

# Western Pennsylvania Hospital News

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**25<sup>th</sup> Anniversary**

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## Hospital Workforce Recognition: Top Ways Employee Recognition Will Increase Engagement and Retention

**By Peter W. Hart**



In today's healthcare and hospital workforce environments, staying competitive and compliant requires a focused and motivated workforce. Keeping all employees motivated and engaged from administrators to physicians and nurses to technicians and support staff is essential for optimal patient care and profitability. Yet, the rapid pace of healthcare reform with short and long-term changes in regulations, compliance, research, and consumer concerns requires high morale from the entire organization and all of the external moving parts to

achieve optimal growth, purpose and profitability.

Over 90% of North American companies have "recognition" programs. But, according to surveys, more than 60% of their employees don't feel recognized. This significant disconnect must be addressed immediately or the consequences will hit companies hard. According to a recent Deloitte Talent Edge 2020 study, employers are at risk of losing their top talent and the unfortunate truth is that this exodus is hitting organizations at the same time as predicted talent shortages are projected.

Today, the world's best organizations treat recognition as a critical business process, closely tied to improving employee retention, engagement, and performance. Companies deciding whether to launch an employee recognition program or improving an existing one should consider the following approach, tips and techniques. Below are the top tips for recognition to increase engagement while positively impacting retention.

Make recognition a strategic priority. Supervisors need to be trained on the merits of employee appreciation and given suggestions and methods to put the practices into action. Managers must be made aware that meeting and exceeding their deliverables and quotas is directly linked to the employee satisfaction of their teams. It is essential that executive staff communicate the importance as well, so that all managers take employee recognition seriously and deploy it on a day to day basis and not just monthly, quarterly or annually.

Make it purposeful.. Did a manager notice how an employee handled a difficult situation? How about their excellent interactions with patients or other staff? Managers should take note of daily working behaviors with both patients and colleagues and recognize these actions in addition to customer service and performance goals.

See **RECOGNITION** On **Page 4**

## Breaking Down Barriers in Transplant Surgery: Velma Scantlebury, MD, FACS

**By Drew Wilson**

Under the best of circumstances, a surgeon prefers that a patient enter the operating room as calmly as possible, but Velma Scantlebury, MD, FACS, recalls one patient where there was little she could do to pacify him.

"This was in 2000, while I was working on the transplantation team at the University of Pittsburgh Medical Center," recalls Dr. Scantlebury, who is currently the associate director of the Division of Transplantation at Christiana Care Transplant Center, in Delaware. "The nature of transplant surgery is that the patients and their families don't always get to meet the surgeon prior to surgery."

This might have been one of those times when not meeting each other would have helped. As Dr. Scantlebury and the team were moving one patient, who lived in Erie, from his room to the operating room, he suddenly looked up at her and said, "You're a woman."

"Yes," she replied.

"And you're black," the patient said, which Dr. Scantlebury calmly affirmed.

"Please, please, please don't kill me!" The patient pleaded, gripping the sides of the gurney strongly enough to make his knuckles turn white. "I have a young daughter."

While Dr. Scantlebury can laugh about it now, the story illustrates one of the obstacles – if not the biggest obstacle – that women, particularly minority women, face in surgery: overcoming the preconceptions that they are somehow inferior because they are not Caucasian males.

"There is a bias toward male surgeons," says Dr. Scantlebury. "It's often a hindrance that keeps women from advancing in medical careers."

This is just one of the points that Dr. Scantlebury sought to drive home to the



Dr. Velma Scantlebury, one of only two African American women who are transplant surgeons, spoke to the high school girls who attended Carlow University's Prepare to Care Summer Workshop.

high school girls attending Carlow University's Prepare to Care summer workshop for those interested in a career in health care.

See **SCANTLEBURY** On **Page 4**



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## Publisher's Note

### There's Still Hope for Our Children

Recently, I was made aware of a wonderful organization in Pittsburgh called Entrepreneurship Youth, a non-profit organization that helps middle school and high school students, who are at risk of failing academically, learn about business creation and experience ownership. It partners with educators, parents and youth work professionals who want to use entrepreneurial learning and business creation to engage young people in learning.

I applaud the efforts of this organization for engaging these young people and showing them that their opportunities for success can be limitless. We always talk about the fact that our children today will not have the same opportunities that we did. So it pleases me that we're doing something to change that fact. But what kind of world are we sending our young men and women into?

As a former school teacher and a proud graduate of Youngstown State University, I grew up with the golden rule—don't lie, don't cheat, and don't steal. We were also taught to have respect for your common man even if you disagreed with them. That's why it worries me that today's youth are entering a world where we have fallen athletic heroes, corrupt business leaders, and politicians who are bickering all the time, whether it's at the local, state, or federal level.

In fact, as of this writing, I just read an article on CNBC where the Senate Republican leader Mitch McConnell said that "a long-term solution to the United States' fiscal problems was not likely as long as President Barack Obama remains in office." he was quoted as saying, "...I have little question that as long as this president is in the Oval Office a real solution is probably unattainable..."

So basically, one person is the only reason that we're in the mess that we are in, and magically if you shift that one person, everything will be fine? Really? If that is true, look at the sports world, particularly the Pittsburgh Pirates. It's taken them 18 years to finally become competitive. How many players and managers did they have to shift around to find the right chemistry?

It makes me feel bad that the message that we are sending to our children is that the only way to solve a problem is to remove the opposition or just do everything that you can to make that person



miserable until they come around. Forget about compromise. The sniping at one another in the political world is also disgusting. But many of us have already lost faith in the political system and have grown frustrated with the gridlock in Washington.

Of course, few children probably look to politicians as their role models. Many look up to athletes, but even they get in trouble. Just last week, Hines Ward was picked up on a DUI in his home state of Georgia. Look at the problems that have befallen other superstars such as Ben Roethlisberger, Tiger Woods and Kobe Bryant over the years.

Even in my world of publishing, you have the Rupert Murdoch situation, where his media holdings' journalistic integrity and ethical standards are now being scrutinized. Where does it end? I'm just puzzled by it all and I don't want to see our children head down these same roads.

I look at these students who are part of Entrepreneurship Youth and other similar programs across the country and I just have to believe that they have the right role models and mentors in their lives so they can head down a different path from today's so-called leaders and heroes.

My only hope for them is that they learn from their entrepreneurial experiences as well as from their moms, dads, extended family members, and teachers, about the importance of compromise and working with one another. We have a responsibility to our youth to teach them that and it also doesn't cost money to teach them to be civil to one another. That's free.

As always, I would love to hear your thoughts. Please email me at [hdkart@aol.com](mailto:hdkart@aol.com).

**Harvey D. Kart**  
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## Walk at the Waterfront On Saturday, September 17

Top Ten Fundraisers will be guests at a luncheon hosted by Honorary Chair, Pittsburgh Steeler, #25 Ryan Clark and his wife, Yonka.

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**RECOGNITION** From Page 1

Define the targets carefully. Recognition will fall flat if employees don't know the business objectives being recognized and their roles in achieving those objectives. Make sure the rules are clearly spelled out for expected employee behaviors and overall performance expectations.

Celebrate with others. Not all recognition needs to be based on individual performance. Make time to celebrate team achievements and project goals reached as a group. Whether sharing a pizza, cookies or a lunch together, foster camaraderie among employees.

Build peer to peer recognition. Supervisors can't see everything going on in order to recognize everyone. All employees should be encouraged to be on the look-out for exemplary actions and to nominate their colleagues for incentives.

Instant results merit instant recognition. Make a big deal out of every occurrence of goal achievement and highlight those achievements in staff meetings. Remember, re-energizing and re-fueling is critical for a positive attitude and a dedicated workforce.

Just because. All employees must show up to get paid – but their attitude while on the job can be influenced by managers. Assure that managers have sufficient budgets to maintain the positive flow of everyday recognition events and activities. Managers can handout chocolate bars, soda & snacks, or movie tickets as tokens of appreciation and to show support for employees' steady performance and commitment to the company's success.

Constant positive feedback. Whether it is work done by an individual or exceeding benchmarks as a group – announce it like a winning touchdown to keep the momentum going and reinforce team spirit. Managers should stroll the maze of cubicles, offices, and floors and make time to give genuine pats on the back and positive verbal feedback for what employees are doing well. Everyone appreciates a "thank you!" †

*Peter Hart is President & CEO of Rideau Recognition Solutions (www.rideau.com) and has been advising and serving the industry for over 20 years. He can be reached at PeterHart@Rideau.com.*

**SCANTLEBURY** From Page 1

Dr. Scantlebury, who was born in Barbados and grew up in New York City, is the first African-American woman in the field of transplantation surgery, and one of only two African-American women transplant surgeons in the United States. She was selected as one of the Nation's Top Doctors in America for 2003, 2004, and 2006, and was honored with the National Kidney Foundation's Gift of Life Award for her work in the field of kidney transplantation.

She earned her bachelor's degree in biology from Long Island University, and her medical degree from Columbia University. She completed her internship and residency in general surgery at Harlem Hospital Center in New York City, and completed her training in transplantation surgery at the University of Pittsburgh Medical Center, from 1988 until 2002, under the leadership of Dr. Thomas Starzl.

Dr. Scantlebury moved to the University of South Alabama as director of the Gulf Coast Regional Transplant Center, and remained there until 2008 when she accepted the position at Christiana Care Hospital Systems.

In 1996, Carlow honored her as a Woman of Spirit®, an award that recognizes local, national, and international women whose successes inspire us and whose lives embody the values and mission of Carlow University.

In a question and answer session following her presentation to the girls at Prepare to Care, she was asked what advice she would offer to those who want to follow in her footsteps.

"Like what you do, and surround yourself with people who make a positive impact on you," she told them. And the patient from Erie who pleaded with her before surgery?

"He did well. And we have become friends since that day."

*Carlow University's Prepare to Care summer workshop, which is sponsored by UPMC, is open to all high school girls entering grades 9-12 interested in exploring the healthcare professions. It is one of three summer workshops Carlow presents annually, the others being "Summer Science Nation," which explores careers in science, and EcoCamp, which focuses on environmental science. For more information about how to register for next year's workshops, please call Laurie Petty at (412) 578-8851 or via e-mail at ljpetty@carlow.edu. †*

## TRI RIVERS EXPANDS MUSCULOSKELETAL SERVICES

### SPINE SURGERY



Frank N. Grisafi, M.D., attended Jefferson Medical College of Thomas Jefferson University and completed his orthopedic surgery residency at West Virginia University Hospitals in Morgantown, W.Va. He then completed the Bohlman Spine Fellowship at Case Western Reserve University School of Medicine in Cleveland, Ohio, where he refined his skills in the conservative and surgical management of various spinal conditions.

**Beginning July 18, Dr. Grisafi will see Tri Rivers patients in the North Hills and in Butler for:**

- Back & neck pain
- Spinal stenosis
- Spinal arthritis
- Disc herniation
- Compression fractures
- Sciatica

### RHEUMATOLOGY



Betsy F. Shook, M.D., attended the West Virginia University School of Medicine and completed her internal medicine residency at Riverside Methodist Hospital in Columbus, Ohio. She then completed a rheumatology fellowship at the University of Pittsburgh Medical Center, where she refined her skills in the treatment of rheumatoid arthritis, lupus and other connective tissue diseases. Additionally, Dr. Shook treats a full range of general rheumatic and arthritic conditions.

**Beginning August 1, Dr. Shook will see Tri Rivers patients in Cranberry/Mars for:**

- Rheumatoid arthritis
- Vasculitis
- Lupus and other connective tissue diseases
- Osteoporosis
- Gout



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**PRIMARY CARE SPORTS MEDICINE:** Anna M. Dumont, D.O.

**RHEUMATOLOGY:** Betsy F. Shook, M.D.

# Getting Started with Google+



By Daniel Casciato

Earlier this month, Google entered the social media fray and unveiled Google+, its answer to Twitter and Facebook. Essentially, all of Google and its social products are now part one large social network. In fact, next time you log into your Google Docs or check your Gmail account, you'll see a new navigation bar that integrates sharing capabilities with all of its products.

Keep in mind that, Google+ should not replace Facebook or Twitter. Rather, it should just be another part of your social media strategy. As we stressed before, like a wheel, your website or your blog should remain the hub,

or central piece, of your communications with your internal and external audiences. All of your social media channels should merely be spokes of your wheel, driving your readers back to your hub.

In future issues, we'll talk more about Google+, but first below are our impressions so far.

**Design** - Lots of white space which makes it easy on the eyes. But it's pretty simplistic, much like other Google-related products. Grade: B-

**Usability** - Very simple to navigate and only a few features to learn. You'll quickly grasp it. But it's also a blast to use. Grade: A

**Google+ Stream** - This is similar to your other social media streams, and combines the best of Facebook and Twitter. In fact, if Facebook and Twitter had a child, this would be it. You can decide which stream of content to see—your network of friends, colleagues, people you're following, or all streams. Grade: A-

**Google+ Circles** - Love this functionality the best. Simply drag and drop your contacts into a circle—choose from Friends, Acquaintances, People to Follow, or just create your own circle. When you see someone you'd like to add, just click and drop. It's that easy. Grade: A+

**Google+ Profiles** - If you have a Gmail or any type of Google account now, this just automatically ports that data into the Profile section. Simply put, it's just your personal data. Nothing groundbreaking here. Grade: B

**Google+ Hangouts** - This is the feature that has everyone abuzz. With Hangouts, you can do video chats with a group of people. Very easy to hold a teleconference using this concept or just chatting with family members or friends. Face-



book came to the game late on this one. Although they have partnered with Skype, their video chatting capability is limited to one-on-one chats. Another cool aspect about Hangouts is that the camera angle will switch to the person who is talking at the time. That means, you don't have to worry about having multiple video feeds opened. Grade: A

**Google+ Sparks** - Interesting feature, but one that few people are using now. You'll select items of interest to follow. It's akin to Google Alerts. If you want to follow healthcare, just add it as an interest and you'll be kept up-to-date on topics related to healthcare. Grade: B+

Overall, we give Google+ an A. Knowing how Google operates, they'll continue to evolve its new social networking tool, adding features and improving the current ones.

*Are you using Google+ yet? Let me know what you think and we'll share your comments in a future issue. Just email me at [writer@danielcasciato.com](mailto:writer@danielcasciato.com). Want to add me to your Circle, my Gmail account is [danielcasciato@gmail.com](mailto:danielcasciato@gmail.com).*

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THE SECOND ANNUAL RITA M. MCGINLEY SYMPOSIUM

Exploring Social Justice  
of Vulnerable Populations:

# THE FACE OF THE IMMIGRANT

September 29–30, 2011

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A two-day scholarly forum for nurses and other health care professionals to address issues of social justice in health care for immigrant populations.

For information visit [WWW.DUQ.EDU/SOCIAL-JUSTICE](http://WWW.DUQ.EDU/SOCIAL-JUSTICE)

## Highmark Inc. and Consortium Ethics Program Partner to Integrate Ethics Education for Highmark Case and Care Managers

Ethical issues in the delivery of health care arise in acute care institutions, home care and rehabilitation facilities and also at third-party payer organizations. One local health plan addressing these issues is Highmark Inc., one of the largest independent licensees of the Blue Cross and Blue Shield Association in the nation, serving 4.8 million health plan members in Pennsylvania and West Virginia.

Through the leadership of Donald R. Fischer, M.D., senior vice president and chief medical officer and Carey T. Vinson, M.D., vice president of quality and medical performance management, Highmark Inc. made a decision to join the Consortium Ethics Program (CEP) in 2006. CEP Director Rosa L. Pinkus, Ph.D. facilitated Highmark's initial involvement. Highmark, along with CEP, arranged a series of onsite seminars at the health plan as a way to introduce case and care managers to the basic issues of health care ethics.

Under the direction of Mary C. Goessler, M.D., medical director of quality and medical performance management, Highmark broadened its ethical stance by establishing a relevant ethics program that reflected the specific and unique ethical needs that arise for health plan providers. Dr. Pinkus and members of the Ethics Consultant Education Team, who are also designated CEP representatives at Highmark, developed an institution-wide ethics education series. The Ethics Consultant Education Team/CEP representatives at Highmark are Joan Braszo, L.S.W.; Dolores Fuhrman, M.S.N.; Mary Ellen O'Boyle, M.P.H.; Mary Goessler, M.D.; and Gloria Shoemaker, Ph.D.

In the summer of 2010, the Ethics Consultant Education Team at Highmark working with Dr. Pinkus began specifying what the unique issues within the organization were. Since the team members were knowledgeable about Highmark's organizational culture and had completed four years of education with the CEP, they were in the best position to craft an onsite educational plan. Before developing a formal plan, the team conducted focus groups specifically with case and care managers to uncover the dilemmas they were facing on the job. After

# Education Update

identifying these dilemmas, the team was able to translate them into ethical issues.

A corporate ethics education plan was approved by a steering committee of senior management and medical directors chaired by Dr. Goessler. The purpose of the ethics education plan was to utilize CEP resources to obtain speakers on the ethical issues identified in the focus groups and then eventually to have members of the Ethics Consultant Education Team educate Highmark staff. The team consulted with Dr. Pinkus to arrange for speakers and topics that could be taught through webinars to case and care managers. At this time, webinars on topics of boundary issues, confidentiality, etc. are being presented to case and care managers by the Ethics Consultant Education Team members.

The team of representatives at Highmark is only one example of how CEP members can take the "train the trainer" approach to CEP education. By encouraging CEP representatives to become "ethics resource persons" within their institution, the program encourages use of the educational approaches to health care ethics beyond the classroom. Partnering with frontline professionals, such as the team at Highmark, enables the CEP faculty to do what it does best, assist in translating "cutting edge" ethics knowledge into educational experiences directed toward assisting the everyday work of the frontline employees.

The CEP is the regional, health care ethics education network in Western Pennsylvania with a mission to cost effectively assist health care professionals, their institutions and the local health care community in developing and sustaining awareness and expertise in clinical health care ethics through education. To learn more about the CEP, go to [www.pitt.edu/~CEP](http://www.pitt.edu/~CEP).

*Highmark Inc., based in Pittsburgh, is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Highmark serves 4.8 million members in Pennsylvania and West Virginia. For more than 70 years, Highmark's commitment to the community has consistently been among the company's highest priorities as it strives to positively impact the communities where it does business. For more information, visit [www.highmark.com](http://www.highmark.com).* †

## Jameson Hospital School of Radiography and School of Nursing Hold Graduation Ceremonies

Jameson Health System's School of Radiography and Specialty programs held its annual graduation ceremony at Mohawk High School Auditorium, Bessemer, PA. There were a total of twelve graduates, five in Radiography, one in Nuclear Medicine, two in Magnetic Resonance Imaging, one in Mammography and one in Computerized Tomography.

Radiography graduates were: Tracy Esposito from New Castle, Nicholas James Hunter from New Wilmington, Michael J. Lechner from Hermitage, Stephanie Rae Pridon from Poland, Ohio and Victoria Aida Steiner from Campbell, Ohio. Specialty program graduates were Sarah E. Brown, New Castle from Nuclear Medicine; Amanda Lenn, New Castle and Marisa A. Lukasko, Sharpsville from Diagnostic Medical Sonography; Elizabeth Kennedy Moffatt, New Castle and Bonnie S. Sanchez, Fontana, California from Magnetic Resonance Imaging; Matthew P. Kamensky, Lowellville, Ohio from Computerized Tomography; and Jenna Tanner, New Castle from Mammography.



School of Nursing



School of Radiology

Michael J. Lechner won the outstanding academic award and Stephanie Rae Pridon won the Lucien Clinical Excellence Award for outstanding clinical student. Tracy Esposito won the Phoenix Award, given to the graduating student who had to overcome the most personal obstacles to complete their education.

In addition, 39 students received diplomas from the Jameson Memorial Hospital School of Nursing at commencement exercises held in Orr Auditorium, Westminster College in New Wilmington. The following students received awards:

**Kevin Shaw - Julie Wojtowicz Award** - given to the graduate who has exhibited determination, perseverance, dedication and compassion in surmounting financial, physical, social or other adversities of life.

**Robyn Bennington - Lawrence County Medical Society Award** - for outstanding ethical conduct.

**Ryan Vatter - Leo and Mitzi Robinson Memorial Award** - for exceptional ability in meeting the psychosocial needs of the elderly in the community.

**Jonalyn Brickner - St. Francis Hospital of New Castle School of Nursing Alumni Award** - for clinical excellence throughout the program of study.

**Bonnie Overby - Jameson-Shenango Alumni Award** - for the best all-around nurse as chosen by the graduating class.

**Jonalyn Brickner - Travis A. French Award** - for exceptional ability and understanding in the care of the childbearing family.

**Cassandra Reed, Jennifer Spatara, Amanda Masotto - Rene D. Jenkins Memorial Award** - for outstanding contribution to the School of Nursing.

**Kimberly Tindell - Spirit of Nursing Award** - awarded by the School of Nursing faculty to the graduate who best embodies the spirit of nursing.

**Robyn Bell - Mark L. Rosenblum Student Nurse Scholarship Award** - given to the graduate who has consistently demonstrated a high level of scholastic achievement.

The following are graduates and their hometowns:

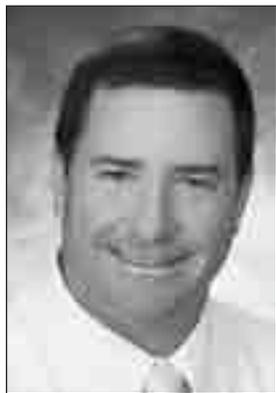
**New Castle, PA:** Robyn Bell, Kathleen R. Gerstnecker, Mary Janacone, Courtney Link, Susan Mays, Bonnie Norris, Amanda Wagner and Amanda Weaver; **Sharon, PA:** Michelle Cooper, Cassandra Reed, Rhianna Snyder and Jennifer Spatara; **New Wilmington, PA:** Megan Aliulis and Samantha Morgan; **Grove City, PA:** Ryan Vatter; **Mercer, PA:** Robyn Bennington and Alissa Newton; **Bessemer, PA:** Linda Corcoran; **Transfer, PA:** Gregory Gerasimek; **Greenville, PA:** Megan Baker and Michelle Baker; **Darlington, PA:** Jonalyn Brickner; **Beaver, PA:** Katica Kovacs; **Sharpsville, PA:** Samantha Ricciardi, Larry Lisi and Amanda Masotto; **Ellwood City, PA:** Karlie Zito; **Volant, PA:** Kevin Shaw; **Pulaski, PA:** Brittany Main; **Youngstown, Ohio:** Elizabeth Carrier and Bonnie Overby. **Lowellville, Ohio:** Michelle Lisko; **Hubbard, Ohio:** Kari Holden; **Burghill, Ohio:** Julianne Jablonski; **Niles, Ohio:** Carla Scherich; **Vienna, Ohio:** Dawn Schultz; **New Springfield, Ohio:** Kimberly Tindell; and **Streetsboro, Ohio:** Vickie White-Muir.

For more information, visit [www.jamesonhealth.org](http://www.jamesonhealth.org). †

# Nursing Students Graduate from Conemaugh School of Nursing

Conemaugh School of Nursing held its graduation last month at The Johnstown Career and Technology Center, Richland Township. Forty two students graduated from its nursing program.

## AWARDS WERE PRESENTED TO:



Michael Rogers



Jodi Zahurak



Alexis Pauley



Amber Matyi



Rosellen Bence



Frederick Corradini

**Michael Rogers:** The Meyer and Sally Bloom Valedictorian Award, The Conemaugh Health System Medical Staff Outstanding Student Nurse Award, and The Sally Jordan Leadership and Management Award.

**Jodi Zahurak:** William L. Hughes Salutatorian Award and The Director, Conemaugh School of Nursing Student Service Award.

**Alexis Pauley:** The Faculty, Conemaugh School of Nursing, Communication and Health Teaching Award.

**Amber Matyi:** Conemaugh School of Nursing Alumni Association Spirit of the Pink Cross Award.

**Rosellen Bence:** The Boyd Lingenfelter Humanitarian Award and the Conemaugh School of Nursing Alumni Association Spirit of the Pink Cross Award.

**Frederick Corradini:** The Director, Conemaugh School of Nursing Student Service Award.

## ADDITIONAL MEMBERS OF THE GRADUATING CLASS ARE:

Trina Arce, Colleen Beam, Jody Bodenschatz, Tera Brady, Matthew Carr,

# Education Update

Hillary Cooper, Brianna Coulter, Kevin Daum, Christopher Donoughe, Lesha Foshee, Casey Freedline, Nicholas Freedman, Daphne Gallucci, Carly George, Courtney Giger, Kari Gletto, Anna Hernandez, Betsy Karashowsky, Beth Kauffman, Quenna Kist, Lydia Lehman, Elizabeth Leister, Matthew Leslie, Adam Lloyd, Katherine MacDowell, Lauren McKool, Cassandra Ohrel, Brittany Redvay, Laura Rosman, Molly Sambor, Michelle Shandor, Emily Spinos, Sarah Van Dyke, Jennifer Vizzini, Abigail Williams, and Miranda Wiser.

## THE HONORS LIST FOR WINTER SEMESTER 2011 INCLUDED:

Highest Honors: Lauren Ellis, Jolyn Gontis

High Honors: Alexis Pauley, Michelle Shandor

Honors: Frederick Corradini, Lisa Flickinger, Lesha Fosheé, Carly George, Jason Harity, Joshua Haskins, Anna Hernandez, Jessica Leap, Lydia Lehman, Jacob Norman, Michael Rogers, Hannah Scheffel, Kelley Shoemaker, Leanne Wilson, Maria Younkin, Jodi Zahurak

For more information, visit [www.conemaugh.org](http://www.conemaugh.org).

*Submissions? Story Ideas?  
News Tips? Suggestions?*

Contact Daniel Casciato at  
[writer@danielcasciato.com](mailto:writer@danielcasciato.com)



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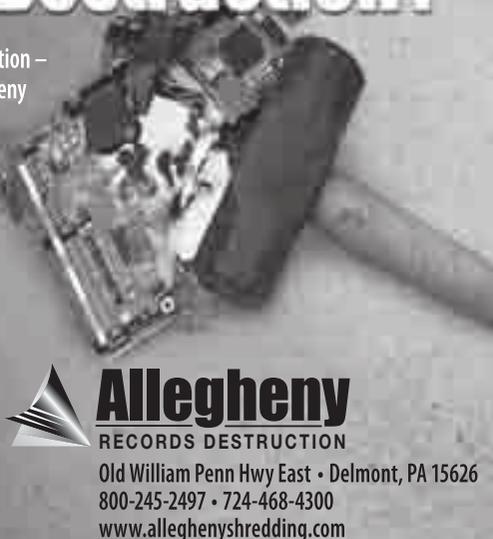
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# New Technology/Equipment Acquisitions: Balancing Needs vs. Wants



By Ross Swanson

In today's rapidly-changing market for healthcare landscape, choices about what technology or new equipment to evaluate, if and when to make a purchase, and how to implement are significant ones. Many important questions surface when getting started with this daunting process; in fact, the list of considerations could be endless when factoring in facility size, scope, and location.

But, despite the many and varied questions that can arise, there are ways to streamline this process and increase the chances of successful planning and implementation. Corazon recommends the following:

**Implement a structured service line management model.** This program arrangement can give an organization a "leg up" throughout the capital planning and product evaluation process since all related areas for one specialty are grouped together. Service line management should also allow for an expedited approach to the evaluation process when timing for these acquisitions is so crucial. In fact, those hospitals that have a fractured [and thus a delayed] process for the initial steps in technology evaluation will find many items outdated once a final decision has been made.

**Find balance between needs and wants.** When working with clients across the country, the biggest struggle throughout this process comes from a capital resource perspective. Hospital and program leaders must weigh options and choose what the organization *needs* vs. succumb to pressure from physicians and staff about what they *want*. Decisions should be made based on what the hospital can reasonably afford, while still improving care delivery. The biggest, flashiest, and most expensive new technology isn't necessarily always best. Also consider the ROI. We often recommend that a full ROI should be reasonably expected from a technology or equipment investment within one year for smaller, niche technologies, and 3-5 years for large-scale capital items that may cross multiple services.

**Consider new financial distributions.** Corazon promotes an innovative model, wherein one lump sum of capital dollars is allocated to the entire service



line. This lump sum can have a relative relationship to the revenue generated by the program and/or to the importance of the program as it relates to the bottom line of the hospital. Money is then allotted to various areas of the service line through determinations of the service line leadership and key physician leads based on strategic priorities, cost/benefit, and other factors.

Creating a specialized **Product Evaluation Committee** whose sole mission is to evaluate, implement, and ensure the profitability of the newly-adopted technology or equipment is the best way to not only accomplish the above, but also streamline the go/no-go decision.

The following best-practice approaches can make the most of the committee:

- Meet at least quarterly; if less often, the committee will fall behind on internal requests and/or new technology in the marketplace.
- Use a structured and standardized approach for requests.
- Define clear guidelines regarding the process, expected turnaround time, as well as budget stipulations. Such rules emphasize the value of communication, and reinforce the formality of the Committee.
- Make the status of requests available. Some organizations track updates online, which can allow for 'real-time' inquiries.
- Be transparent. Once the analysis is complete, the Committee should share the documentation that led to the go/no-go, such as the business plan or pro forma that provides the rationale behind the Committee's decision.

Within any organization, the decision to implement new technologies is never an easy one. This is particularly true with technologies directed at cardiovascular and/or neuroscience diagnoses and treatment, which often come with the highest price tags.

The addition of new technology oftentimes will challenge all involved – from leadership to physicians to clinical staff – to behave and interact in new ways. A new technology or equipment acquisition will likely become a tough terrain of managing conflicting priorities, multiple personalities, and restricted capital; however, allocating the time and resources into setting-up a structure, as well as providing education around that structure is critical to its success and will eliminate future headaches.

Just because an organization 'builds it' or 'buys it' doesn't mean that new patients will come... Every new purchase or investment must have a solid plan that details essential action steps, assigns accountable parties, and targets completion dates.

The infrastructure of Committees, a rigorous business evaluation process, and the quantification of clinical benefit can round-out a robust technology/equipment acquisition process that can assist hospitals with charting their way through these tough decisions. The result: a clear path for program growth and success. †

*Ross Swanson is a Vice President at Corazon, a national leader in consulting, recruitment, and interim management for the heart, vascular, and neuro specialties. Visit [www.corazoninc.com](http://www.corazoninc.com) for more information. To reach Ross, call 412-364-8200 or email [rswanson@corazoninc.com](mailto:rswanson@corazoninc.com).*

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## New Technology at The Residence At Hilltop

The Residence at Hilltop is using new technology to provide an advanced level of health care and safety to its residents. Recently, an emergency remote personal care monitoring system was installed throughout the Residence and it's the first of its kind in the area. The system goes far beyond traditional call systems and it comes at no extra cost to the residents.

Each resident receives a pendant containing a large button and instructions on its use. A call bell station also is located in each resident's apartment bathroom.

When a resident initiates an alert by pushing the button on the pendant or pulling the alarm cord in the bathroom, the device transmits a Wi-Fi signal with the location of the alert and identity of the resident asking for assistance. An operator then calls the portable phone of the direct caregiver with that information.

A resident could be having lunch in the dining room, outside on the patio visiting a friend or watching a movie in the theater room and staff will locate that resident immediately due to the wireless location tracking feature of the system.



A resident from the Residence at Hilltop displays the pendant containing the emergency alert button.

The new system supports one of the major goals of The Residence at Hilltop – the quiet facility concept and it greatly improves staff's ability to respond quickly and efficiently to any resident's need for assistance.

"If a request is not answered in a timely manner, the information is relayed to the person on next level of the calling tree so someone responds," said Walter Young, executive director of the Residence.

"The detailed, time-stamped reports generated by the software allow me to analyze and adjust workflow to create a better caregiving experience for patients and staff.

"Residents love the system," he said. "It has built in accountability. In addition to tracking a resident's location during a call, it also tracks information such as staff response time and how often a resident uses the system. I was amazed at how quickly both residents and staff adapted to the system.

"We have coupled this system with our fire alarm and smoke detection system for total integration throughout the facility and it is upgradeable to allow for new technology as it develops," Young said.

For more information, visit [www.residenceathilltop.com](http://www.residenceathilltop.com).



## Consolidating Network Appliances with Virtualization

By Dan Joe Barry

Virtualization has transformed the economics of running data centers. Indeed one could say that without virtualization, data centers would have faced a serious power consumption dilemma. With virtualization, it is now possible to make more efficient use of physical resources and thereby space and power consumption, which lead to cost savings.

Cost, space and power will continue to dominate the agenda as Internet data traffic continues to grow between 50% and 60% per year. Indeed, for data centers, traffic could grow even quicker as cloud computing centralizes more computing resources and more devices are used to exchange data, such as mobile phones, tablets, TVs, etc.

As more computing resources are centralized, monitoring, analyzing and securing these resources becomes more important than ever. Yet, network appliances today are typically single server implementations with few implementations providing more than one application. It is not uncommon to find several network appliances accessing a single monitoring location. For example, a typical scenario could be three appliances monitoring the same connection with one monitoring specific flows, another providing performance analysis and a third providing intrusion detection functionality.

Since cost, space and power are major issues for data centers, reducing the footprint of network appliances also becomes a major consideration. Many network appliances require all the processing power they can get and thus cannot share processing resources with other applications. Examples are 10 GbE Intrusion Prevention Systems or Application Performance Monitoring systems.

But, there are also a large number of monitoring, analysis and security appliances that run at lower speeds or do not require as much processing resources. Here, there are opportunities to consolidate these appliances into a single server solution.

If all appliances are based on the same operating system, it is possible to consolidate them using intelligent network adapters that can distribute data and share data between multiple applications. Such solutions exist today.

However, if the appliances are based on different operating systems or environments or expect to have full control over available hardware resources, then an alternative solution is required. Virtualization can be used in such instances to consolidate these very different applications. A number of different solutions are possible depending on data sharing and distribution needs. The following describes various solutions based on VMware that can be used to consolidate multiple network appliances onto a single physical platform.

See **CONSOLIDATING** On **Page 11**

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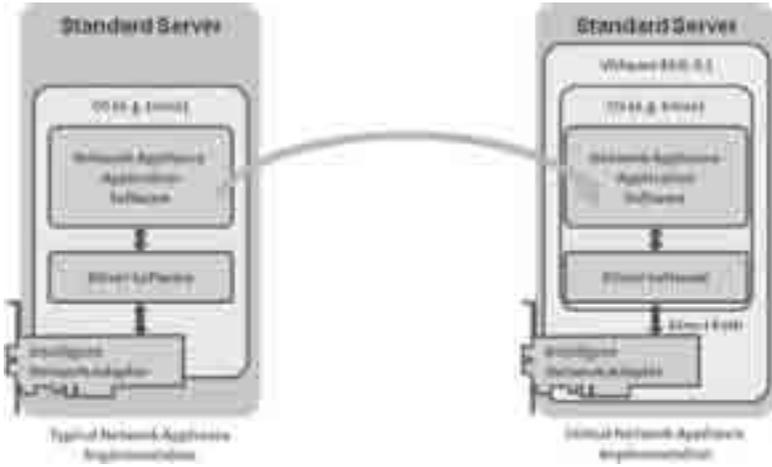
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**CONSOLIDATING** From Page 10

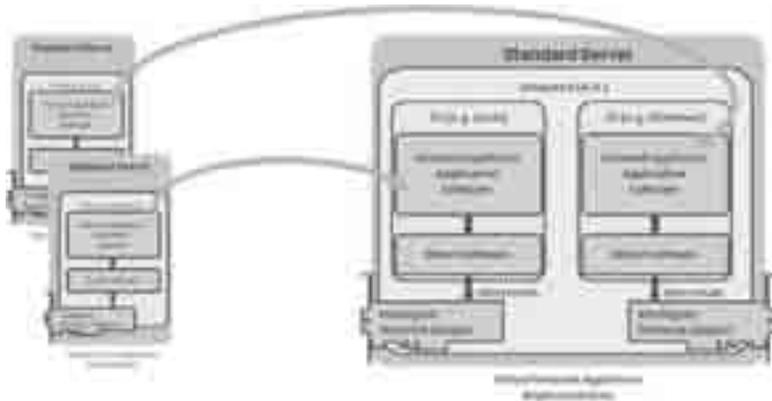
**USING VMWARE DIRECT PATH**

VMware Direct Path allows a virtual machine to control a physical network adapter. This allows existing network appliance applications to be transferred to a virtual environment:



This is the first step in consolidation. To the network appliance application software, it still appears as if it is running on its own server with full control of the intelligent network adapter. The driver software has been updated to support VMware Direct Path, but otherwise, no changes need to be made.

With this solution, a consolidation can be performed for multiple network appliances:

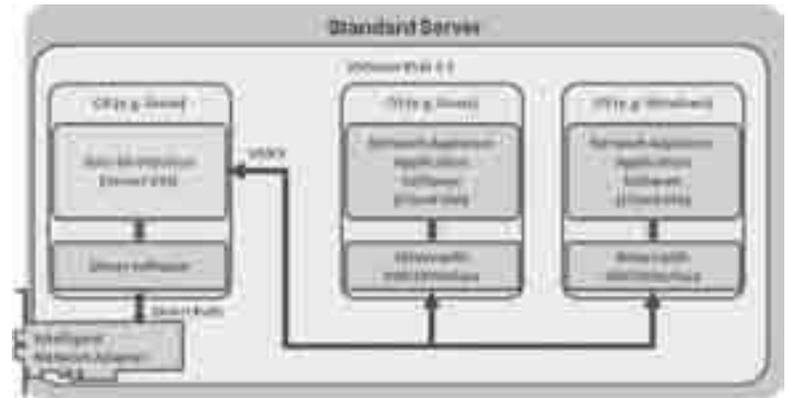


As can be seen, each network appliance can be based on a different operating system and execution environment, but still be supported on the same physical server. The only restriction is that each virtual machine needs its own network adapter as only one virtual machine can control a given network adapter at one time.

**SHARING NETWORK ADAPTERS**

While the above implementation works, it still requires that a network adapter is dedicated to each virtual client. This limits the number of applications to the number of slots in the server. If all the virtual clients need to access the same point in the network, a separate load balancer would be required to distribute the data between the network adapters.

By distributing data within VMware, we can eliminate the load balancer and reduce the number of network adapters required.



See **CONSOLIDATING** On Page 12



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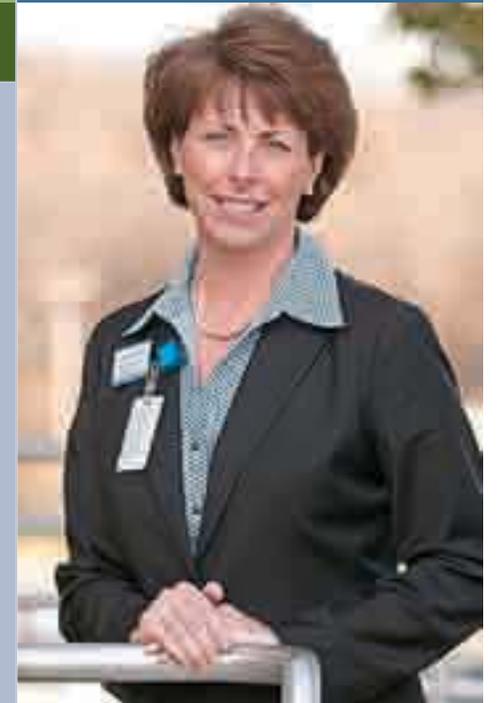
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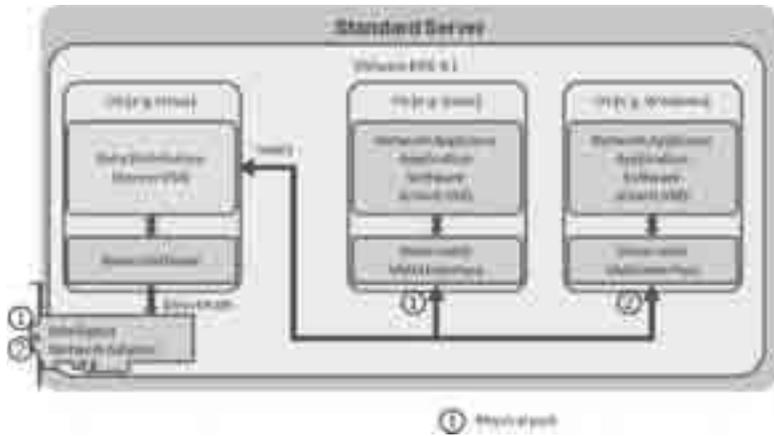
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## CONSOLIDATING From Page 11

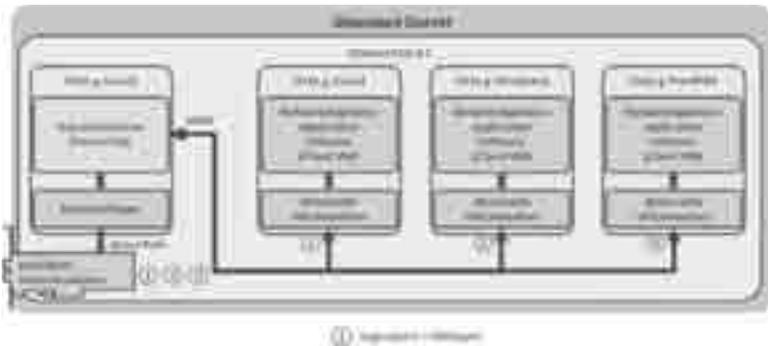
By using a data distribution virtual machine as a server virtual machine based on VMware's VMCI (Virtual Machine Communication Interface), it is possible to distribute and replicate data to multiple virtual machine clients. The data distribution virtual machine can thus distribute or replicate data captured by a single intelligent network adapter to multiple client virtual machines each supporting a separate network appliance.

### DISTRIBUTING DATA ON A PER PHYSICAL OR VIRTUAL PORT BASIS

One method of distributing data to multiple client virtual machines is by physical port:



In the example above, data on each port of the network adapter is mapped to a separate client virtual machine. However, this limits the solution by the number of physical ports on the network adapter.



A more interesting solution is to use logical ports:

Some intelligent network adapters are capable of identifying flows and thus defining logical ports providing specific flow data. These logical ports can be mapped to VMCI ports allowing specific data to be distributed to dedicated network appliances running on client virtual machines. The number of virtual ports that can be supported is limited by the implementation on the network adapter, but can be up to 32.

### SHARING DATA BETWEEN MULTIPLE VIRTUAL MACHINE CLIENTS

As mentioned earlier, it is not uncommon for multiple network appliances to need to access the same data at the same point in the network at the same time. The captured data needs to be shared and replicated to multiple network appliances.



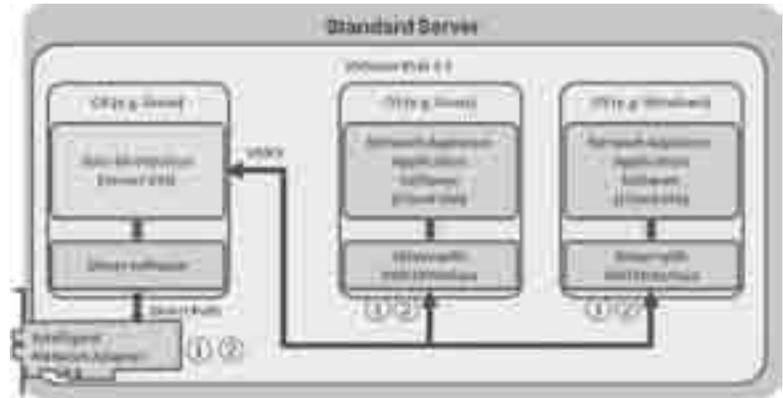
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The data distribution virtual machine can be used to replicate the data captured by the intelligent network adapter to each virtual machine that requires that data. The only limitation is the bandwidth of the VMCI interface itself, which is dependent on the processing power of the supported CPU chipset.

### PERFORMANCE EXPECTATIONS

Implementations of the solutions described above have been made providing a benchmark for expected performance. Napatech has successfully demonstrated that the VMCI interface can support up to 30 Gbps of data replication and distribution to multiple virtual machines. This allows any combination of port speeds and number of virtual clients to be implemented as long as the total consumed VMCI bandwidth does not exceed 30 Gbps.

### BENEFITS OF NETWORK APPLIANCE VIRTUALIZATION

As stated previously, not all network appliances can be virtualized, especially high-speed, high-performance appliances that require all the processing resources available. However, for less processing intensive appliance applications, there is an opportunity for consolidation that is compelling.

One of the advantages of using virtualization for consolidation is that each network appliance can be re-used to a large extent with the same operating system and environment. This also means that it is possible to upgrade the physical hardware without needing to upgrade the supported network appliance virtual machines. As physical servers continue to increase in power and performance, even more appliances can be consolidated onto a single physical server.

As network interface speeds change, it is possible to upgrade the intelligent network adapter to support a higher speed interface without having to change the support network appliance virtual machines. This possibility can also be used to upgrade existing network appliances to support higher speed interfaces in a fast and effective way.

For example, a 10 Gbps network appliance can be upgraded to support 40 Gbps by porting four instances of the network appliance software to four virtual machines running on a single server supported by a single 40 Gbps intelligent network adapter. Four logical ports are created to distribute the data between the four virtual machines making sure that none of the virtual machines receive more than the expected 10 Gbps of data. Thus, a 10 Gbps network appliance becomes a 40 Gbps network appliance without having to re-haul the network appliance application software.

This approach can also be used to upgrade older network appliances supporting legacy operating systems or where resources to update the network appliance application software no longer are available.

### VIRTUALIZATION ENABLES CONSOLIDATION OF NETWORK APPLIANCES

Consolidation of network appliances is the last frontier of virtualization in the data center. Cost, space and power demands require that network appliances are as effectively and efficiently utilized as their application server counterparts. While many high-speed, high-performance network appliances already make optimal use of the server resources available to them, there are a number of opportunities for network appliance consolidation that can be exploited, especially as we move to higher network speeds and ever more powerful physical servers. †

Dan Joe Barry is VP of Marketing at Napatech. For more information on Napatech visit [www.napatech.com](http://www.napatech.com).

# The Art of Interviewing for Your Blog



Writing a healthcare blog post on a regular basis is difficult. That's why I recommend to my clients that they create an editorial calendar and start slow. Forget about doing a daily a blog post—you'll burn out quickly and you'll hate blogging. Instead, start off with a weekly blog post and gradually build up to two posts per week, then three, and then maybe a daily blog post. Whatever you ultimately decide, make sure you write on a regular basis and on the same day of the week so your readers know when to expect new material.

That being said, there are times when you may be desperately seeking material for that upcoming blog post.

In this case, I always recommend that you reach out to your professional network and interview someone—an expert in their field. It can be as simple as a Q&A format, or it can be something that you just turn into a brief article. Below are tips I learned from journalism days, but they still apply to any healthcare blogger.

- **Be prepared:** research your topic first. Preparation allows you to ask good questions and signals your subject that you are not to be dismissed lightly. Read all that is available, such as Web sites and other articles. Talk to those who know the subject. A common ingredient of the superb interview is a knowledge of the subject so thorough that it creates a kind of intimacy between the journalist and the interviewee.

- **Find your sources.** If you can't find anyone in your professional network, try an online source like ProfNet or HARO.

- **Know the tentative theme** for your piece and determine how this interview will fit that theme. In other words, know what information you'll need from the source.

- **When you have answered those questions,** prepare a list of questions. The best way to have a spontaneous conversation is to have questions ready. That way you can relax, knowing that you will not miss an important topic.

- **Listen.** Look the subject in the eye and listen carefully to his/her answers. Be sure to smile. A smile helps both you and your subject relax. Think of your meeting with your source as a structured but friendly conversation, not an interview.

- **During the interview,** try to establish a rapport with the person early on. You may want to wait a bit before pulling your notebook out. This meeting stage may determine how the rest of the interview will go. Do you share a common interest or friend? If so, mention that. If you're chatting with them in person, when the source is speaking, nod or make some verbal remark to show you are listening and understand. Sit on the edge of your chair and lean forward. This is a posture that projects an eager, positive attitude.

Finally, here are some tips for formulating great interview questions:

- **Be sure to frame your question** without a bias towards one response

or another. Phrase your questions in a neutral way.

- Mix open-ended questions, such as, "Tell me about your love for antique cars," with closed-ended ones, such as, "How old are you?"
- The closed-ended ones elicit basic information; the open-ended allow the interviewee to reveal information or feelings that you did not anticipate.
- Long, complex, multi-part questions generally do not elicit very good information.
- The single best follow-up question one can ask: "What do you mean by that?"
- The second-best follow-up question: "Well, give me some examples." †

*Daniel Casciato is a full-time freelance writer. In addition to writing for the Western PA Hospital News, he's also a social media coach. For more information, visit [www.danielcasciato.com](http://www.danielcasciato.com), follow him on Twitter @danielcasciato, or friend him on Facebook ([facebook.com/danielcasciato](https://facebook.com/danielcasciato)).*

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# Local American Red Cross Blood Services Region CEO Recruited to Visit Chinese Blood Centers to Discuss Best Practices

By John A. Hagins

On the request of the American Red Cross and Association of Donor Recruitment Professionals (ADRP), this spring I presented lectures at six Chinese blood centers concerning donor recruitment best practices. In turn I experienced first-hand that while blood center operations differ between the two countries, the need for blood transcends all national and cultural barriers.

My itinerary included blood centers in Changsha, Guangzhou, Hangzhou, Jinan, Shijazhuang and Zhengzhou, all located in eastern China. The lecture series was planned by Caridian BCT, which sponsored the itinerary and was in response to feedback from Chinese blood center officials seeking assistance in improving their volunteer blood donor recruitment programs. In recent years China has transitioned from a paid to volunteer donor program. With double digit growth projected annually for the foreseeable future primarily due to increased access to healthcare and a corresponding increase in the number of surgeries and treatments that often require blood transfusions, Chinese blood centers realize that they must expand their recruitment efforts.

Blood centers in China are much more decentralized than in the United States. There are approximately 390 Chinese blood centers that function in a fairly independent manner, with local blood center directors, who are usually physicians, determining donor eligibility as well as collection, manufacturing and distribution standards. For example, a blood center in one province may permit individuals to donate blood four times a year while a center in a neighboring city but different province may permit someone to donate blood six times each year. Such differences mean that Chinese blood centers cannot share blood products across provincial boundaries, unlike U.S. blood centers which commonly share resources and follow the same blood collection regula-

tions.

In China, blood donors give 250 ml donations while in the United States most give twice that amount, or equivalent to a pint of blood. From a practical perspective, almost all blood collected in China is donated on buses. While we use such vehicles in the United States, the vast majority of donations are given at donor centers or onsite at businesses, schools, hospitals, churches and other community centers.

Although methods differ, blood donors in the U.S. and in China help to save lives. After visiting the first two blood centers, I had the weekend to explore Beijing and the surrounding area. With me were my interpreter, Jason, and a guide, Lee. As we were travelling to The Great Wall, Lee inquired as to what I did in the United States. When I told him I worked for a blood center, his face became animated.

Of course when you talk about blood anywhere there are always those who feel a little uneasy. In this case it was not unease but an understanding of the importance of having donated blood available. Lee explained that six months ago when his wife was giving birth to their child, things did not go well. She ended up losing a lot of blood and after the baby was born, she needed a blood transfusion.

Lee was astounded by the almost immediate impact the transfusion had on his wife's condition and after the transfusion she recovered nicely. He is so grateful that someone took the time to donate blood so that his family could be happily living together.

As I visited the six centers and listened to the struggles that the blood centers experience in recruiting blood donors, I realized how similar the experiences are to those in the United States. Overcoming lethargy, fear and very busy life schedules is a constant effort for blood centers in both China and the U.S. I think the



John Hagins outside the blood center.

important part is to recognize that there are people throughout the world who care enough to recruit, collect and process blood products to meet patient needs and there are millions of people who are willing to give of themselves, give their blood, to help a total stranger in need.

In coming years our region looks forward to additional opportunities to support and share with our peers in China. †

*John A. Hagins is the CEO of the American Red Cross, Greater Alleghenies Blood Services Region. An active member of the American Association of Blood Banks (AABB), Hagins has presented on multiple topics including quality of life for collections staff, managing recruitment activities and apheresis platelet donor recruitment and collection. Hagins served on the AABB donor recruitment/public relations committee and is past ADRP president.*



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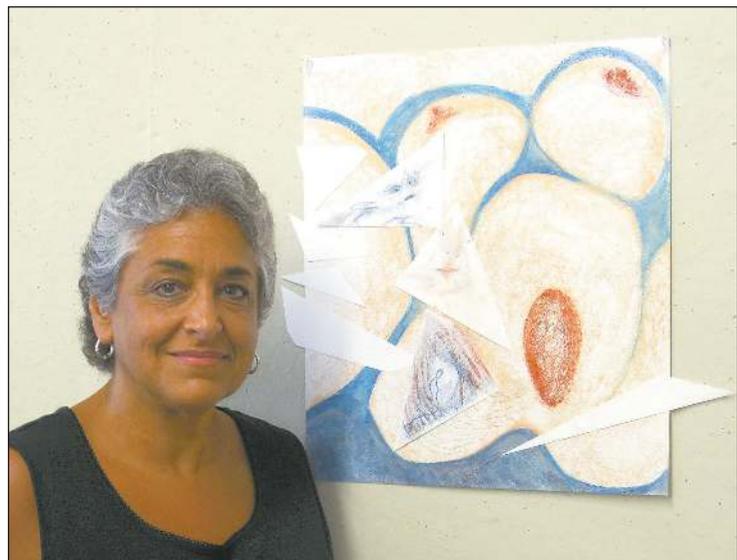
# Artists Among Us — Art Therapist Nina Denninger Discovers New Artistic Medium in Education

by Christopher Cussat

Nina Denninger is an incredibly grateful individual. This is because over 30 years ago, she found her life's passion (art therapy) and she has been gainfully employed in her profession ever since. Today, Denninger is an Associate Professor and Program Director of the Graduate Art Therapy Program at Seton Hill University.

"There is never a day when I wake in the morning and don't want to go to work," says Denninger, "Sometimes, when I am teaching or supervising students, I am amazed that I am getting paid to spend my time as I do."

Denninger is also a registered and board certified art therapist (ATR-BC) and a licensed professional counselor (LPC). "My specialization, I suppose, is art therapy education. I have directed undergraduate and graduate art therapy programs around the country (including Bowling Green State University, OH; California State University, Sacramento, CA; and Seton Hill University, PA)—and I have had the privilege and pleasure of training others to work with clients in diverse settings," she adds.



Years ago, her favorite artistic media were ink and stone. "I loved doing intricate pen and ink drawings and loved carving relatively soft stone." But over the years, Denninger has discovered that artistic expression can transcend paper, canvas, and

sculpture. "I like to think, however, that my most creative endeavor has been eliciting the hidden treasures that exist in the students I have taught!"

Denninger believes that she was drawn to stone work, art therapy, and education at a very young age—and she has even discovered an interconnection among them. She explains, "As a child I was deeply, deeply moved by the film, 'The Miracle Worker.' I was fascinated by Anne Sullivan's capacity to see all the potential that existed in Helen Keller, and her desire and ability to bring Helen out of her isolation and into her selfhood." Denninger feels that this process was similar to the work she did with stone—eliciting the form that was hidden within. "In retrospect, I can appreciate how that has been the motivating 'gestalt' of most of my life's activity. For years, I have been 'educing' and honing the hidden talents and compassion in my students."

Like many of those whom we profile in this series, Denninger also has found it difficult to find time to create her own artistry while balancing the demands of her professional obligations. "I don't [find that balance], unfortunately—at least not in terms of working with traditional art materials. As the director of a graduate art therapy program, I have a broad range of administrative responsibilities. In addition

to teaching and supervising interns, that prevents me from having long periods of time in which to pursue concepts in artistic media."

But Denninger has realized the intrinsic artistic value that lies in molding new artistic students. "As I mentioned earlier, much of my artistic and creative endeavor takes the form of honing the skills required to elicit the talents, skills, and empathy that reside in the students I train."

As far as she is concerned though, Denninger has found balance at least in her career, and she does not think that she is missing out on anything by not being a "full-time artist." She explains, "I feel my artistic interest is already manifested as a career in my current health-related profession. This is the wonderful marriage between art and psychology that makes art therapy so fascinating and aesthetically satisfying."

In fact, when asked if she would ever consider devoting herself to developing her art for the purpose of exhibition or sale, Denninger answers, "Probably not." She adds, "I was drawn to the field of art therapy because in art therapy, art products are not treated in the same way they are in most other art-related professions. Exhibition of artwork made in art therapy is possible, but making art for display or consumption by others is not the goal."

Denninger concludes that art therapy (and other expressive therapies) is vital to healthcare because they engage people in various forms of self-expression that can transcend the normal defenses we put up in the course of everyday life. "Expressive therapies tap into imaginal realms and enable people to experience deep personal transformation without necessarily having to verbalize their experiences. So although I rarely have time to personally pursue art making in any depth, my life has been devoted to getting others to spend time making, exploring, and enriching their own creative processes—and this has been immensely satisfying." †



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# Coffee and Cancer

By Nick Jacobs



Several years ago at the Clinical Breast Care Project's offsite retreat with the physicians from Walter Reed Army Medical Center, our biomedical informatics group had prepared a demonstration for the Scientific Advisory Board, a group of distinguished scientists, breast cancer consultants and physicians from the United States and Canada.

As the 7PM meeting time approached, it was obvious that there was not going to be a quorum present to start the formal meeting. The two additional members had called in and we sat waiting patiently for the remainder of

this august body to join us; fifteen minutes passed, then twenty and finally at about 7:25 PM the group burst apologetically into the conference room to begin the call.

In case you're wondering what would have caused such a delayed response from an otherwise very prompt group of individuals, it was the introduction provided by the biomedical informatics group of how this data repository's capabilities could be explored. The advisory group was so captivated by the power of this tool that they literally became lost in the excitement of the demonstration.

This form of science was fascinating to me because, having trillions of pieces of data available from thousands of women allowed the queries to be guided by the data itself. When this power was coupled with the normal questioning generated by the intellectual curiosity of the individual scientists, outcomes were beyond fascinating.

For example, you could ask the question, "How many of you drink coffee?" The thousands of participants whose biopsies both malignant and benign were being stored in the tissue repository at our research institute had agreed to answer over 500 demographic questions relating to their very personal and now anonymous lives. A graph appeared showing the proportion of women who were coffee drinkers. When I then asked, "How many cups a day do you drink?" a new graph appeared with that information as well. My final question was, "How many of you were diagnosed with breast cancer?" This resulted in an interesting fusion of information. The women who consumed the most coffee had the least amount of breast cancer. Of course that general assumption needed to be researched, confirmed and proven in numerous ways, but there it was way back in about 2005.

A report that touched on this topic was released during the second week of May, and it was fascinating. (<http://app1.kuhf.org/articles/npr1305726381-Coffee-May-Lower-Risk-Of-Deadliest--Prostate-Cancer.html>)

"It was a Harvard study that followed almost 50,000 male health professionals for more than two decades. Over 5,000 of the participants got prostate cancer - 642 of them the most lethal form. "For the men who drank the most coffee, their risk of getting this bad form of prostate cancer was about 60 percent lower compared to the men who drank almost no coffee at all," says Lorelei Mucci, an epidemiologist at the Harvard School of Public Health and an author of the study. The same group reported about a 50 percent reduced risk of dying from prostate cancer among men who took two or three brisk walks a week. As a part of our funding, similar studies performed by the Preventative Medicine Research Institute under the direction of Dr Dean Ornish also confirmed this exercise theory of risk reduction for prostate cancer.

The new study shows that getting a 60 percent reduction in risk of aggressive prostate cancer requires at least six cups a day. However, men who drank three cups a day had a 30 percent lower chance of getting a lethal prostate cancer, and that's not bad. Earlier research suggests coffee reduces the risk of diabetes, liver disease and Parkinson's.

But here is best part of this story—Just last week, Swedish researchers reported that women who drink at least five cups of coffee a day have nearly a 60 percent lower risk of a particularly aggressive breast cancer that doesn't respond to estrogen.

Mucci says more research is needed before officially urging people to drink coffee for its health benefits. Meanwhile, she says, "there's no reason not to start drinking coffee."

So all of these years later the National Cancer Institute is using about 200 of these CPCP biopsies from that same tissue repository to map the Human Breast Cancer Genome, and everyday new reports are emerging that confirm the value of this research. All of this from a little coal mining town in Western Pennsylvania three seconds in air miles from where Flight 93 went down. Now that's a story. †

Nick Jacobs, international director for SunStone Consulting, LLC, is known as an innovator and advocate for patient centered care. With 22 years in health care management, he is author of the health care book, "Taking the Hell out of Healthcare" and the humor book, "You Hold Em. I'll Bite Em." Read his blog at [healinghospitals.com](http://healinghospitals.com).

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## Landau Building Company Announces New Hire



Phil Dorenkott

Landau Building Company recently announce that Phil Dorenkott has joined the company to perform business development. He joins Landau Building Company after spending over twenty-five years with USG Corporation in various sales and marketing roles. Most recently, Dorenkott was the Architectural Services Representative for USG Building Systems with responsibilities for commercial ceiling and drywall systems. He is a graduate of Miami University and earned an MBA from the University of Pittsburgh.

Learn more at [www.landau-bldg.com](http://www.landau-bldg.com). †



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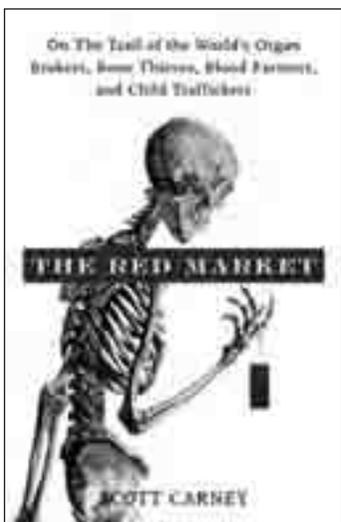
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# “The Red Market” by Scott Carney

c.2011, William Morrow \$25.99 / \$27.99 Canada 254 pages



This week, you gave away part of yourself. But that’s just what we do, isn’t it? There’s a need somewhere, and we roll up our sleeves to donate blood. We see children with cancer, and we cut our hair to give them. Some people go further with kidneys or bone marrow.

Even in death, you can donate.

It seems like a good way of saving lives: you give, someone else gets. But author Scott Carney says there’s much more to it than that. In his new book “The Red Market”, he shows the dark, hidden side of medical altruism.

Following completion of a graduate program at a Wisconsin college, Scott Carney’s “short-lived professional academic career” abruptly halted with the death of one of his students who was

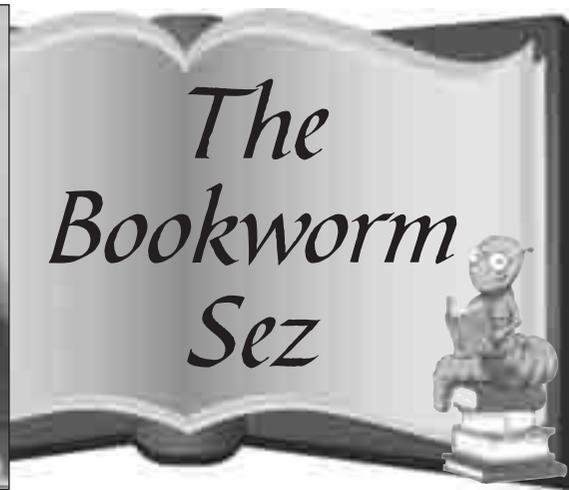
studying abroad in India. Taking responsibility for her remains, Carney “confronted the physical nature of mortality,” which forced him to see that “every corpse has a stakeholder.”

In many cases, though, the stakeholders are varied and the body isn’t dead. India, as it turns out, is a major world hub for what Carney calls a “Red Market” in which human organs become big-money commodities, despite social taboos.

We like to believe that altruism begets organ donations. Here, we freely give blood, sticker our driver’s licenses, and sign up for registries, but there is no such thing as altruism in the Red Market. “Donor” is a misnomer.

Take kidneys, for example: in India, entire towns are filled with people who’ve been promised the equivalent of several months’ salary in exchange for kidneys, which are then sold to desperate buyers with the means to pay the price, usually a fraction of the cost of a kidney transplant back home.

Making families is a big business, too, and Carney uncovered sordid truths about in-vitro fertilization, surrogacy, and foreign adoptions. He looked into skele-



tal remains, their thefts, and their use in American medical schools. He recalls his college days, and a brief stint as a human guinea pig. He writes about the world’s blood supply, its constant state of “low”, and the hidden danger that could mean to your health.

Don’t let anybody ever tell you that you’re worthless. After reading “The Red Market”, you’ll know that’s not true.

Author Scott Carney warns readers early that some of what he writes about is disturbing, and he’s right. It’s hard to consider humans as commodities, difficult to think of women as little more than incubators, and horrifying to read about crimes committed in the name of money. Carney tells us about things we’d just as soon not think about.

In the end, he makes no bones about a solution to the Red Market but it, too, is controversial. Still, he says, though other scholars have come to the same conclusion, it “... won’t solve every problem.”

If you’re mindful of your health and want to stay abreast of global issues that might affect you, this is a book you’ll want to read. With “The Red Market,” being informed won’t cost an arm and a leg. †

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

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# Collaborating to Improve Nutrition and Support Local Agricultural Communities

By Steve Ronstrom

In 2008, Sacred Heart Hospital in Eau Claire, Wisconsin, decided to buy more local food to enhance patient safety, food quality and secure a regional supply chain. As we extended our commitment, we discovered that additional benefits to public health and the local economy aligned well with the Franciscan mission of the Hospital Sisters Health System. The program keeps dollars in the community, creates jobs and supports family farms and sustainable agriculture. Plus, humanely-raised meat and organic produce is more nutritious, tastes better, has a longer shelf life and requires less energy to transport.

In July 2008, we at Sacred Heart Hospital pledged to spend 10 percent of our annual food budget to purchase local food. In November 2010, we raised that amount to 15 percent, and by enlisting other institutions to the cause, the goal of creating a sustainable local food economy became within reach.

## OVERCOMING BARRIERS

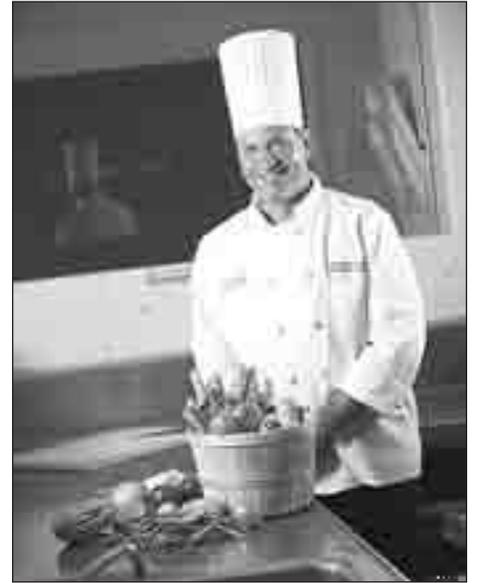
At the outset, challenges were numerous. Local infrastructure for processing and distributing food for institutional use no longer existed because of competition from national firms. In addition, local producers and institutional consumers were unfamiliar with each other's needs, and were not prepared to deliver fresh food on a regular schedule in the portion-controlled sizes required to meet hospital dietary guidelines. Cost was also an issue. Ensuring producers enough profit to sustain locally produced food meant we might pay up to 20 percent more.

To address the logistical and technical issues, we helped to create the Producers and Buyers Co-op, a multi-stakeholder cooperative that links local farms with institutions in western Wisconsin. The Co-op was developed in collaboration with local farmers, and received support from state, federal and private grants. It also received significant technical support from River Country Resource Conservation and Development Council, a non-profit trusted in our local agricultural communi-

ty.

Launched in March 2009, the Co-op became the vehicle by which members of the entire supply chain could schedule production in advance and organize the buying and selling of products. It has resulted in producers delivering portions sized by processors to meet strict hospital culinary and dietary guidelines. Producers are also able to prepare ground beef and pork products in forms that institutional kitchens, such as the one at our hospital, can handle efficiently. The Co-op also helps ensure producers and processors comply with safety regulations and adhere to specified organic produce and human animal standards.

As the local food project gained momentum, cost has become less an issue. The Co-op helped producers find markets for prime cuts of meat that organizations, like hospitals, can't use. Also, employees and visitors to Sacred Heart's cafeteria are happy to pay 35 cents more for an entrée of locally produced food, because they know their purchases are helping to support our local economy. We estimate the net cost for the program is about \$20,000 annually, but about \$15,000 is offset by increasing prices to cafeteria patrons.



Sacred Heart Hospital located in western Wisconsin decided to take a look at their organization and see how they could reduce, reuse and recycle.



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## LEADERSHIP SUPPORT – AN ESSENTIAL INGREDIENT

Developing a local food-buying network requires changes in institutional food service operations and may entail additional costs. Support from the hospital's board of directors and senior leadership is essential to free up resources and time to make and maintain operations. With our Franciscan mission and recognition of the importance of creating a stable buyer to allow local farmers to increase production, we made the initial pledge to spend \$200,000 annually on local food.

The financial commitment from Sacred Heart was essential to create stable demand for local products. This, in turn, made it possible for local producers and processors to make the long-term investments to increase production. The result was a local food network that has moved more than \$177,000 in vegetables, beef, pork, bison and poultry from 18 producers and four processors to three institutional buyers in its first year. The Co-op is well on its way to tripling that figure in 2011 and 2012.

## BENEFITS TO BUYING LOCAL

Developing a Co-op for a buy local program was essential to help support and expand our local economy in western Wisconsin. Because of support, several farms and processors have substantially expanded production, hired new help and entered new markets as a direct result of the program. A processing plant that shut down years ago has reopened due to an increased demand for business.

The return on investment is difficult to quantify, but buying local creates substantial goodwill in the community and generates a type of "social capital." Furthermore, the project ties businesses and larger institutions in the community together and creates new opportunities to collaborate.

While there were some hiccups along the way, we stayed true to what we believed and were able to help our community prosper through a buy-local program and the development of the Co-op. I encourage other hospitals to think about the benefits of developing such a program in their region. We'd be happy to help answer any questions along the way. †

*Steve Ronstrom is CEO of Sacred Heart Hospital. For more information, please visit*

## Regulatory and Customer Demands Present Business Associates with Opportunity to Add Strategic Value

By **Scott A. Rogerson**



Firms providing support and assistance to healthcare organizations often enter into debate with their customers as to whether they and their offerings fall into the definition of a business associate and therefore require execution of a Business Associate Agreement (BAA) or Business Associate Contract (BAC).

In many cases, the answer is clear. According to the Health Insurance Portability and Accountability Act (HIPAA), a business associate is "a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information (PHI) on behalf of, or provides services to, a covered entity" (45 CFR

160.103). The regulation provides some examples of this relationship such as a firm providing claims processing services to a hospital, a CPA or attorney that requires access to PHI to provide their services, independent transcription services, and others. However, exceptions to this relationship also exist and include the two most commonly cited: the exception of disclosures by an entity to a health care provider for treatment of the individual and disclosures that are incidental when services provided do not involve the use or disclosure of PHI (45 CFR 164.502(e)).

In many cases, the wording provided by the regulation is clear, and the thought exercise to determine the relationships a health care provider has with supporting individuals or organizations can be easily accomplished. However, the continued adoption of electronic medical record technology and emphasis on quality and efficiency has placed PHI on the doorstep of many organizations that have never before had to consider their own ability to safeguard this data.

One such example is the evolution of the role of medical devices in the healthcare setting. Once "dumb" machines responsible for performing a very specified task, these devices have now become smarter, providing integration into the provider's network and transmission of critical information, along with PHI, to the organization's electronic medical record (EMR) or other systems such as the picture archiving and communication system (PACS).

With these devices gaining intelligence, their manufacturers must provide assistance to the provider to support and service the product periodically. Whether this service is provided on-site or remotely, there is an inherent risk of exposure and potential breach of PHI. But does this warrant the creation of a BAA?

From a strictly regulatory perspective, the manufacturer could argue, perhaps con-

vincingly, that support of their products does not explicitly require access to PHI, and therefore, they are no different than hiring an outside janitorial service. Manufacturers may also contest that when they do provide support and troubleshooting services they are, in fact, functioning as a health care provider in the treatment of a patient. The amount of water these arguments hold depends on the individual and the situation; however, in many cases, providers are preempting the sales process related to these devices with a request that the device manufacturer enter into a BAA regardless of their role as it relates to PHI.

This "hyper-sensitivity" is understandable as providers look to mitigate their own risk exposure. It often launches the provider and manufacturer into a relationship-damaging legal battle over the definition of a business associate and how it relates to their products and services. Frequently, these battles begin before the salesperson ever has the opportunity to demonstrate the value of the product in the context of their environment.

While device manufacturers have always considered the security and privacy controls implemented as part of the product's design to be a value-add to the customer, it has only been in the last few years that some of the leading device manufacturers have worked to move the business associate argument into the same light. While these manufacturers may continue to hold the legal opinion that they do not fall under the business associate definition, they view it of strategic value to ensure that not only does their device conform to the technical safeguards outlined in HIPAA, but their own procedures for providing support and service to their customers comply with the administrative, physical, and technical safeguards as well. This allows the salesperson to quickly bypass the business associate discussion by emphasizing the additional value provided by the manufacturer in safeguarding the information of their patients while building trust between the two individuals and organizations, a core element of good security and privacy practices and at the heart of the current regulations.

These cooperative relationships also enable the manufacturer to continue to innovate and expand its offerings as the devices more closely integrate with the provider's systems. With so much focus on regulation, many of us often lose sight of opportunities to review and revise our organization's policies, procedures, and system configurations to not only better safeguard the security and privacy of PHI, but also increase the efficiency and effectiveness of our processes and prepare ourselves for future growth.

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*Cura chefs and Sherwood Oaks residents pose for the camera after a lively Iron Chef-style competition at the community in February 2011.*

## Two" Big to Fail in Health Care? Are You Up for a Challenge?



By John D. Laslavic

Working for The Hospital Council of Western Pennsylvania for 18 years starting in 1981 and with other providers over the last 30 years, I have watched the landscape change, grow and integrate and the consolidation of the hospital and health care markets in Western Pennsylvania and in other markets across the United States of America. From cost reimbursement to prospective payment to the new government health care laws that were just passed by the national government. All are trying to get it right.

While some hospitals and health care organizations have been very financially successful by gaining economies of scale and adopting best practices, others have faced tremendous financial struggles. Some have joined large integrated health care delivery systems while others have remained steadfast in their desire for their community independence. Some of these moves were excellent and needed. Others were caused by bad behaviors of leaders; you may even recall (e.g. AHERF), that set in motion the opportunity for the consolidation to accelerate.

As a business development company, ThistleSea Business Development works with business owners of all types of companies including medical and health care providers and their employees every day. Having my 30 years of business background and involvement in the business of health care provides me with a unique perspective and, over the years, the privilege of meeting some of the best and most caring health care executives, medical professionals and dedicated employees leading and running the institutions we all rely on for the provision of our communities' health care.

Some of the strong values and tenants of many fine people who were the true defenders of a strong and skillful community-based local medical and health care delivery system still hold true today. Let me share some of these with you below:

- There is a great need for good and affordable health care!
- Learn how to build rapport first, because people do business with those they



know, like and trust!

- Move forward with a cooperative spirit! It truly is not all about you!
- If you're in charge provide strong leadership but bring some humility to your game. Arrogance and pride puts you in a situation where you will not learn.
- Do not take advantage of your position.
- Health care is local, happens locally & not in an ivory tower!
- To really know what's really going on, you must be in the health care setting, that's where care is happening!
- Remember health care involves everyone and just about everything that is made so seek and adopt best business practices because it is critically important for the lives of the individuals and families we serve to get it right.
- Not-for-Profit needs surplus to operate; it is important, as one of the good Catholic Sisters always said, "No money means; no mission". Good leadership provides good financial stewardship.
- Not-for-Profit means that profits (i.e. surplus) don't inure to any one individual or group of individuals, whatever way you cut it!
- Remember who pays your salary, pays your bills and provides you with your security! Serve them well.
- Remember who does the work, provides the care and makes it happen – treat them with dignity and respect.
- Enjoy your work, have an attitude of service, work hard and have fun!

We have seen the decay and demise of institutions on Wall Street that have failed to recognize the long-term commitment to their markets and customers for power and short-term gain. For many reasons these powerful institutions seem to lack the leadership's ability to use their power for the benefit of their customers.

While we find that one in the business of health care and every business for that matter strives for a dominate position in the marketplace, these leaders must also remember and continue to recognize that health care is a bit different. We should strive to provide a variety of health care options for the people in our communities.

It's the businesses, business owners and employees that that pay for the care through their sweat and hard work of their labor and the taxes they pay; let's recognize them as the customer. Are we asking them what they truly need, desire and want? A great quote:

*"No one ever said when a photographer enters the forest, that there's only one great photo in here for one photographer! God said, bring lots of film because I am going to bring it on!"*

Dewitt Jones, National Geographic Photographer & Inspirational Speaker

If we all work together, I know with strong leadership and the talent in the medical and health care delivery systems, we can get it right for all our communities and citizens. It will just take cooperation, humility and caring more for the community our ultimate customer.

Let's leave our medical and health care system better than we inherited it. Are you up to the challenge? †

John D. Laslavic, LPBC, is president of ThistleSea Business Development, LLC. For more information, visit <http://thistlesea.com>.

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# Spend Less, Get More with Five Steps to True Integrated Marketing



By David M. Mastovich

What do healthcare leaders typically think when they are asked to commit more resources to messaging and selling?

While those in the field talk about disciplines like Marketing, Public Relations, Communications and Advertising, decision makers tend to lump them all together and ask:

- Do we really need to do that?
- How much is this going to cost me?
- How will we know if it is working or not?
- Isn't (Insert name of person or department) responsible for that?

## FOCUS ON MARKETING ROI NEEDED

Marketing and messaging professionals passionately explain why their recommendations are vital to the organization. However, they often do not focus enough on the Return on Investment in terms CEO's and CFO's are accustomed to hearing and end up without the buy in necessary for success.

Healthcare leaders also tend to lose patience with multiple departments or vendors (PR, Marketing, Corporate Communications, etc.) that rarely communicate with each other as well as they should. Each function or area sees things in their own biased way.

Sales/Marketing thinks they're king because they bring in the business. Others find them arrogant and demanding. Advertising sees themselves as cool and full of big ideas. Others see them as full of something else. PR talks about framing the message while other departments wonder what they really do. The list could go on and on. The end result is senior leaders perceive these areas as inefficient cost centers with overlapping, duplicative efforts.

Healthcare organizations talk about getting these departments to work together more but become frustrated with mixed results attributed to the type of work and workers involved. Phrases like "You know those creative people," or "He's a marketing guy, they're different," are used to explain it away.

How can your organization overcome this vicious cycle of frustration?

## FIVE STEPS TO INTEGRATION

Senior leaders need to champion the idea of creating a true integrated marketing and PR program and then focus on these five strategic initiatives to make it happen:

1. Develop mutually agreed upon target markets that the organization's messaging and selling efforts will focus on. Drill down each target audience into manageable

segments then make sure each department knows and agrees on the target markets. For example, Sales/Marketing often overlooks the importance of employees as a key target market while Corporate Communications sees this group as vital. Advertising focuses so much on the creative message that they sometimes neglect the tactical components of the campaign. Clearly communicating the specifics about each market segment is the first step toward successful integration.

2. Find out what each target market wants by asking them, through multiple channels. While engaging a market research firm is the most formal of research methods, don't overlook other ways to learn about target markets. Your Sales/Marketing team can ask customers and prospects what they think and track results. Corporate Communications should be able to easily survey employees. Your methodology doesn't have to be perfect. The key takeaway is you should ask your customers, internal and external, what they think and act accordingly.

3. Develop a consistent message and require each department to live by it. Be vigilant about message integrity and consistency but also be flexible. For example, your sales team isn't going to use the slogan from your advertising all the time. Tweak the messaging accordingly for each target market but ensure that the overall theme and key message points are still being conveyed. Consider secret shopping so that you are more aware of what your customers are really seeing and hearing.

4. Work with each department or vendor on clearly defining their goals and the market forces that impact their ability to achieve those goals. Develop a summary of each department or vendor's specific roles and their strengths. Then, convey these key points to everyone involved. The goal is to increase the level of understanding and respect across functions.

5. Instill a Corporate-Wide Marketing ROI focus. Challenge your marketing and messaging professionals to provide rationale in terms of Marketing ROI Success Metrics. Ask them to work in conjunction with Finance to build the metrics. Then, report the success metrics to leaders and managers throughout the organization. The more everyone understands the marketing, selling and messaging goals and processes, the better.

Developing a true Integrated Marketing, PR and Selling program doesn't just happen. But once you invest the time and effort, you will reap the benefits of a positive Marketing ROI. †

*David M. Mastovich, MBA, is the president of MASSolutions, a Pittsburgh based Strategic Marketing firm that focuses on improving the bottom line for client companies through creative marketing, selling, messaging and customer experience enhancement. For more information, visit [www.massolutions.biz](http://www.massolutions.biz).*

# Five Ways To Tell If Your Company's CEO Earns His/Her Pay

Dr. Linda Henman isn't as concerned about CEOs getting paid large salaries as much as she is about them being worth it.

CEOs earned an average annual paycheck of \$11 million in 2010, with pay soaring by an average of 23 percent last year, according to research released by the AFL-CIO in April. As the economy's sluggish recovery has analysts worried, Henman, a consultant for Fortune 500 CEOs, believes that company top dogs who actually earn their money are easy to spot.

"Those at the top have three major responsibilities: Develop the business, grow talent, and make decisions that drive innovation," said Henman, also author of *Landing in the Executive Chair: How to Excel in the Hot Seat* ([www.careerpress.com](http://www.careerpress.com)). "There is much shuffling at the top. Too often Boards don't make wise decisions about CEOs and CFOs, and these executives, in turn, don't make wise hiring decisions throughout the enterprise. But if leaders do a better job, companies can do a better job, which means individuals can do a better job. These leaders create companies where customers want to do business and people can do their best work. That all leads to financial health on the micro level, which translates to better financial health for the country. That's why I think it's important for people to understand if their CEO evidences the ability to soar above the competition, because in the end, only the strong will survive."

## HENMAN'S TOP QUALITIES OF A GOOD CEO INCLUDE:

● **Strategy** – Strong strategic thinking defines the effective CEO. These leaders understand how to match a strong strategy with the tactics and talent to see it through. CEOs who constantly react to events, instead of planning for the future, remain followers and not leaders.

● **Decisions** – When CEOs consistently make good decisions, little else matters; when they make bad decisions, *nothing* else matters. Even though decisiveness distinguishes leaders from everyone else, effective decision-making stands at the center of executive leadership. A decisive CEO who can't hit the target is the same as an indecisive CEO who doesn't even know where to find it. The results are the same.

● **Hiring** – Successful CEOs know how to tie talent to their strategies so they

ensures the company hires the best and the brightest and compensates them fairly. Moreover, they give these people a chance to thrive.

● **Excellence** – Leaders who attract and retain top talent stress excellence. They focus on good execution of plans and strategies, and they don't skew the mission by placing value on tertiary issues that have little to do with execution of strategic goals.

● **Results Orientation** – Too many executives talk about how to motivate the troops. Those who excel in the hot seat do better. They hire people who are self-motivated, define clear objectives, hold people accountable, and then they get out of the way. Couple these practices with challenging, rewarding work, and the organization ends up with both better results and motivated employees.

"It all comes down to leadership, as opposed to management," Henman added. "Managers come in all different flavors: good, bad, neutral, ineffective, overbearing, innocuous, and more. But true leaders, by definition, move people to perform at levels that allow them to beat the competition. Moreover, leadership doesn't necessarily come with a title or a status. Responsibility and accountability come with that title, but leading requires the ability to take people to places they wouldn't have gone if you hadn't been in the picture. Leaders who possess this ability offer golden opportunities for their organizations and the people who work in them; those who don't simply hope for a good golden parachute." †

*Dr. Linda Henman holds a Ph.D. in organizational systems, two Master of Arts degrees in both interpersonal communication and organization development, and a Bachelor of Science degree in communication. For more than 30 years, she has helped executives in military organizations, small businesses, and Fortune 500 Companies define their direction and select the best people to put their strategies in motion. She has helped clients in the retail, financial services, food, medical, hospitality, manufacturing, and technology industries. Some of her major clients include Tyson Foods, Emerson Electric, Kraft Foods, Boeing Aircraft, Estee Lauder, and Merrill Lynch. She was one of eight experts chosen to work directly with John Tyson on his succession plan after his company's acquisition of International Beef Products, one of the most successful mergers of the 21st Century.*

# Managing the Revenue Cycle: Ten Areas for Improvement



By Tony Ryzinski

As we enter the second decade of the 21st century, medical practices face a host of financial challenges. The unknowns of health care reform, changing reimbursement and rising bad debt from the uninsured have introduced a multitude of pressures and uncertainties. Whether your practice aims to maintain physician compensation at desired levels, keep up with overhead expenses or invest in new technologies, the critical factor for success is efficient management of the revenue cycle.

The revenue cycle comprises the numerous tasks of the billing and collection process — namely, gathering and entering data about professional services rendered, and ensuring that bills are paid in full. Think of the medical practice's revenue cycle as a wheel. The spokes are the critical functions of the billing and collection process. Each function has several key touch points, often in the form of tasks, that practice staff or providers must perform. Unless each function is performed effectively, the wheel will fail to turn. If it stops for too long, the business will collapse. These critical billing and collection functions and their related touch points with providers and staff include:

**Contracting with insurers:** Managing and monitoring reimbursement agreements with government and private payers.

**Eliciting and processing patient information:** Scheduling and confirming appointments as well as referrals, registering patients in the practice management system, verifying insurance, obtaining pre-authorizations for treatment, and other tasks.

**Capturing charges:** Logging all services provided to patients, correctly coding services, providing required documentation and other tasks.

**Billing:** Producing and submitting claims to payers and sending statements to patients.

**Processing payments:** Posting payments, handling denials by insurers, and adjudicating accounts.

**Handling accounts receivable:** Monitoring performance and resolving or appealing payer denials.

**Managing collections:** Determining and collecting what patients owe, administering financial policies and receiving payments.

For each function and related touch point, a medical practice establishes and assigns the administrative functions that must be performed. Unfortunately, many medical practices do not take firm control over each of these many wheel spokes. Opportunities to interact with patients and payers are missed and, as a result, the revenue cycle does not operate at peak efficiency.

While dozens of steps can speed up the revenue cycle and avoid missed collections opportunities, here are the 10 most common prospects for improvements. These will, in the long run, produce accurate and compliant billing and ensure that your practice collects what its physicians have earned.

## 1. RECOGNIZE WHERE THE CYCLE STARTS

The revenue cycle starts as soon as the practice defines the terms of its relationship with an insurer — or the practice's policy regarding patients who have no health care coverage. When the patient makes contact with your practice, the revenue cycle wheel begins to turn. The cycle's beginning includes stating the practice's financial expectations, collecting from patients without insurance and verifying insurance coverage and benefits from those who do.

Medical practices historically viewed their billing offices as wholly separate units from the day-to-day activities of scheduling, registering, arriving and treating patients. This perspective comes from a time when practices routinely waited months for payment after providers rendered medical services. This state of affairs is no longer tenable in today's fast-paced financial world, an environment where medical practices'

profit margins have grown ever narrower due to falling reimbursement and rising practice costs.

Operating an efficient revenue cycle requires practice wide buy-in to the following principles:

- **Defining** — and knowing — the terms of insurance contracts and establishing an appropriate but strict policy for patients without insurance.

- **Involving** everyone in the practice in the revenue cycle — clinicians, as well as administrative staff — not just the billing office staff.

- **Ensuring** the accuracy of each data element about the patient — demographic, insurance and other information.

- Recognizing that the process of getting paid starts before the patient walks in the door.

Promote a broader appreciation of this final point — the process of getting paid starts before the patient walks in the door — by requesting schedulers to describe the practice's payment expectations to patients at the time they make appointments. Require them also to reiterate these expectations in appointment-reminder phone calls. Finally, mandate that time-of-service collection is a core function of front-office staff.

Developing a shared vision of where the revenue cycle begins and recognizing that everyone contributes to its success is the first important step toward a successful outcome.

## 2. FOCUS ON ACCURACY

An efficient revenue cycle results in faster throughput, but that does not mean haste. To ensure speed and accuracy, focus attention equally on improving the precision of the data submitted by clinical, administrative and billing office staff.

## 3. SUBMIT CLAIMS DAILY

Send claims to payers as soon as they are ready. Use software or clearinghouse services to help identify problems in any denied claims so that corrected claims can be resubmitted as soon as possible. Send billing statements promptly to patients who don't have insurance or who are covered by an insurer with which the practice does not participate.

Don't mail statements only once a week, a protocol that just adds more days to your receivables. By sending statements throughout the week, you spread out telephone calls from patients who have questions about their bills. This bit of forethought allows managers to structure staff in accordance with anticipated work flow.

## 4. EMPLOY TECHNOLOGY

As insurance deductibles, co-payments and out-of-pocket costs continue to rise, a front office employee who knows how to obtain accurate information about patient financial responsibility is a tremendous asset. However, employees' efforts to request time-of-service payments require the support of both information technology and operational design. For example, appointment schedulers should be able to quickly research patient balances and take credit card payments by phone.

Deploy technology appropriately, and don't overlook staff training. A stellar practice management system can't form the basis of an efficient billing office if employees don't know how to use it.

Using technology wisely also includes:

- Verifying patients' insurance coverage, benefits eligibility and financial responsibility automatically before services are rendered.

- Pre-loading protocols based on coding and payer reimbursement guidelines to electronically scrub claims before submission.

- Transmitting claims electronically.

- Automating secondary claims submission.

- Posting payments electronically through electronic remittance and funds transfer, rather than hand-keying.

- Using remote deposit services so payments go into the practice's accounts as soon as possible, not just once a day or, worse, at the end of the week.

Other technology that can improve the billing process includes online bill payment, computerized payment monitoring and automated, credit card-based payment plans.

## 5. STAY CURRENT

When it comes to billing and collections in health care, rules seem to have been created just to change. Many claims denials and lost billing opportunities occur because medical practices do not set aside a little time each year to track the annual changes made to the CPT®, HCPCS and ICD-9 coding systems. Each annual Medicare fee schedule also brings a host of new rules for covered services and reimbursement.

Medical practices can turn to myriad resources to stay up to date. National specialty societies scrupulously track coding and regulatory changes that affect their members, and most publish newsletters and e-mail alerts about rule changes. To track updates at a local level, tap into state medical societies and professional associations for billers, coders and practice managers. Payers' websites also can provide useful information about changes in payment policies, patient eligibility and other information critical to efficient revenue cycle management.

Practices using paper charge tickets must be sure to revise them each year based on the annual updates by the American Medical Association to CPT codes. An electronic

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