Award for its Work with Local Health Care Community

By Rachael Robertson

At the intersection of health care and the environment is Practice Greenhealth—a nonprofit membership organization that is based on responsible health care practices and environmental stewardship. Practice Greenhealth sponsors an annual conference for leaders in health care sustainability called CleanMed.

This year Global Links, a Pittsburgh-based medical relief and environmental organization, was given the "Champion for Change" award for successful greening efforts within the organization for the fifth year in a row.

Global Links, founded in 1989, recovers nearly 300 tons of surplus medical supplies and equipment annually from hospitals throughout the mid-Atlantic region for use in resource-poor communities, primarily in Latin America and the Caribbean. UPMC Passavant is one of the 46 hospitals that partner with Global Links.

"We care about sustainability because it's our responsibility to be good community stewards," says Diane Kolling, Director of Volunteer Services at UPMC Passavant.

Medical surplus results from various circumstances. Marcy Sunday, Clinician Sterile Support at Passavant, says that constantly evolving technology is a contributor. "Doctors try new products and sometimes decide they like the old one better, sometimes the new. The switch of products leads to surplus that we can't use, but Global Links can."

Surplus also comes from how medical equipment is packaged. Monitor Technician and PhD student Whitney Craig explains that "Often supplies come in packs and the medical staff only needs one or two instruments from that pack. Also each patient room is guaranteed certain supplies. However when not everything is used, those unused items become surplus that would ordinarily be thrown away." This surplus equipment can range from a pair of hospital socks to scissors or even unopened gauze.

Hospital staff say they like having an alternative to disposing of materials that are still in perfectly good condition, according to Hayley Brugos, Medical Outreach Manager and Sustainability Officer at Global Links. The fact that Global Links will not only keep those items out of landfills but also send them to where they are needed is gratifying.

"I am proud to be a part of the team that is redirecting usable medical equipment and supplies to underdeveloped countries where they are much-needed," said Paul Phelos, Team Leader of Clinical Engineering at Jefferson Hospital.

Jefferson, a member of the Allegheny

Erin Jones Photography

A volunteer group from American Eagle Outfitters clean and prepare walkers for a project in Haiti.

Health Network, has been a Global Links partner for eight years, donating 12,396 pounds of supplies and equipment to Global Links in the past year alone.

"It's not just 'stuff,'" says Global Links CEO and co-founder Kathleen Hower. "It's part of a process of health improvement. The IV poles, hospital beds, scales, and supplies translate directly into improved health care in the communities where we work. And that of course means better lives, healthier populations, more

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Do You Want to Get Well?

Addiction is a disease where the patient controls the outcomes

By Michael Campbell

In 1956 the American Medical Association declared that alcoholism is a disease.

The definition was enlarged over the years to include drugs and by 1991, when the AMA expanded the classification of alcoholism to both its medical and psychiatric sections; the disease was generally described as "addiction."

However, decades later, the debate over "what is addiction" continues, because it is a disease like no other.

The addicted person sometimes takes comfort in being able to rationalize their poor behavior by explaining that they have a disease.

But few people will fall for this "get out of jail free" justification. It is hard to compassionately embrace the concept of sickness when someone intentionally lies, manipulates and acts in a selfish manner.

The symptoms of addiction do not look like other diseases, which usually have obvious physical signs.

Instead, addiction's trademark qualities are denial, rationalization and minimization.

The addict and alcoholic will also bristle at the disease concept because they want to be "normal."

A chronic, incurable disease declares that they will never be able to live life completely free of their addiction.

Recovery demands that they tend to their disease, constantly working to keep their thoughts and behaviors from leading them back into the patterns of addictive behavior.

Many addicted people resist the thought that they must continually manage their disease, as does the patient with diabetes.

But perhaps the greatest challenge to the understanding of addiction as a disease is that healing demands the patient's willingness and active participation.

If I have an infection, the prescribed antibiotics will address the problem, regardless of my thoughts and wishes.

The surgery to remove an inflamed appendix will provide rapid resolution to what could be a life-threating problem.

The patient cannot prolong appendicitis by their actions.

But addiction is different.

Wellness requires an act of will.

The only way to beat addiction is because you want to.

At St. Joseph Institute our primary criteria for admission is the declaration by the patient that they want to get well.

We ask a number of questions to assess their motivation and the reason for seeking treatment.

Admission is denied if the motivation is all external — perhaps a court mandate or a spouse's edict.

Outcome studies confirm over and over that success is directly related to the internal motivation of the addicted person.

Recovery requires change, and determination to learn how to live and think differently.

This rarely occurs without a strong "inner desire" to break free from drugs and alcohol and embrace a new life.

I remember a young man who came into treatment pleading for help to leave his addiction behind.

Throughout the program he was compliant and followed the rules without objection.

But his counselor detected that it was all a façade.

Something was providing motivation for treatment, and it was not a deep felt desire to live without his drug of choice.

The answer became clear when his father picked him up at discharge in a shiny new truck — his reward for attending rehab.

Not surprisingly, he started taking drugs soon after dropping dad off at home and picking up his former "using friends" in the new ride.

While interventions make for dramatic television, they do not necessarily represent a good beginning for treatment.

The website for the American Psychological Association cites a study claiming that the success rate for the traditional method of "Johnson interventions" is only 23%.

This is not surprising.

Recovery requires much more than surrender to the pressure from family and friends.

It happens when an individual makes a determined effort, driven by an inner drive to change and live life differently.

Should addiction be reclassified as something other than a disease? I think not.

Research confirms the heritability, etiology and pathophysiology that meet the criteria for disease classification.

However, as healthcare providers we must understand that our ability to ensure recovery is limited.

We have few and very imperfect means of treatment that override the desires of the patient (e.g. methadone and Suboxone.)

The healing we seek is ultimately in the hands of the patient.

Only they have the ability to take what we offer in terms of knowledge, techniques, tools and treatment, and apply it in their lives to achieve wellness.

From a medical perspective this is frustrating because we seek outcomes that the patient does not limit or control.

But with addiction, that may never be possible. ✚

Michael Campbell is Co-Founder and President of St. Joseph Institute, a leading rehab facility located near State College, PA.

Send story ideas to Daniel Casciato at writer@danielcasciato.com

Questions Are the New Answers

By Jim Domino

How can the power of positive inquiry affect your life for the better? In its most basic form, inquiry has to do with how you and I think. Some say thinking is nothing more than asking and answering questions. At the least, it is true that the questions we ask ourselves influence our thoughts and our behaviors. One way to understand the power of questions is to look at how they can affect the results we achieve. For example, please examine the following chain of causes and their effects. To change your results, you must first change your behavior. To change your behavior, you need to change the way you think. How does one do such a difficult task? To change how you think, change the questions you ask yourself. In this manner, there is a direct line from the questions you ask to the results you obtain. Quite simply, asking the right questions gives you the opportunity to think more constructively.

First Principles

In this paper, I will discuss how positive inquiry is used to manage change at the individual, group and organizational levels, and I will present two processes that use positive inquiry to help you to manage change more effectively. In regard to the forces at work in the change process, two principles are essential to a proper understanding of how positive inquiry works. The Simultaneity Principle states that "Inquiry is intervention. The moment we ask a question, we begin to create change."[1] The Anticipatory Principle concludes that "Human systems move in the direction of their images of the future. The more positive and hopeful the images of the future are, the more positive the present day action will be."[2] Given the power of questions to drive change and given the fact that human beings move in the direction of their images of the future, what does this indicate about the types of questions we should ask? Is it not obvious? To get positive results, ask positive questions. The energy for effective change is derived from the dynamic ingrained in asking positive questions.

Methodologies

What follows are two methodologies you can use to transform your life and the lives of those around you. The first technique is called Question Thinking. It was originated by Marilee Adams and described in her book *Change Your Questions, Change Your Life*. The second approach, in the paper, will be Appreciative Inquiry. Appreciative Inquiry was developed by Professor David Copperrider of Case Western Reserve University in the early 1980s. For a detailed description of how Appreciative Inquiry works and the outstanding results it produces, I recommend the book *The Power of Appreciative Inquiry* by Diana Whitney and Amanda Trosten-Bloom. Both Question Thinking and Appreciative Inquiry can be used to manage individual or group change. However, it is true that Appreciative Inquiry can more readily be applied to system-wide change at the organizational level.

Question Thinking

Now, let us examine the use of Question Thinking. Question Thinking is about how the questions we ask ourselves and others provide opportunities for new thinking and new direction in our lives. As Ms. Adams describes it, "... real change always begins with a change in thinking — and most specifically in the questions we ask ourselves."[3] Question Thinking postulates that at any given moment, we are faced with a choice. The choice of which mindset we will use: the Learner Mindset or the Judger Mindset. The Judger Mindset is often entered into as a reaction to a negative event. For example, someone receives a poor evaluation on their performance review at work. If that person begins to think about who is to blame, they will immediately assume a Judger Mindset. They may likely ask themselves questions like, "What is wrong with me? Why am I such a failure?"[4] These questions will keep them mired in the quicksand of the Judger Pit. If they want to leave the Judger Pit, they will need to begin asking themselves different questions. They should ask themselves questions like, "What can I learn? What are the facts? What assumptions am I making? What do I want? What is possible?"[5] These questions will lead the person out of the Judger Pit and onto the path of the Learner Mindset. The Learner Mindset is a way of thinking that leads to thoughtful choice and positive solutions.

Ms. Adams' thesis is that the questions we ask ourselves influence our mindset, thinking and behaviors. If we change the questions we ask ourselves, we can change our mindset. Consequently, we can move from a negative thought process to a more positive one.[6] A negative mindset tends to close us down. It removes our awareness of possibilities. It keeps us in a self-reinforcing loop of criticism and regret. A positive focus opens us up to possibilities, and it provides a pathway to potential solutions. The merits of Question Thinking are substantiated by the field of Cognitive Psychology. According to Cognitive Psychologists, our internal dialogue plays a significant role in what we think, what we feel, and how we behave. Here is how you can use Question Thinking to improve your performance at work.

If you need to make an important decision or if you find it difficult to be objective, try using what Ms. Adams' calls the ABCC Choice Process. The technique is stated as follows, "(A)ware: Am I in Judger Mindset? (B)reathe: Do I need to step back, pause and look at this situation more objectively? (C)uriousity: Do I have all the facts? What is happening here? (C)hoose: What is my choice?"[7] This handy tool will help you be less judgmental and more solution focused. In addition to the ABCC Process, you can use these four questions[8] prior to team meetings to create a learning environment:

1." What do I appreciate about them?"

2. "What are the best strengths of each one of them?"

3. "How can I help them collaborate most productively?"

4. "How can we stay on the learner path together?"

As Adams' suggests, these questions "'... invite everyone, including you, to listen more patiently and carefully. With Learner questions we listen in order to understand the other person rather than find out who is right or wrong. That makes it possible for everyone to get curious, feel safe taking risks, and participate fully, even when they're facing tough challenges.'"[9]

Achieving outcomes like these are critical to any organization, department or manager's success. Any manager who gets his/her team to fully participate during challenging circumstances will make significant contributions to the success of his/her company.

Appreciative Inquiry

The second methodology that uses positive inquiry to manage change and that is presented in this paper is Appreciative Inquiry. This approach is based on the inherent energy that is released when questions are focused on the positive. According to Whitney, Trosten-Bloom, "Appreciative Inquiry is the study of what gives life to human systems when they function at their best. This approach to personal change and organization change is based on the assumption that questions and dialogue about strengths, successes, values, hopes and dreams are themselves transformational. In short, Appreciative Inquiry suggests that human organizing and change at its best is a relational process of inquiry, grounded in affirmation and appreciation."[10] You may be thinking, 'That sounds too good to be true?'

Frankly, my first thought when I initially became acquainted with Appreciative Inquiry was exactly that. I thought Appreciative Inquiry seemed too good to be true. I was so steeped in the view that to solve a problem, I needed to analyze it. I did not realize there was another, better way. When organizations face problems of poor customer service, low sales, or internal conflict, they frequently look to consultants for help. All consultants are familiar with techniques and prescriptions for problem solving. The typical consultant will work to "fix" the problem by first thoroughly examining it. Appreciative Inquiry does not seek to "fix" the problem. Instead, it strives to nurture the growth of the positive core whose seed is already present in the organization. Appreciative Inquiry is not prescriptive. It creates a framework in which employees themselves uncover what is best for them. Appreciative Inquiry develops an environment in which employees capacities for courage, confidence, growth and under-

standing are nourished and enhanced. Appreciative Inquiry is about strengthening the system organically, from its core outward. Appreciative Inquiry is unique and in some sense counterintuitive, yet it most certainly is effective. It has a 30 year record of success in the fields of business, healthcare, religion, charitable giving and government.

In the remainder of this paper, I will demonstrate how and why Appreciative Inquiry works. One key reason Appreciative Inquiry works is its use of the activity called Affirmative Topics. The following example illustrates this point. In the late 1990s, British Airways (B.A.) decided to use Appreciative Inquiry to handle a variety of concerns it needed to address. One of these issues was late baggage. The consultants on the project asked the group of B.A. employees to provide more detail about this issue. The Appreciative Inquiry consultants wanted to understand why this was such an important concern for the group. The B.A. employees cited many examples of how late baggage and the problems it entailed for customers caused problems for the company.[11] A particularly troublesome incident occurred when a wedding dress didn't make it in time for the wedding, and the airline had to pay to replace the dress.[12]

The consultants paraphrased the responses they heard. Then, they said, "'Given that organizations move in the direction of what they study, what is it that you want more of at B.A.? In this case, we know you do not want more lost or delayed baggage. But what do you want more of?'"[13] Eventually, the B.A. group determined what they wanted. They decided that they wanted customers to have an "Exceptional Arrival Experience." One of the areas of focus for the project then became how B.A., its employees, and the entire organization would create such an experience for its customers. The old, less effective, technique was to analyze the problem. This leads to the creation of a solution that is grounded in the soil of negativity, focused on what went wrong. The more effective Appreciative Inquiry approach emphasizes what employees want more of, and what is right with the organization. It is upon the base of a strong and positively focused AffirmativeTopic that the entire Appreciative Inquiry project will grow. As Whitney and Trosten-Bloom describe it, when employees begin to understand the impact of selecting an appropriate Affirmative Topic, "Light bulbs go off as they realize that no amount of research or knowledge about turnover will help them create a magnetic work environment where long-term, committed employment is the norm. Nor will an understanding of obstacles to profitability help employees develop business literacy and enhanced margins."[14]

This section began by asking the question, Does Appreciative Inquiry work? My first attempt at answering that question discussed Appreciative Inquiry in general terms. Next, I will share my thoughts on my personal experience with Appreciative Inquiry. My first experience with Appreciative Inquiry occurred in the fall of 2012. At that time, I attended a four day seminar titled "The Appreciative Leadership Development Program" (ALDP). The seminar was conducted by the Corporation for Positive Change. This workshop was designed to evaluate my leadership abilities. It also gave me the opportunity to develop leadership skills in the areas of inquiry, inclusion, illumination, inspiration and integrity.[15]

My Appreciative Inquiry Experience

I had many incredibly uplifting experiences during the four days of the ALDP workshop. However, the activity that stands out the most, above everything else were the Appreciative Interviews. The Appreciative Interviews comprised a day and a half of seminar time, but to me, they seemed to go by in the blink of an eye. First, we paired up into interview teams. Then each person took a turn answering questions like. "What do you love most about your work? Describe a time when you had a highpoint experience as a leader? What do you value most?"[16] As I answered these questions, I felt fantastic. It was wonderful to be able to speak about things that were so valuable to me and emotionally significant. In most of our working lives, we our discouraged from acknowledging our emotions. This leads to behavior that is inauthentic and often devoid of passion, enthusiasm and energy.

Appreciative Inquiry encourages the discussion and expression of your unique identity including your values, feelings, thoughts and behaviors. This process supports everything that makes you unique. During and immediately after the interviews, I had a tremendous feeling of acceptance and a sense of being truly heard and understood. I felt supported, and I was encouraged to move forward with my personal and professional goals. Some of those goals had remained dormant for a long period. During the ALDP workshop, I certainly found being interviewed helpful and inspirational. Yet, my experience as the interviewer was also powerful, perhaps even more so.

To share someone's most intimate thoughts and heartfelt longings was profoundly moving for me. It was an honor to be given such a gift. As the interviewer, my task was to listen to my partner with all the attention I could muster. I focused on my partner as completely as I could. I watched my partner's body language and facial expressions. I listened carefully for my partner's use of language and intonation. With my partner, I tried to be encouraging, supportive and hopeful. I would characterize the interview activity during the ALDP workshop as rewarding, but it went much further than that for me. The experience had a sacred quality to it. This sacredness lifted it into the realm of the spiritual. There is simply no other way to describe it. After experiencing Appreciative Inquiry first hand, I can attest to the fact that it is instrumental in forming solid relationships. Appreciative Inquiry gives you the opportunity to relate to your colleagues at work as people. This is a rare gift in a work world that values titles and highlights one's perceived status.

In addition to creating rich relationships, I also felt many other positive emotions during the ALDP workshop. I felt a great deal of personal reinforcement. I felt charged up and confident in a way I had not experienced before. After the ALDP workshop, I was ready to take on new challenges. I came to realize why having my own consulting business meant so much to me. My business is important to me because it gives me the chance to express the best of what is in me. In answer to the original question, does Appreciative Inquiry work? From my own experience, I can answer that question with an enthusiastic, yes!

To summarize, so far, I have presented a general description of Appreciative Inquiry along with my own personal experiences of it. Now I will examine how Appreciative Inquiry works and the results it produces for organizations. Appreciative Inquiry uses a 4-D Cycle to achieve results. The first D is Discovery. The first activities in the Appreciative Inquiry process involve discovery of what gives life to organizations. This stage also includes the creation of a Change Agenda and Affirmative Topics.

Discovery is a reflection of what is best about the present. The second D is Dream. The Dream stage is a time to imagine bold possibilities for the future. The next D is Design. This stage drives innovation, and It is in this stage that the outlines of the new organization begin to take shape. The final D is Destiny. In this stage, the organization delivers on the Change Agenda.[17] As Whitney and Trosten-Bloom state, "The 4-D cycle can be used to guide a conversation, a large meeting, or a whole-system change effort. It can serve as a framework for personal development or coaching, partnership or alliance building, and large-scale community or organizational development. Whatever the purpose, the Appreciative Inquiry 4-D Cycle serves as the foundation on which change is built."[18]

Appreciative Inquiry Results for Organizations

Yet, a key question remains, what kind of results does Appreciative Inquiry produce for organizations? An example from the book *The Power of Appreciative Inquiry* is an Appreciative Inquiry project begun in 1998 at Hunter Douglas Window Fashions Division (HDWFD). The project was designed to accomplish several critical things[19]:

- "To create a collective vision that could engage and excite the entire organization and its stake-holders."
- "To re-instill the creativity, flexibility, intimacy, and sense of community that had contributed to the division's original success."
- "To enhance the skills of existing leadership and build bench strength by identifying and training future leaders."
- "To transcend the silos that had recently emerged between management and the general workforce, across business

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Unintended Consequences

(From the movie: Place at the Table)

By Nick Jacobs

McKesson announced recently, the results of a major benchmark study that measures the state of healthcare's transition from volume (fee for service) to value (value-based care).

One of the big takeaways is that fee-for-service is rapidly being eclipsed by value-based models. More than two-thirds of payments are expected to be based on value measurement in five years, up from just one third today.

How do we make the adjustment to value based models of care without extreme measures that have, heretofore, never really been on the dashboard of indicators that health systems use to measure their success?

When the British government controlled India, the leadership became concerned about the high number of venomous cobras in Delhi. This resulted in the government's decision to offer a bounty for every dead cobra presented. The citizens of Delhi began to farm cobras, then killed them and turned them in for bounties. When the government figured this out, they stopped paying the bounties. The farmers then turned all of their farmed cobras free, an unintended consequence of government actions.

One thing that is an absolute in this reimbursement transition is that this country in general and health systems in particular had better take a much more serious look at the realities of population health. The United States ranks worst in food security among the participating countries in the IMF (International Monetary Fund): Singapore, Denmark, Switzerland, Sweden, Germany, Hong Kong, Japan, Ireland, Canada, Greece, the United Kingdom, Cyprus, Portugal, Slovenia, Spain, Italy, Israel, Korea and then THE UNITED STATES because one in six Americans don't have enough to eat, 50,000,000 Americans.

Since 1980, the price of fresh fruits and vegetables has gone up by 40% and the price of processed food has dropped by almost exactly the same percentage. For three dollars, the daily allotment for food stamps in this country, a consumer can afford to purchase about 312 calories in fruits and vegetables and 3767 calories in processed foods. Why is this?

In a 2011 list of contributors to lobbyists hired to influence federal campaigns, the top four entities in dollar amounts were Healthcare at $80M, Securities and Investments at 101.6M, the AGRI-Business at 124.7M and, finally, Oil and Gas at $149M. Farm policy in this nation has resulted in 70% of all FDA supplemental dollars being distributed to only 10% of farms, AGRI-business. Welfare to the poor is scorned while subsidies to AGRI-business are embraced.

Twenty four million people in the United States live in food deserts, and 75% of those food deserts are in urban areas.

This trend began during the Reagan administration where large sums were spent on the military and subsidies to the poor were cut significantly. If we look at the number of hungry citizens in this country, we see the following progression: Reagan – 20 million, George H.W. Bush – 30M, Clinton – 33M, George W. Bush – 49M and Obama – 50M. One in every two children in this country will be on food assistance at some time in their life, and our children will be the first generation to live sicker and die younger than their parents 'generation.

We have pitted agriculture subsidies against nutrition. The recent Healthy Hunger Free Kids Act represented a $.06 per meal increase over the next ten years, one half of which was paid for by cutting the food stamp program. In a country where $700B was spent on the Banking Industry bailout, $1.37 trillion was given in tax cuts to the top two percent of our population, and only $4.5B was allocated for child nutrition, the unintended consequences are already destroying our health care system.

With 25,000,000 diabetics and 75,000,000 pre-diabetics in the United States, rampant inflammatory disease, heart disease and cancer, we are already seeing why we also rank so low in world healthcare and mortality rates. If we are to reverse any of these trends, we must begin by changing our food policy. ✚

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.

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To increase awareness of its exams and certifications, the organization created the digital publication, *CertAlert*, and companion digital tool, *CertCentral*, enabling members to manage their certifications online.

As a result of these efforts, NAHAM saw an increase in certification applicants, with more than 800 tests taken during the 2013 quarterly testing windows.

For more information about SmithBucklin, visit http://www.smithbucklin.com/ or call 1-800-539-9740. ✚

David Schmahl is executive vice president and chief executive of Healthcare + Scientific Industry Practice of SmithBucklin, the association management and services company more organizations turn to than any other. Founded in 1949, our mission is to achieve the missions of the client organizations we serve and provide uncompromised stewardship for their long-term prosperity.

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Rycon Construction Inc., general contractor for the project, proved to be a valuable partner in the execution of the building. Rycon project manager Brandon McKee brought an appreciation for working with the design team and the client to the project. Rycon understood the need to look ahead and "around corners" to anticipate coordination issues before they arose. For a healthcare client with multiple user-group stakeholders in the project, the actual built product is often a moving target. Rycon was able to adjust to revisions and user-group final decisions without no delays in the project schedule.

As an outpatient facility the Owner would typically not have a cadre of on-site facility staff. It was important that building systems such as HVAC and lighting be "smart" systems that report back to the Owner at the main facility. Controls for these systems were carefully selected and vetted with Rycon facilitating this process. They did not want to overpay for underperforming controls. Aramark served as commissioning agent on the project for building systems as well as the building envelope.

Delivering Satisfaction

Total change orders for this project were about 3% of the total construction cost. Over 95% of the post bidding changes resulted from owner initiated requests used to adjust the construction to new program requirements that user groups brought forward after design was complete.

IKM set a bold direction for the design of the building, but it was the strong level of teamwork among the client, the general contractor and the design team that enabled the design vision and the price point to be delivered in a way that more than met the client's expectations. Children's Hospital of Pittsburgh is pleased with product it received and South Fayette now has a strongly identifiable work of architecture that the public can readily connect with the services offered there. ✚

Bob Bailey is Specifications and Constructability Specialist for IKM Incorporated. Bob has been a full-time specifier for 25+ years with experience in higher education, healthcare, corporate, parking structures, K-12 education, laboratories, student housing, recreation centers, and historic restoration/ adaptive reuse. His project experience includes a number of LEED-certified projects including several LEED Gold projects. He is the founder of Pittsburgh Specifiers' Roundtable, a past president of CSI Pittsburgh, and a winner of CSI Pittsburgh's Roswell S. Johnson Memorial Award for specifications writing. His responsibilities at IKM extend to improving the firm's continuing education effort and intern development program.

units, and between operations and support functions." [20]

Here are the results that this five year project produced from "... 1998 to 2003, HDWFD experienced significant gains in sales, profitability, and efficiency: sales up 30%, profitability up 37%, employee turnover down 52%, returned goods down 55%."[21] As these statistics clearly demonstrate,

Appreciative Inquiry also creates results at the system-wide, organizational level. As previously mentioned, I can attest to the fact that Appreciative Inquiry works on a personal and small group level. Yet, one final question needs to be answered. Why does Appreciative Inquiry work? Whitney and Trosten-Bloom attempted to answer this question through a series of client interviews. The most notable and significant interviews occurred with the employees of HDWFD. Through these interviews, they discovered that Appreciative Inquiry works by liberating personal and organizational power. They call the six conditions of liberation the Six Freedoms.[22]

The first freedom is the Freedom to be Known in Relationship. Appreciative Inquiry gives people the chance to be known outside of their role at work. It also creates a context in which relationships can grow. Often, these relationships are built across organizational boundaries.[23] The second freedom is the Freedom to be Heard. Appreciative Inquiry supports listening with compassion and curiosity. The listener strives to understand the speaker at a deeper emotional level that goes far beyond the mere understanding of the words themselves. Through deep understanding and cooperation, meaning is created. Eventually, positive stories begin to spread throughout the organization, and people who are normally marginalized are given a voice. [24]

The third freedom is the Freedom to Dream in Community. In this freedom attention is paid to the visionary. There is a focus on the future, not the past, and individual dreams become known by the entire organization.[25] The fourth freedom is the Freedom to Choose to Contribute. This aspect of Appreciative Inquiry enhances one's capacity to contribute and learn. Because people join Appreciative Inquiry activities on their own initiative, they have a greater commitment to accomplish their goals.[26] The fifth freedom is the Freedom to Act with Support. With Appreciative Inquiry, whole-system support promotes the acceptance of challenges, and it prompts cooperation. Because people are called upon to act on things they find inspirational, they will act in service to the organization.[27] The sixth and final freedom is the Freedom to be Positive. In today's corporate world, being positive is not the norm. Appreciative Inquiry provides a bold invitation to be positive and to be proud of the work that one does.[28] In the Appreciative Inquiry process, the Six Freedoms combine to produce a powerful, self-perpetuating force for good in organizations and the world at large.

Conclusion

The energy and force behind positive inquiry comes from two principles. The Simultaneity Principle and the Anticipatory Principle. The Simultaneity Principle states that questioning is intervention. The Anticipatory Principle states that human beings move in the direction of their images of the future. Like the plant that grows in the direction of the sun, human beings move toward what they imagine the future will be. In this paper two methodologies, Question Thinking and Appreciative Inquiry were presented.

These techniques use the force of positive inquiry to effectively manage change. These processes were described in the hope that they might be helpful strategies you could use to effectively manage change at the individual, group and organizational levels. As we saw, the questions we ask matter. The questions we ask ourselves, the questions we ask others, and the questions we ask in organizations, make a difference. One concept is quite clear, if you want to change your behavior, change the questions you ask yourself, and pay attention to the types of questions you ask. Because the more positive the initial question is, the more positive the future result will likely be. ✚

Jim Domino is a change management consultant who specializes in working with healthcare organizations. He helps organizations increase their performance through the acceleration of positive change. His web site is phaseivinc.com.

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Honoring the Doctors Who Make VA Team A Success

VA Pittsburgh Healthcare System honored two of its doctors — Brian Williams and Asif Khalid — as outstanding physicians of the year during Doctors' Day observations at University Drive on March 28.

In his remarks, Dr. Ali Sonel, VA Pittsburgh Healthcare System chief of staff, noted that VA's emphasis on Veteran-centered, team-based, evidence-based care enables physicians to make decisions based on what is best for the patient. Sonel used the opportunity to gather System physicians to highlight successes over the past year, including key accomplishments, awards, and physician projects.

Williams was recognized for work that has significantly improved post-surgery outcomes for Veterans, said Sonel. Williams directs ambulatory anesthesia, regional anesthesia and acute pain medicine services as well as Interdisciplinary Medical Perioperative Assessment Consultation and Treatment clinic at VAPHS. Williams's nomination highlighted his commitment to improving care for Veterans, evident through his dedication to patient and family education, as well as to training and developing close working relationships with anesthesiologists, physicians, nurses, and physical therapists.

Williams has also received rave reviews from residents who learn valuable skills and lessons from him and benefit from his "helpful, calm, and empowering demeanor."

Khalid was recognized for his exceptional

Dr. Ali Sonel, chief of staff; Dr. Asif Khalid, recipient of Outstanding Physician of the Year award; Dr. Frederick DeRubertis, vice-president of medicine service and Dr. Khalid's nominator, and Director Terry Gerigk Wolf

clinical skills, said Sonel. Khalid is chief of gastroenterology and hepatology. He is widely recognized as an expert endoscopist, who takes on the most difficult cases and champions endoscopy instead of rectal blood samples as a screening tool for colorectal cancer, said his nominator, Dr. Frederick DeRubertis, vice president of medicine service.

Khalid is also recognized for being an exceptional mentor and teacher. Students and colleagues especially note his patience and skill in leading by example, DeRubertis said.

Sonel also presented the inaugural Chief of Staff's Clinical Excellence award to Dr. John Gurklis. Gurklis, recognized for behavioral health care improvements, will keep the award for a month before selecting a colleague as the next recipient of the trophy. Gurklis's nomination highlighted his efforts to make the best use of inpatient psychiatry beds and eliminate the need to refer Veterans to community facilities. He also strives to improve therapy groups on inpatient units.

Sonel concluded the event by stating: "We appreciate the work of all of our physicians."

Doctors' Day observances date back to 1933, starting with Eudora Brown Almond, the wife of a Georgia physician. Almond chose the date to commemorate the anniversary of the first use of general anesthesia in surgery in 1842. The first National Doctors' Day was celebrated in 1991.

VA Pittsburgh Healthcare System employs more than 150 full-time doctors, in addition to more than 80 part-time as well as contracted physicians and hundreds of rotating medical residents and students each year. ✚

Editor's note: This article also appears on the VA Pittsburgh Healthcare System's website at www.pittsburgh.va.gov.

IMPACT Clinic Improving Surgical Results

VA Pittsburgh Healthcare System recently implemented VA's Interdisciplinary Medical Perioperative Assessment Consultation and Treatment (IMPACT) clinic model. IMPACT provides a comprehensive medical assessment for Veterans scheduled for surgery. The clinic goes beyond the normal cardiopulmonary preparation and looks at the following aspects of Veteran health:

- baseline cardiopulmonary disease
- obstructive sleep apnea
- risks for surgical site infection
- chronic conditions
- substance use issues
- psychosocial concerns

The goal of the clinic is to ensure that Veterans are as well-prepared as possible before surgery and has been shown to improve outcomes following surgery.

The IMPACT clinic was identified as a best practice during a recent survey by The Joint Commission.

Serving Children with Medical Complexity

The Children's Institute of Pittsburgh's Care Coordination Program for Children with Medical Complexity will launch this June. The Care Coordination Program is a new service in which a team of health care professionals from The Children's Institute works with families to ensure that their children with medical complexity receive the services they need, when they need them.

Outcomes are expected to include better health, better healthcare, and lower healthcare costs.

Care Coordination will be available to Western Pennsylvania children and young people with medical complexity, which may include — acquired brain injury, congenital heart disease, cancer, spinal cord injury or multiple major diagnoses.

Children with medical complexity often have multiple physician specialty visits, therapies and other providers visits in a given year. The coordination of their services can be extremely challenging for families.

For more information about this new program, please call 412.420.2599. ✚

LECOM Institute for Successful Aging Invests in Patient Care Through Revolutionary Device

The LECOM Institute for Successful Aging, a regional leader in the care of older adults, has begun using a revolutionary new technology in the rehabilitation of its patients.

The Institute's Inpatient Rehabilitation Unit (IRU) has been using the AlterG Bionic Leg™, the world's first wearable, robotic mobility assistance device activated by the patient's intent to move. It gives patients with impaired or diminished mobility resulting from illness or injury the support and confidence they need to take the proverbial next step.

"We're excited to be the first local health care provider to partner with AlterG and to treat our patients with the leading mobility assistance product," said Danielle Hansen, D.O., Associate Director of the LECOM Institute for Successful Aging and Vice President of Acute Care Services and Quality/Performance Improvement at Millcreek Community Hospital. "It will be an important complement to our existing programs and treatment options."

A 37-year-old man who suffered his second stroke and has considerable weakness in his left side is the first patient to be treated at the IRU with the AlterG device. With the help of the device and the IRU staff, he is making considerable progress in learning to walk again.

"Wearing the device on his left leg, the patient has been able to walk progressively further with each session," said Shelly Mayes, Director of Therapy for the IRU. "He's also walking better, in terms of his balance and being able to walk in more of a straight line. The goal is to help him along gradually so that he'll be able to walk without the assistance provided by the device."

The AlterG Bionic Leg helps patients rebuild their neuromuscular pathways and improves active motor learning by providing functional strength and dynamic stability; the leg facilitates increased neuroplasticity (changes in neural pathways and synapses

Patrick Beason, a physical therapy assistant with the LECOM Institute for Successful Aging's Inpatient Rehabilitation Unit, helps a stroke victim learn to walk again with the AlterG Bionic Leg.

due to changes in behavior, environment and neural processes), thereby helping patients improve stance and gait. The device is ideal for orthopedic physical therapy patients and those recovering from nervous-system related injuries. Potential patients include stroke victims and individuals suffering from Parkinson's, Multiple Sclerosis (MS) or other degenerative diseases.

The AlterG device was designed to be lightweight while also providing the assistance needed to more actively participate in sit-to-stand, overground walking and stair-climbing exercises that are critical to the recovery of gait and balance. When the patient begins to stand or ascend a stair, the software's sensors detect the weight shift and the knee angle changes; the device then applies assistive force in leg extension to help lift the patient. When the patient sits or goes down stairs, the device offers resistance so as to facilitate a smooth, controlled descent.

As the patient is walking, the device allows the leg to move freely during the swing phase while providing added support during the stance phase. The sensitivity of the sensors can be adjusted depending on the specific needs of the patient and as the therapist deems appropriate.

Introduced by AlterG in the summer of 2013, the Bionic Leg can help stroke patients nearly double their effective balance and triple their walking speed in as few as eight rehab sessions.

Treatment with the AlterG Bionic Leg is offered at more than 125 hospitals, physical therapy facilities and skilled nursing facilities worldwide.

The device received the ninth annual Invention and Entrepreneurship Award in Robotics and Automation (IERA) during the 2013 International Conference on Robotics and Automation in Karlsruhe, Germany.

The LECOM Institute for Successful Aging offers primary care and consultative clinical services in geriatric medicine, including memory assessment, geriatric assessment, balance disorders and falls prevention, mental health, and osteoporosis and geriatric fracture prevention. Its specialists work with primary care physicians, patients and families so as to encourage independence and shared decision-making in outlining an appropriate plan of care.

The Institute for Successful Aging and Millcreek Community Hospital were the first local health care organizations to be accorded NICHE (Nurses Improving Care for Healthsystem Elders) certification. The national certification was given in recognition of their commitment to providing the highest levels of patient-centered care for older adults. ✚

Duquesne's School of Nursing Wins $50,000 Grant for Minority Students

For the fifth time in seven years, the Robert Wood Johnson Foundation has awarded the Duquesne University School of Nursing a grant to help students from underrepresented groups and disadvantaged backgrounds enter the field of nursing.

The $50,000 grant is administered through the foundation's New Careers in Nursing program (NCIN), an initiative established to address the national nursing shortage by diversifying the nursing profession.

The School of Nursing received the block grant for the 2014-2015 academic year.

It will be awarded equally to five incoming students in the accelerated Second Degree BSN program, a one-year course of study for students who have already earned a degree in another field of study but wish to earn a bachelor's in nursing.

Only nursing schools that offer accelerated nursing degree programs are eligible for the funding, and schools that earn NCIN grants also provide additional mentoring and leadership development to the students receiving the scholarships.

This is the final year that NCIN funding will be available. Since 2008, the first year that NCIN funds were available, the foundation has provided $400,000 to Duquesne's School of Nursing.

That funding has helped pay tuition for 40 eligible Second Degree BSN students at Duquesne.

The Robert Wood Johnson Foundation is the nation's largest philanthropy devoted to public health.

For more information, visit www.duq.edu. ✚

Penn State World Campus to Offer First Doctoral Degree in Nursing Practice

The nursing profession, with more than 3 million members, is the largest segment of the U.S. health care workforce.

As the health care system becomes more complex, these professionals will need advanced education and training, according to the Institute of Medicine, which recommends doubling the number of nurses with a doctoral degree by 2020.

Penn State's College of Nursing aims to help with an online doctoral degree, the doctor of nursing practice (D.N.P.), delivered by Penn State World Campus, starting this fall.

The doctor of nursing practice program is the first doctoral degree to be offered through World Campus.

The program is designed to prepare nurses for the highest level of clinical nursing practice.

Nurses have two entry options. Those who have a bachelor's degree in nursing can enter the B.S. to D.N.P. path, which includes 61 credits and a minimum of 1,000 hours of clinical practicum.

Nurses who have a master's degree in nursing can take the M.S.N. to D.N.P. path, which includes 38 to 46 credits and allows candidates to apply up to 550 clinical hours from their master's program toward the clinical practicum requirement.

Doctoral candidates will participate in three in-person intensive sessions at Penn State's University Park campus or Penn State Hershey Medical Center.

They also will identify an evidence-based practice project and do a public oral presentation on their project.

Applications are now being accepted for the doctor of nursing practice degree.

For information, visit www.worldcampus.psu.edu/degrees-and-certificates/doctor-nursing-practice. ✚

Send story ideas to Daniel Casciato at writer@danielcasciato.com

Duquesne Health & Wellness Center for Older Adults Earns Prestigious Award


Dr. Lenore K. Resick

A team of retired nurses, led by a Duquesne University School of Nursing clinical professor and endowed chair holder, has received the Public Service Team Award of the Jefferson Awards, becoming regional winners in the equivalent of the Nobel Prize for volunteerism.

Dr. Lenore K. Resick, executive director of the School of Nursing Community-Based Health & Wellness Center for Older Adults, and a cadre of dedicated volunteer nurses were recognized as regional winners in the Jefferson Awards, presented by the Pittsburgh Post-Gazette.

Resick, who also holds the Noble J. Dick Endowed Chair in Community Outreach at Duquesne University, initially saw an opportunity to offer convenient nursing care to seniors who might be at ease in friendly, confidential, one-on-one situations that would allow them to fully understand their health conditions and consequences without traveling to a doctor's office — and to routinely keep tabs on their status.

For eight years, Resick and the Retired Nurses Working in Neighborhoods (RN+WIN), have been providing residents at urban senior centers around the city with personalized health assessments, blood pressure screenings, tips on managing chronic diseases and clear explanations about medications and blood work.

The volunteer nurses provide care to approximately 750 older adults during more than 2,000 nursing center visits in 10 Pittsburgh neighborhoods each year, according to Resick.

"As nurses, our lives are dedicated to caring for other people — and, through this program, you can see that the caring doesn't stop with nurses in retirement," said Resick. "We're very proud of the work our volunteers do to contribute to better health outcomes in our own community, and we're extremely pleased that others have recognized their dedication, commitment and impact."

For more information, visit www.duq.edu. ✚

New Online BSN Offers RNs 8-Week Terms, Specialty Areas

Applications are now being accepted for the Duquesne University School of Nursing's new online program that will enable registered nurses (RNs) to earn a Bachelor of Science in Nursing (BSN) degree.

Classes for the RN-BSN Program start in the fall of 2014, and students may complete the program on a full-time or part-time basis.

A recent report from the Institute of Medicine recommends that 80 percent of the country's nurses should have a baccalaureate degree by the year 2020.

Research shows that RNs prepared at the baccalaureate-degree level and higher are linked to lower mortality rates, fewer medication errors and overall positive outcomes.

Studies indicate that nearly 40 percent of U.S. nurses in the workforce hold either a hospital diploma or associate's degree in nursing.

Duquesne's RN-BSN degree, which requires 126 credits, offers every course online and can be completed in eight-week terms, allowing students to easily take six credits per semester. Specialty areas include ethics, quality and safety, forensics, veterans health, global health and human rights, and professional development.

All non-nursing courses will be offered in the program through Duquesne University's School of Leadership and Professional Advancement. Students may take any of the required non-nursing courses at Duquesne or at another pre-approved university. RN-BSN students will receive 60 transfer credits for their prior lower-division nursing courses, and other college credits can be transferred as well.

For more information, call 412.396.6550 or visit www.duq.edu/rn-bsn. ✚

Quality Metrics Reassure Families

Parents of a child with a disability or injury are confronted with unexpected and unsettling questions. Is the care my child will receive the very best? How long will she have to stay in the hospital? Will she be able dress herself and walk again? What will happen when she can finally come home?

The Children's Institute of Pittsburgh is using technology to answer these questions and provide families with peace of mind. Digital screens mounted in the lobby and cafeteria prominently display quality metrics including outcome statistics, average length of stay, satisfaction rates, and more.

Digital messaging is one way The Children's Institute is transparent about the quality of its care.

"It gives patients and their families a nice snapshot of our program outcomes and also gives them an idea of what to expect," said Staci Gratton, Quality Coordinator. "It reassures them that we have a lot of experience."

The Children's Institute's statistics are definitely reassuring. Across all categories of inpatient care, 94 percent of patients and their families rated their care "excellent" or "good" in 2013.

For outpatient care, that number was 100 percent. In 2013 the average inpatient stay was only 33 days, and over 96 percent of traumatic brain injury patients returned home after care; in some facilities, more patients are unable to return home and instead go, for example, to a long-term care facility.

This commitment to excellence has earned The Children's Institute accreditation from the respected Commission on the Accreditation of Rehabilitation Facilities (CARF), and set it apart from all other facilities as the only freestanding pediatric specialty rehabilitation hospital in Pennsylvania with this distinction.

Stacey Vaccaro, Chief Operating Officer of The Children's Institute, said the digitally-displayed data gives families realistic expectations as they begin rehabilitation.

At admission, a child is evaluated on how well he or she is able to get dressed, walk and complete other tasks. This incoming WeeFIM score – a measure of functional independence — is compared with the score at discharge and one month later through a follow-up call to the family.

The average WeeFIM score for patients at The Children's Institute jumps significantly from admission to discharge.

This is important since the objective is always to return the child home as soon as possible.

"The sooner we can get them into a home environment, the better a patient is likely to do," Vaccaro said.

Cathy Mangino credits the family-focused therapy and caring staff with the dramatic recovery of her son, Francis. At age 17, he suffered a traumatic brain injury during a 2011 car accident.

"When he got there, he couldn't do anything except lie there," she said. "The staff taught him how to do everything, from lifting his arm to being able to communicate with us to walk and shower himself."

After six months of inpatient care, Francis returned to his Finleyville home in February of 2012 — but not before the Mangino family learned how to care for him.

"They taught us how to put him in the car, how to give him his feeding and medication."

The outgoing 19-year-old continues to improve with outpatient therapy and by attending The Day School. "The Children's Institute is wonderful," Mangino said. ✚

Community College of Allegheny County

CCAC honored **Renee Thompson** with its first, "Outstanding CCAC Nursing Alumna for Excellence in Leadership Award." The award was presented to Thompson on May 10th prior to its pinning ceremony for graduating nurses. ✚

Dean, Kathy Mayle (left) and Renee Thompson (right)

Excela Health

Excela Health Orthopedics and Sports Medicine welcomed foot and ankle specialist **Ryan Flanigan, MD**, to its practice this spring.

Dr. Flanigan received his medical degree at the University of Rochester School of Medicine and Dentistry and completed his orthopedic residency at the University of Rochester Medical Center.

He completed his foot and ankle fellowship at Mount Sinai Medical Center of New York City. This University of Notre Dame alumnus has provided physician coverage to several sports teams, including the American Hockey League's Rochester Americans, Monroe Community College Men's Hockey, and various New York high school football teams. ✚

Ryan Flanigan

Cowden Associates, Inc.

Pittsburgh-based Cowden Associates, Inc., an independent actuarial, compensation and employee benefits consulting firm, hired **Michael Crawford**, as Senior Consultant in their Health and Benefits practice.

He brings 15 years of experience in the health and employee benefits consulting arena and group health underwriting industry. Crawford earned a Bachelor of Science degree from Allegheny College majoring in mathematics.

He holds a Pennsylvania Life, Accident and Health License, and is currently pursuing the Certified Employee Benefits Specialist (CEBS) designation from the International Foundation of Employee Benefit Plans.

Additionally, Mike has passed several exams through the Society of Actuaries. ✚

Lake Erie College of Osteopathic Medicine

Four faculty members at the Lake Erie College of Osteopathic Medicine (LECOM) received awards at the annual conference of the American Association of Colleges of Osteopathic Medicine (AACOM), held in Washington, D.C.

Christopher Keller, Ph.D., Associate Professor and Director of Microbiology/ Immunology; **Kim Moscatello, Ph.D.,** Professor of Microbiology and Immunology and Director of the Directed Study Pathway; **Jonathan Kalmey, Ph.D.,** Assistant Dean of Preclinical Education and Professor of Anatomy; and **Randy Kulesza, Ph.D.,** Assistant Dean of the Post Baccalaureate and Master's in Biomedical Science programs and Associate Professor of Anatomy, were chosen for Innovation in Medical Education Awards by the Society of Osteopathic Medical Educators.

The awards recognize "specific educational innovations that have resulted in meaningful change."

Dr. Keller and Dr. Moscatello were recognized for "Tools in the Toolbox: Interactive Board Review Electronic Media for Microbiology and Immunology," a set of resources they developed for students preparing for the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA).

Dr. Kalmey and Dr. Kulesza were recognized for "Gross Anatomy Forums: Synthesizing, Assimilating, and Applying Clinical Anatomy," interactive sessions they designed to help first-year students in Human Clinical Gross Anatomy apply course content to clinical medicine. ✚

Christopher Keller

Kim Moscatello

Jonathan Kalmey

Randy Kulesza

Mount Nittany Physician Group

Mount Nittany Health announced the addition of **Erin Gabany, CRNP,** to Mount Nittany Physician Group Urology. Gabany obtained a Bachelor of Science in Nursing from The Pennsylvania State University, and a Master of Science in Nursing from the University of Cincinnati. She is a member of the Pennsylvania Coalition of Nurse Practitioners, the American Academy of Nurse Practitioners and has a dual chapter membership in the Sigma Theta Tau International Honor Society of Nursing. ✚

Shriners Hospitals for Children

Mary Jane Antoon

Mary Jane Antoon, MSN, RN, NEA-BC, FACHE, Director of Operations for Shriners Hospitals for Children—Erie Ambulatory Surgery Center and Outpatient Specialty Care Center, has been named the new administrative leader of the facility effective June 1.

Antoon came to Shriners Hospitals for Children–Erie in 2002 as the Director of Patient Care Services.

She was named Director of Operations at Shriners Hospitals–Erie facility in 2013, the title she will maintain as Erie's new leader.

A Fellow and Board Certified Healthcare Executive in the American College of Healthcare Executives, Antoon received her BSN degree, Magna Cum Laude, from Villa Maria College and her MSN degree in nursing administration, with distinction, from Villa Maria College of Gannon University.

She is also Board Certified as a Nurse Executive, Advanced by the American Nurses Credentialing Center.

Prior to joining the Shriners Hospitals–Erie staff, she held several nursing leadership positions at Hamot Medical Center, including serving as Nurse Manager of the Surgical Intensive Care, Heart and Medical Cardiac Intensive Care units.

Her professional memberships include the American College of Healthcare Executives, American Organization of Nurse Executives and Sigma Theta Tau.

Antoon currently serves as the treasurer of the Board of Directors for the Bradley H. Foulk Children's Advocacy Center of Erie County. ✚

UPMC Altoona

Jamie A. Baser

Jamie A. Baser was recently hired as a marketing and communications specialist at UPMC Altoona.

She is responsible for writing, editing and designing internal publications and serves as the contact person for website and intranet maintenance and enhancement.

Jamie holds a bachelor's degree in Public Relations from Penn State and resides in Hollidaysburg. She previously worked as Hollidaysburg Main Street Manager for the Hollidaysburg Community Partnership and the Borough of Hollidaysburg.

Kathleen Sweeney

Kathleen Sweeney, D.O., a UPMC Altoona physician, was honored with the 2014 Affiliated Teacher of the Year award by the Philadelphia College of Osteopathic Medicine (PCOM).

Dr. Sweeney is associate director of Altoona Family Physicians (AFP) and the AFP director of osteopathic medical education.

She has been teaching PCOM students for 24 years. AFP is part of UPMC Altoona.

UPMC Altoona

Deborah Steinbugl

Deborah Steinbugl, assistant in the Medical Records Department, retired from UPMC Altoona this spring with 26 years of service.

Steinbugl began her career in the Medical Records Transcription Department in 1988.

Deborah also intends to spend time volunteering in her retirement.

She is an active member of St. Mary's Catholic Church.

Lindon T. Kwock

Lindon T. Kwock, M.D., has joined the UPMC Altoona medical staff in the Department of Radiology.

Dr. Kwock is board-certified by the American Board of Radiology.

He received his medical degree from Tulane University, New Orleans; did his internship training at University of California, San Francisco, and his residency training at University of Illinois, Chicago.

Dr. Kwock completed an MRI fellowship with emphasis on musculoskeletal radiology at Proscan International in Cincinnati. ✚

West Penn Hospital

West Penn Hospital welcomed neurological surgeon, **Richard M. Spiro, MD,** physician with the Pennsylvania Brain and Spine Institute.

Dr. Spiro specializes in general neurological surgery, spinal surgery, reconstruction and the minimally invasive treatment of spinal disorders.

He has particular interest in treating spinal abnormalities, degenerative disc disease, spinal stenosis, carpal tunnel and spinal tumors.

He attended the U.S. Coast Guard Academy and Johns Hopkins University where he received his undergraduate degrees in Biomedical and Material Science Engineering.

He received his medical degree at the University of South Alabama College of Medicine and performed his neurosurgery residency and spinal surgery fellowship at the University of Pittsburgh Medical Center.

Dr. Spiro is certified by the American Board of Neurological Surgery. ✚

ACCOUNTING/CPA

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KFMR is a full service accounting and business consulting firm headquartered in Pittsburgh, PA. Services we provide to the healthcare industry include: accounting and tax services; compensation structuring and fair market value analysis; outsourcing financial strategies (on-premise laundry); physician and healthcare entity valuations; and merger & acquisitions advisory services.

For more information on how KFMR can help your business, please visitwww.kfmr.com/healthcare or call 412.471.0200 — David J. Pieton, CPA, ASA | John R. McMurtry, CPA.

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THE CHILDREN'S HOME OF PITTSBURGH & LEMIEUX FAMILY CENTER

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 21, and a 16-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.

Facebook: http://www.facebook.com/ChildrensHomePgh

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eKidzCare is a pediatric focused home health agency providing high quality health care options to children with medically complex health care needs. Our mission is to establish ourselves and be recognized as a leading force in providing medical home care to children with special needs. Using our experience and dedication to the pediatric healthcare industry, we will take every opportunity to make the lives of our children and families more comfortable, enjoyable, and fulfilled.

eKidzCare provides a full spectrum of home health services including extended hour shift care, skilled nursing visits, well baby visits, injection and diabetic teachings, and assistance at school as well as on school field trips. The children we commonly care for are medically fragile, frequently requiring feeding tubes, tracheostomy tubes and ventilators. Some common diagnosis include cerebral palsy, seizure disorders, cancer, autism and multiple congenital anomalies.

At eKidzCare, we know that finding a compassionate, dedicated and qualified care professional can be a difficult process. We also recognize when a match is made between a caregiver and a family, magic can happen. Each member of the eKidzCare team supports and upholds our core values to provide care with compassion, integrity, and trustworthiness.

www.ekidzcare.com

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ASSISTED LIVING

ASBURY HEIGHTS

Asbury HEIGHTS

The quality of care at Asbury Heights is exemplified by our five-star rating from the Centers for Medicare & Medicaid Services, and we are proud of our more than 100-year history of meeting the living, social and health needs of older adults.

In addition to achieving a coveted five-star rating, Asbury's readmission rate is far below the industry standard and is, on average, less than 2% thanks in large part to the commitment and dedication of our staff to identify and report problems that could result in a medical issue.

The needs of older adults often change over time. Asbury Heights is a CCRC that provides independent living, personal care, nursing and rehabilitation, and memory support care. Individuals living at Asbury have access to our expert staff and a continuum of care without having to leave the Asbury campus. Our team of board-certified, fellowship-trained geriatricians provides outstanding medical care in a comfortable and convenient setting.

Through our Living Well at Asbury initiative and our resident-centered care, we help individuals live life at their best. Improvements in physical and emotional health have come about from years of research. People are living longer and living better as a result. Living Well at Asbury is built on evidence-based care – combining knowledge gained from research already conducted with a closer look at the specific needs of each of our residents.

Our Mt. Lebanon location provides convenient access to our campus from around the region. At Asbury, the social wellbeing of our residents is as important as their physical wellbeing. Social opportunities are plentiful – from relaxing in our library to attending a musical performance in our large social room or participating in activities like cooking, baking, bridge, arts and crafts, bingo, parties and shopping excursions. Our well-equipped fitness center provides the perfect combination of physical exercise and convenience with trained staff to offer assistance and guidance on any piece of equipment and to lead classes for many fitness levels.

For more information, contact us at 412-341-1030, or visit our web site at www.asbury-heights.org.

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Presbyterian SeniorCare Positively Living

PRESBYTERIAN SENIORCARE

Presbyterian SeniorCare is a not-for-profit that's been focused on just one thing for more than 85 years — helping older adults live positively. What drives us is our mission, and a commitment to excellence.

Our goal is to make sure that older adults age with grace and dignity. As the region's largest eldercare provider, we do this by providing a continuum of services and living options, and by investing significantly in our people. We believe that people are what make the difference between good and great. Everyday lives are being enriched and changed positively by our compassionate and well-trained staff and volunteers — people whose dedication to excellence is consistent with our faith-based mission of improving the lives of older adults from all walks of life.

Today Presbyterian SeniorCare is privileged to serve more than 6,500 older adults through our continuum of 56 communities at 44 locations across 10 Western Pennsylvania counties. Our care and service options include: personal care and skilled nursing communities, specialized Alzheimer's and dementia care, over 35 affordable and supportive housing communities, our premier continuing care retirement community Longwood at Oakmont, as well as in-home and community-based programs.

In 2006, Presbyterian SeniorCare became the first Aging Services Network in Pennsylvania, and the third and largest in the nation to receive accreditation from Commission on Accreditation of Rehabilitation Facilities-Continuing Care Accreditation Commission (CARF-CCAC). CARF-CCAC reissued that accreditation for a five-year term through 2016, representing the highest level commendation that can be awarded to an eldercare provider. Additionally, we also have been awarded the CARF-CCAC accreditation through 2016 as "Person-Centered Long-Term Care Communities" for our nursing communities, recognizing our superior performance in fostering an environment of autonomy, choice and flexibility for our residents.

For more information about Presbyterian SeniorCare, 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.

WESTMORELAND MANOR

Westmoreland Manor with its 150 year tradition of compassionate care, provides skilled nursing and rehabilitation services under the jurisdiction of the Westmoreland County Board of Commissioners. A dynamic program of short term rehabilitation services strives to return the person to their home while an emphasis on restorative nursing assures that each person attains their highest level of functioning while receiving long term nursing care. Westmoreland Manor is Medicare and Medicaid certified and participates in most other private insurance plans and HMO's. We also accept private pay. Eagle Tree Apartments are also offered on the Westmoreland Manor campus. These efficiency apartments offer independent living in a protective environment.

Carla M. Kish, Director of Admissions

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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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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 800-447-2030. Fax 412 436-2215
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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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Solutions for Independence offers several services

SOLUTIONS FOR INDEPENDENCE
Providing Life Care Consulting and Planning for the Aging and Disabled

to seniors and their families. These services include but are not limited to assistance, with health care decisions, physician appointments, medication management & acting as a liaison between clients, their families and their physicians.We also provide assistance with long-term-care decisions including housing, assisted living/nursing home options, insurance and government benefits programs. We can also act as power of attorney or legal representative.
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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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Webinar: "The ISO Revolution is Here"
August 7, 12pm EST
Register at http://www.creative-healthcare.com/Event-Calendar

The Changing Healthcare Environment: What Every Nurse Needs to Know
August 9
Sewall Center
Robert Morris University Campus
Register at www.rtconnections.com

Healthy Brain, Healthy Memory with Dr. Linda Sasser
August 12, 11am
Longwood at Oakmont, Commons Ballroom
500 Route 909, Verona, PA 15147
RSVP by calling 877-214-8410 or visit
www.longwoodatoakmont.com/brain

Oncology Symposium (CME credits)
August 28
Monongahela Valley Hospital's
Anthony M. Lombardi Education Conference Center
1163 Country Club Road, Monongahela, PA
Call 724-258-1750

Webinar: "The Missing Link in Improvement Capability"
September 4
12pm Eastern
Register at http://www.creative-healthcare.com/Event-Calendar

PBGH Symposium: Punt or Pass — How to Score in Today's Health Care Game
Sept. 4
Pittsburgh Marriott City Center
To register, visit http://www.pbghpa.com/

Family Hospice and Palliative Care Memorial Walk
Saturday, September 6
North Shore Riverfront Park (near Jerome Bettis' Grille 36).
More information and registration available at
FamilyHospicePA.org

2013 HPNA 7th Annual Clinical Practice Forum
October 3-5
Register at www.HPNA.org (for discount use promo code MAILE)

22nd Annual Mercy Parish Nurse and Health Ministry Symposium: *"Take Care Tips: How to Care for Yourself While You're Taking Care of Others"*
Presented by Pittsburgh Mercy Health System
Saturday, October 25, 8 a.m. to 1:30 p.m.
Keynote speaker: Jennifer Antkowiak
UPMC Mercy, Sister M. Ferdinand Clark Auditorium,
1400 Locust Street, Pittsburgh, PA 15219 (Uptown)
Three continuing education credits available to nurses and social workers.
Call 412.232.5815 or email ParishNurse@pmhs.org.
Register by Oct. 17 at www.pmhs.org/parish-nurse-program/education-and-resources.aspx.

Women's Health Conversations: Prioritizing your Body, Brains and Bliss
November 6
David L. Convention Center Ballroom
Visit www.womenshealthconversations.com.

Southwestern PA Partnership for Aging Annual Meeting
Wednesday December 3rd, 8am to 4pm
Robert Morris University in Moon Twp.
Call 412-595-7554 or email
lcichon@homeinsteadpgh.com

Health Care Event & Meeting Guide

Visit www.wphealthcarenews.com for a listing of upcoming conferences, networking events, workshops, and seminars. If you want to add yours to our list, please email Daniel Casciato at writer@danielcasciato.com.

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employees with disabilities covered by the ADA to take medical leave as a reasonable accommodation.

The case reminds all health care employers that the FMLA and ADA have distinct requirements regarding employee medical leave.

Health care employers should review their employee medical leave policies to ensure that they provide the flexibility required under the ADA.

When any employee requests medical leave, employers should take note if such leave is related to a covered disability under the ADA and requires a reasonable accommodation.

Health care employers that enforce rigid maximum leave policies will likely violate the ADA and cause costly lawsuits. ✚

Antoinette Oliver and Elaina Smiley are attorneys at Pittsburgh-based law firm Meyer, Unkovic & Scott. Antoinette can be reached at aco@muslaw.com, and Elaina at es@muslaw.com.

productive members of communities. The payoff is enormous. ”

Global Links is meticulous about what items are distributed to each of its projects, and those standards determine what it is able to accept from US hospital partners. It is a vast and complicated operation, and depends heavily on volunteer labor.

Global Links volunteers sort donations and make sure that each item will not expire for at least a year. Current-dated materials that don’t have a long enough shelf life for overseas donation are shared with local organizations that will be able to use the products before they expire.

“We are careful to give our partners only what will be appropriate for the care they provide,” explains Brugos. “We want to ensure that each item they receive from Global Links is something that fills a need, and that will support or improve their patient care. We think long term – we want to make a difference in each community where we work.”

“Combining an environmental mission with a mission to improve health is one solution to two problems,” explains Hower. “That’s why we are so pleased to have won this Practice Greenhealth award for five years running. It means that people are taking the responsibility for environmental and global health seriously.

“It means,” she adds optimistically, “that more people are starting to see the world the way we do, that everything is connected.” ✚

Rachael Robertson is Communications Intern at Global Links. For more information, visit www.globallinks.org.

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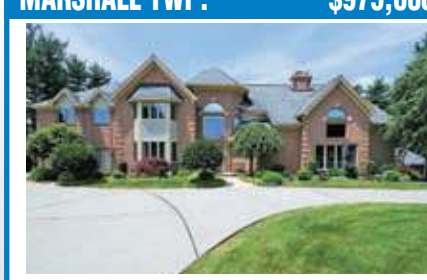
MARSHALL TWP. $975,000



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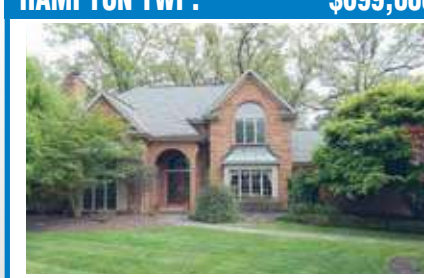

The Villa of North Park – Custom built solid brick on a cul-de-sac amidst wooded privacy! 4BR 3/2 baths. Full of recent updates. Stunning 2 story foyer with curved staircase. Rich woodwork thru-out, paneled den with custom ceiling, huge beamed family room. finished gameroom with bar. large wooded lot. Walk to North Park. **MLS1000217**

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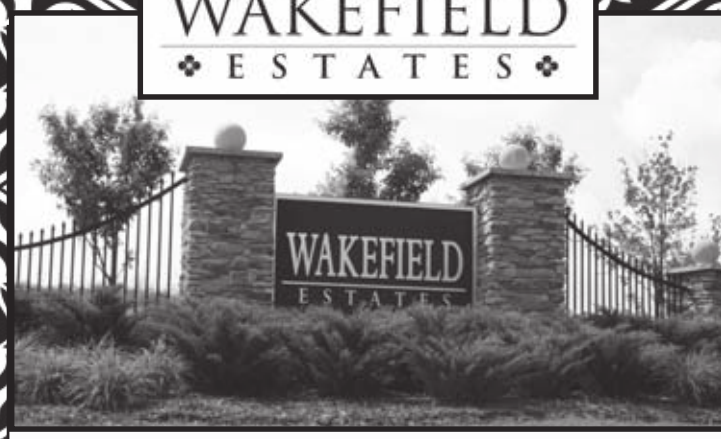

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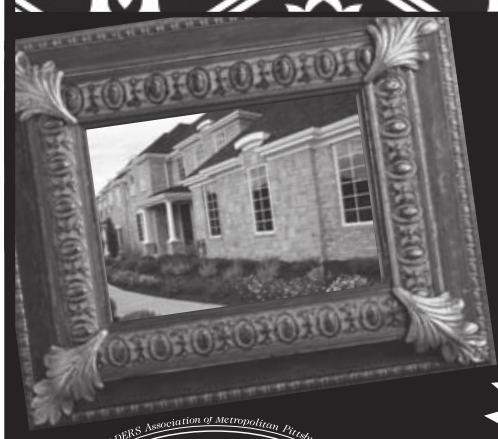

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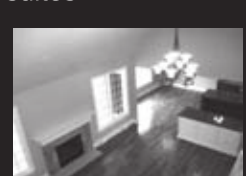

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for all the right reasons.

More than **93%** of our rehab patients are discharged home*

The majority of our patients come from the hospital setting with a goal of getting back to their lives. Our focus is working with patients, their families and physicians on setting goals and working each day to achieve them. We are getting them home, exceeding the national average of 75%*.

Contact us today for more information or to schedule a tour:

ManorCare - Bethel Park
412.831.6050

ManorCare - Greentree
412.344.7744

ManorCare - Monroeville
412.856.7071

ManorCare - North Hills
412.369.9955

ManorCare - North Side
412.323.0420

ManorCare - Peters Township
724.941.3080

ManorCare - Pittsburgh
412.665.2400

ManorCare - Shadyside
412.362.3500

ManorCare - Whitehall Borough
412.884.3500

* All data is based on industry averages and HCR ManorCare 2013 results.

Your best way home is through our doors®

www.manorcare.com

ManorCare® Health Services