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THE REGION'S MONTHLY HEALTHCARE NEWSPAPER

2007 A LOOK AHEAD

Jacqueline Dunbar-Jacob

Expanding the Role of Nurse Practitioners

BY JACQUELINE DUNBAR-JACOB, PHD, RN, FAAN

I applaud Governor Rendell's recent initiative to expand the role of nurse practitioners, allowing them to practice to the full extent of their educational preparation, and improving patients' access to quality healthcare in Pennsylvania.

In a variety of health care settings, from hospitals to home care, nurse practitioners already perform many of the same functions as physicians. They administer vaccinations, order and interpret diagnostic tests, prescribe medications and perform other tasks related to routine care. Even in critical care, nurse practitioners have taken on duties in the domain of medical residents.

Currently, Pennsylvania regulations restrict nurse practitioners in their performance, while 23 other states are so advanced that they allow nurse practitioners to practice independently of physicians.

Governor Rendell's plan not only could maximize nurse practitioners' contributions to health care in Pennsylvania, but it also will make great strides toward implementing a simple tactic that may

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ACMS Set to Tackle Change Under Dr. Gopal's Leadership

BY RON PAGLIA

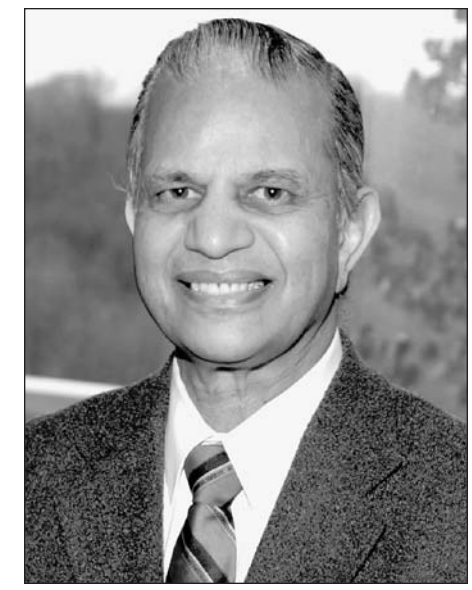
Years ago, when he first began practicing medicine in the United States, Krishnan A. Gopal, M.D., FACS was, by his own admission, "rather naive" about the politics of his profession.

"Like most physicians, I was concerned about my work, about taking care of my patients," Dr. Gopal said. "But I soon realized you can't stay outside the loop to get things done. You have to work from within."

That theory, buoyed by some four decades of experience, will help guide Dr. Gopal as president of the Allegheny County Medical Society this year.

While his term began January 1, Dr. Gopal formally assumes the duties as the 142nd president of ACMS at the group's traditional inauguration dinner January 27 at the Westin Convention Center and Hotel. He succeeds Terence W. Starz, M.D., in the top leadership post and has an ambitious agenda of business topped by topics such as change and accountability for the 3,500 members of the ACMS.

"There are, as the saying goes, only two things that we can count on in life, death and taxes," Dr. Gopal, a native of India, said. "But we must add another factor, especially in our profession, and that is change. It evolves every day and affects the way we practice medicine and care for our patients."



Dr. Krishnan A. Gopal

Dr. Gopal, a surgeon specializing in colon, rectal and gastrointestinal surgery, said he decided to confront change early in his career.

"I volunteered to be an ACMS delegate to the Pennsylvania Medical

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2007 Brings Both Challenges and Opportunities to Healthcare Organizations

BY PATRICIA RAFFAELE

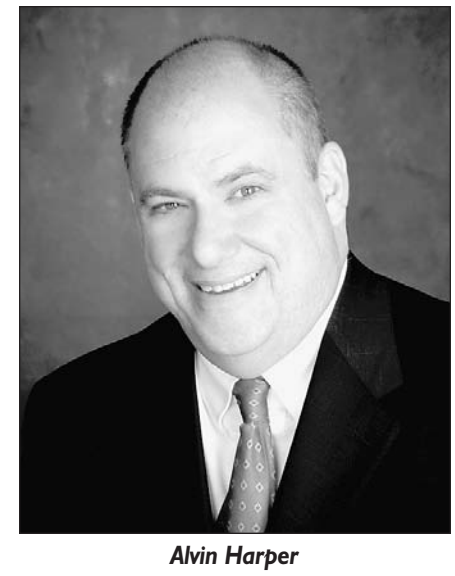
Pay for performance, the reporting of clinical and financial data (transparency), revision to the state Medical Assistance program, assuring western Pennsylvania's fair share of Medicare reimbursement, advancing the paperless exchange of clinical and financial data as well as workforce issues will be on the agenda of healthcare providers in 2007, according to Alvin (A.J.) Harper, president of Hospital Council of Western Pennsylvania (Hospital Council.)

In addition, the new year will begin with a new plan for the delivery and payment of healthcare in Pennsylvania as Governor Edward Rendell is set to unveil his healthcare reform strategy in February. It is anticipated that some form of universal health coverage and the elimination of hospital-acquired infections will be detailed in the plan.

"The Pay for Performance (P4P) concept will continue to gain momentum in 2007," Harper said. "thus it is critical that providers, payers, and employers understand and agree as to what P4P is. Our member institutions are committed to continual performance improvement, however determining how and what to measure and report requires a collaborative effort."

Along with the trend to improve the quality of care through infection prevention and other initiatives, is the trend of health care organizations becoming more transparent in the reporting of quality and financial information to the public.

Depending on the employer or the payer, providers may be asked to collect outcome data on mortality, morbidity, and readmission. "When looking at outcomes, the discussion immediately turns to accounting for the patient's severity of illness. Trying to



Alvin Harper

measure severity of illness from claims data is rather limiting, and collection of clinical data elements from the medical

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Publishers Note... By Harvey D. Kart

What's the Hurry?

It might sound odd for someone who publishes a newspaper to say this but, for at least the past four weeks, I haven't taken the papers delivered to my home out of the plastic sleeves in which they arrived. There's a nice pile of them, looking almost like a stockpile of firewood, in a corner of my home.

Each day, as I walk past them, I feel a little twinge of guilt. But not for the reason you might guess.

See, in this information overload world we live in, I find myself increasingly relying on the Internet to provide all the news I need each day. In other words, I trust someone else – someone I'm sure I've never met – to decide what should be important to me.

Okay, I guess you could argue that the same is true with a newspaper. After all, some editor or collection of editors has to pick the news from so much that is going on in the world and fit it onto the number of pages made available, mostly by advertisers. But at least there is a greater quantity from which to choose, with some effort to include items of limited interest.

I don't know how I got into this habit of deferring my choice to another. In fact, this whole concept rubs against my personal belief system. For example, I don't like a lot of seasoning on my food; consequently, something that irritates me in a restaurant is allowing the chef to decide how much salt, pepper or anything else should be added. (This, as you can imagine, makes me a preferred customer at most of my regular eateries. Not.)

Anyway, just as I don't want to miss the natural taste of a steak, I really don't like having my news prioritized, filtered, sliced, diced, or otherwise manipulated. And every day that I opt to go online rather than get newspaper ink on my fingers, I feel a little regret. Maybe it's a generational thing, but it just doesn't feel right. Again, I publish a newspaper, so take this with a grain of salt. (I don't usually like to use clichés, but that one seemed appropriate given my earlier food analogy.)

But if taken to its local conclusion, this trend could mean the elimination of newspapers and I think that would be tragic.

And it doesn't stop there. Another past practice that seems to be giving way to technology gone wild is the face-to-face time individuals used to spend with their physicians. In the good ol' days – and, again, it's at least in part a generational thing – we talked to a doctor about a health issue. We may not always adhere to the advice we received, but we listened.

Now, in too many instances, we visit the Internet first. Then, despite all the warnings about the reliability of much of the information we find there, we often self-diagnose. Bowing in part to the adage "If you can't beat 'em, join 'em," many physicians and health organizations are creating online services to at least preliminarily diagnose and direct patients who cannot or simply choose not to schedule an appointment and sit in a waiting room.

This is not all bad, of course. But, to paraphrase Simon and Garfunkel, "Slow down, (perhaps) you move too fast." Maybe it's me, but there seems to be more to reading a newspaper than just absorbing information. There's also a tactile, even emotional connection to the act of holding a newspaper in your hands and moving through it at the pace of your choosing. It's akin to eating what we now call comfort food: just about anything digestible will end hunger, but only certain things can fill your heart and soul as well as your stomach.

The same is true of the chemistry that occurs between individuals when one happens to be a physician. Even if we program a computer to deliver a diagnosis with empathy – "You are dying Mr. Jones; I am sorry" – it is never going to be the same as hearing it from another human being.

Harvey D. Kart

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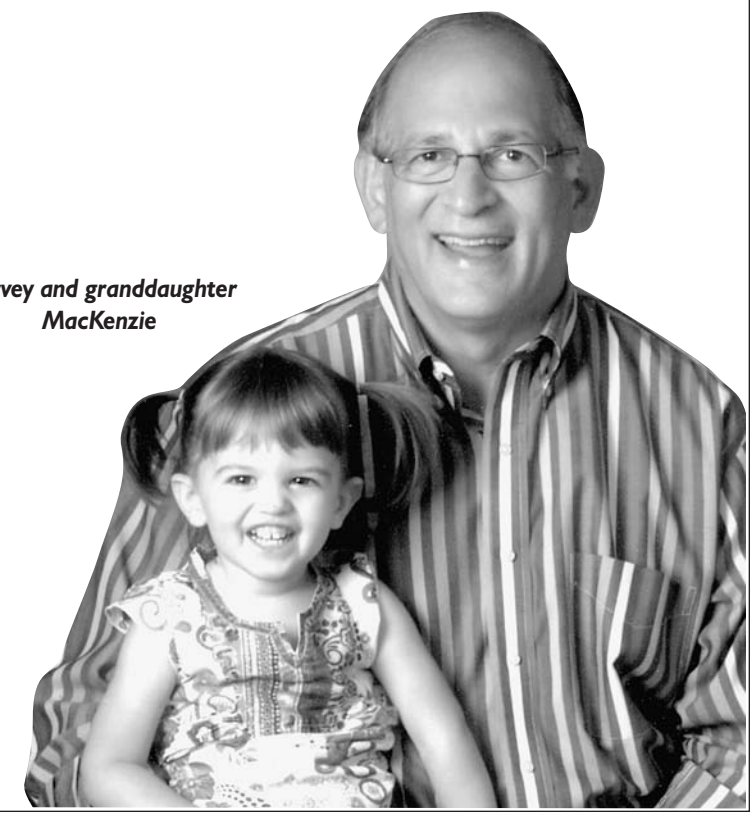

Harvey and granddaughter MacKenzie

West Penn Hospital
Achieves Prestigious Magnet Recognition For Excellence in Nursing

The Western Pennsylvania Hospital is the first hospital in Pittsburgh and the first in Western Pennsylvania to achieve the coveted **Magnet designation from the American Nurses Credentialing Center.** On par with winning an Olympic gold medal, Magnet recognition status is one of the highest honors a hospital can receive for excellence in nursing.

West Penn is now among fewer than 3 percent of the world's healthcare facilities awarded the prestigious Magnet designation, which is diligently sought by hospitals throughout the country. Research shows that Magnet hospitals consistently provide high quality care and outperform other facilities in recruiting and retaining high caliber nurses, physicians, and other employees.

Magnet designation means that West Penn Hospital nurses are among the best of the best. It recognizes the outstanding work they do each day and reflects their dedication to providing the highest quality of care for our patients and their families.

West Penn is proud to be a Magnet hospital. We are proud of our exceptional nurses, physicians, and entire staff. Earning Magnet recognition status is a distinguished honor that reaffirms and amplifies our core values and commitment to excellence. It further validates that our patients are the focus of everything we do.

THE WESTERN PENNSYLVANIA HOSPITAL

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Commentary

Financial Winners and Losers Among Hospitals

BY CLIFF SHANNON

Employers who sponsor job-based health insurance coverage can be forgiven for lacking interest in hospitals' financial circumstances. Employers are understandably preoccupied with rising health insurance premiums and the effects on their businesses and employees. Nevertheless, deteriorating hospital finances are directly relevant to health insurance affordability and access to health care services.

Taken as a whole, the financial health of Pennsylvania's general acute care hospitals improved in FY05. Netting out the numbers for all institutions in our state, hospitals' total operating margins rose from $506 million in FY04 to $981 million in FY05. This increased profitability was underpinned by average revenue growth of 7.4%, versus operating expense growth of just 5.7% (only two times the rate of inflation!).

But this apparently rosy picture is deceptive. Just five of the state's 176 general acute care hospitals accounted for one-half of all hospital profits. The most profitable hospital in our state, UPMC Presbyterian-Shadyside, chalked up FY05 net income of $150 million, or nearly one-fifth of all hospital profits.

Our state's consistently profitable hospitals are a literal handful of urban facilities that can spend freely on new buildings, seven-figure physician salaries, the latest high-tech equipment, and lavish advertising campaigns. They are the dominant hospitals in their respective urban market areas and command significantly higher payments from commercial insurers than competing hospitals. Also, their patient populations are comprised of relatively fewer Medicare beneficiaries and uninsured people, which is key because Medicare generally pays hospitals significantly less than it costs to deliver services, and uninsured people generally can't pay much or anything.

In contrast, the large majority of Pennsylvania hospitals either eked out small profits last year or lost money. Pennsylvania's "have-not" hospitals include 59 that have lost money during the past three years. Among these three-year losers, 56 are small-medium community hospitals. These hospitals' patient populations include disproportionately more Medicare beneficiaries and uninsured -- i.e., more patients on which it is impossible for the hospitals to break even. Have-not facilities are fighting a losing struggle: to afford expensive new technology, to raise capital for needed bricks-and-mortar improvements, to keep up with skyrocketing medical malpractice insurance premiums, and to pay the rapidly escalating salaries commanded by physician specialists and other short-supply health care professionals.

Rich, dominant hospitals can't be faulted for playing financial hardball according to the existing rules. But recent years' rural hospital closings are harbingers of what is to come for affected communities unless steps are taken in Harrisburg and Washington, D.C. to save community hospitals from rapidly deteriorating financial and competitive circumstances.

Medicare underpayments to hospitals are a huge problem. If a majority of a hospital's patients are Medicare beneficiaries (and this is the case for many community hospitals), and Medicare pays, on average, only 70 cents for every dollar of care costs, it is impossible for the affected hospitals to make ends meet. A fix for this problem must come from Washington, D.C., where, thus far, a succession of Presidents and Congresses have postponed Medicare's bankruptcy by promising full benefits but paying providers only a fraction of what it costs to deliver on those promises. Employers that provide job-based health care benefits should demand an end to this federal deception – because hospitals and other health care providers offset their losses on Medicare by charging commercially insured patients an average of 15-20% more.

But state government has an important role to play, too. Governor Rendell's health care reform plans will come up short if they don't address community hospitals' financial crisis. For starters, our state government should use the financial leverage of billions spent annually on Medicaid, state-subsidized health care programs, and taxpayer-financed health care benefits for state employees in order to make a more level playing field among competing hospitals and assure the survival of threatened community hospitals.

The governor should appoint a special commission that includes representatives from community hospitals, commercial insurers, and key state agencies in order to develop a rescue plan for the dozens of community hospitals that are in acute financial distress and a long-range strategy to preserve access to essential health care services for the people of affected, largely rural communities.

Such moves would be bound to raise concerns among the most profitable hospitals and health care systems. But consider the effects of trimming UPMC Presbyterian-Shadyside's $150 million profit by $50 million and distributing that money among two-dozen or so financially ailing western Pennsylvania hospitals. By any standard, UPMC Health System would still be a rich organization, and Presbyterian-Shadyside would still be the most profitable hospital in our state. But $50 million would be a huge boost for the economic and health care security of the residents of scores of communities and dozens of counties that are in danger of losing local access to local hospital services.

Cliff Shannon is president of SMC Business Councils, a trade association representing small businesses headquartered in Pittsburgh with a branch office in Harrisburg, PA. He can be reached via e-mail, cliff@smc.org.

Commentary

Why Must Successful Health Professions Programs End?

BY JOHN E. PRESCOTT, M.D.

Unless Congress acts quickly, West Virginia and the nation will lose – perhaps forever – two effective programs that bring quality health care to residents of rural areas and to minority communities.

The federal budget for 2007 will set national priorities through its funding decisions. Congress is on track to eliminate both the Health Careers Opportunity Program (HCOP) and Centers of Excellence (COE) from Title VII funding.

HCOP offers high school students laboratory research experiences and pre-college science enrichment courses, as well as mentoring, peer support, and advising. COEs nurture and mentor the students who participate in these programs to ensure that they enter the health professions workforce.

These programs prepare minority and disadvantaged students for medical school or other health professions training. In West Virginia, this often means financially disadvantaged students, students who are the first in their families to go to college, and rural students who don't ordinarily think of health professions.

At West Virginia University, we have worked with more than 650 young people in these programs. The results are truly amazing: 84% have successfully graduated from college or are on track towards graduation. At least 143 have successfully graduated in health professions or allied health programs, and are now ready to serve.

West Virginia did not depend solely on Federal dollars to create opportunities for these students. Our state took bold steps in the 90's to invest in our future health care. We are seeing great results. State and privately-funded programs, like the Health Sciences and Technology Academy, have helped us identify promising students early and give them encouragement and resources to succeed. We have been recognized nationally for our efforts, and for the partnerships that we have built among our health schools, our communities and our state government.

Across the country, HCOP and the COEs have helped 500,000 aspiring health professionals. A study published recently in the Journal of the American Medical Association found that HCOP participants were three times more likely to enter medical school than non-participants. A recent survey conducted by the Association of American Medical Colleges found that without Title VII funds, 83 percent of HCOP and COE programs will shut down, opening large gaps in the fragile medical education pipeline.

But we have not yet solved our health problems. People in rural communities, members of ethnic and racial minorities, and people with economic problems have far more health problems, and far less access to care, than most Americans. Shortages of health professionals are more acute in these areas, and may grow more urgent as the population ages. We desperately need to encourage young people, particularly from the communities most in need, to prepare themselves for challenging careers in health care.

Without programs such as Title VII that seek to reach out to all well-prepared aspiring doctors, our physician workforce will not reflect the nation's growing diversity. Eliminating federal support for Title VII is a step in the wrong direction. Reinstituting Title VII funding will revive these crucial programs, which have been instrumental in preparing rural, low-income and minority students for careers in medicine.

John E. Prescott, M.D., Dean, WVU School of Medicine, can be reached at 304-293-6607.

The Executive Edge

Do We Know Everything About Healing?

BY NICK JACOBS

Is it possible that we do not know everything there is to know about healing and health? In 1974 my neighbor asked me to help him with a piece of concrete that had been dislocated by the winter's frosts. We both bent over, lifted the 250 lb. slab, and his instructions were to drop it into place on the count of three. Well, at the count of three I glanced and saw his foot still firmly planted under the concrete. He had planned to pull it out. I didn't realize that, and held onto the concrete. I then could not stand up straight, and was bent like the letter L. Clearly, something had happened to my young year old back.

My neighbor carefully placed me into the front seat of his car, drove me straight to the emergency room, and the treatment began. First an x-ray where the physician asked if I had ever been a professional football player. When I had stopped laughing, I wiped the tears away from my eyes, and said, "Nope, but thanks." We can't miss the nuance of what occurred next. Muscle relaxants and the threat of what has been described as traction resulted in nothing, absolutely nothing. I couldn't walk, couldn't sit, couldn't stand, and felt as if a long hot knife was stuck in my back.

Two weeks later another friend saw me struggling to walk, put me in his car and drove me to a physician's office. This was a doctor that I was not familiar with, but he was pleasant, took my blood pressure, suggested that I have a Martini every night before dinner, looked at my feet and said, "Oh, this is simple, your sacro is out." He pulled on my right foot and said, "Okay, we're done here." I stood up and felt fine.

He was a DO, a doctor of osteopathic medicine who had been trained in manipulation. Although I was a teacher at the time, it seemed perfectly clear to me that medical professionals with varying views on treatments don't necessarily talk much.

In 1997 when I became the CEO of a hospital, my first decision was to become a Planetree Hospital and to create a menu of options for our patients. Because I am not clinical or medical, nothing was particularly sacred to me. My only concern was that our patients got better, and that we didn't fill our halls with quacks and unqualified tricksters.

Consequently, we introduced many aspects of complementary and alternative medicine, but the difference at our facility was that we used only medical professionals to deliver those modalities. We opened our patient rooms to accommodate family members 24 hours a day, seven days a week. We placed double beds in our OB suites. We employed musicians, aroma and massage therapists. Our therapy dogs are there for the asking.

The concept is to provide a healing environment. The concept is to allow certified accupuncturists, manipulation trained DO's, PT's, OT's and others to provide those treatments chosen by our patients. The United States citizens are spending billions of dollars each year on these treatments, and many times they are administered by uncertified individuals.

It is my desire to give our patient partners choices. If they get better because their loved one is permitted to stay with them around the clock, or if a dog's love moves them back to health, it doesn't really matter to me. Just so they get better.

We use a very strenuous allied health professional credentialing process to approve these clinical specialists. We take medicine very seriously, and we pay out more than a million dollars each year on general liability and malpractice insurance but have paid out, on average, less than $20,000 a year for all claims in these areas because, if you treat people as partners, not patients, if you treat them with kindness and love, and if you don't make them leave their dignity at the door, they will be your partner. If you create a healing environment void of negative energy, mean employees and limited access to their loved ones, they will heal.

As a consumer, does it make you wonder why we all aren't embracing this philosophy?

Nick Jacobs, currently president of Windber Medical Center and Windber Research Institute is currently writing a book,"Who Put the Heal in Healthcare" and will be a regular contributor to this publication. Nick can be reached at jacobsfn@aol.com or visit windbercare.com.

Write Us! If you would like to submit a commentary for publication in *Hospital News,* email your submission to hdkart@aol.com

Customer Service: *Why Can't Mr. Goodman's Example Help Us In Healthcare*

BY JAN JENNINGS

My childhood was centered in a working class bedroom community near Pittsburgh and just outside of McKeesport, Pennsylvania. McKeesport was a typical Western Pennsylvania mill town. U. S. Steel was booming, and the centerpiece was the U. S. Steel National Tube Works.

Saturday was a big day for us. We would go shopping in McKeesport. It was a mysterious and exciting experience with dozens of foreign languages being spoken on every corner of Fifth Avenue. My parents were both born on peanut farms in Virginia. This was all very strange to them as well.

There were all kinds of stores, and the city was bustling in the 1950's. There was one store that was first among equals, at least for my family. It was the Goodman's Jewelry Store. It was a family business, and the senior Mr. Goodman, through my ten-year-old eyes, was probably 200 years old. He had a very serious looking and craggy face. But could he dress. To this day I always think of him as the best dressed man I ever saw.

This store was special to our family. Somehow the Goodman's learned and remembered our names, all of our names. They were patient as my Mother looked over all of the wonderful items we could never afford. The Goodman's had a kind and gentle spirit and found a way to steer my parents to items they both wanted and could afford. Occasionally, one of my parents would purchase something for the other that was a little over our heads. Mr. Goodman would escort one of my parents to a corner glass case, and he would fill out a slip and put their purchase on a monthly payment plan. They never asked for a social security number, references, employer information, banking relationships, net worth, prior income tax filings or distinguishable birthmarks. There was no credit card or charge plate like some of the other stores, and they would mail a monthly bill which my parents would pay promptly. My parents respected the owners of the Goodman's Jewelry Store because they were always treated with kindness and respect any time they visited the store, in good times and in bad.

It is interesting that sometimes we noticed that the Goodman's did not agree with one another about one thing or another. We have no idea what these little snits were about because they maintained them in the privacy of speaking Yiddish. Their desire and commitment to exclude their customers from their internal disagreements was both fascinating and appreciated. They were always tougher on each other than they were on us . . . their treasured customers.

Although an unusual item for a jewelry store, in 1959, my parents bought me my first electric typewriter at Goodman's. It came with a gray steel typing stand, and I used it faithfully for ten years until I graduated from college. My love for writing down my thoughts originated with that little typewriter.

There were Sunday afternoon drives when we would drive through the better neighborhoods of McKeesport and became familiar with the location of the Goodman home. It was a beautiful place, modest by today's standards. It is clear to me now that the Goodman's did not get rich serving that community, but they were always first to contribute to the local schools, police and fire departments and countless other local charities. They were Jewish, and we were Christian. It did not matter to them, and it did not matter to us.

In 1968 I asked a woman to marry me, and, to my surprise, she said yes. Like a homing pigeon, I and my prospective fiancé and bride-to-be headed for the Goodman's Jewelry Store. Everyone in the Goodman family seemed older, and, sadly, the patriarch of the family had passed. To my delight, one of the Goodman brothers remembered me and spent hours with us selecting a diamond and a setting. He showed us examples of cloudy diamonds, flawed stones and provided more information about diamonds than I knew existed. In the end, we bought an engagement ring. When it was time to pay, Mr. Goodman pulled me aside and told me he would extend the same credit arrangements that he had always extended to my father and mother.

Healthcare leaders could learn a lot from the Goodman family. Here are several ideas:

• Remember that it is important to know your patients and families, physicians, board members, auxilians, volunteers and other internal stakeholders. There is no substitute for sincere, honest and face-to-face communication.

• The demonstration of civility and good manners is like throwing a "note in a bottle" into the ocean. It always comes back to enrich the life of someone.

• The internal problems of the hospital or health system should be maintained in private. I am not suggesting a crash course in Yiddish. I am suggesting that it makes stakeholders uncomfortable to see the leadership team of the hospital or health system throwing sand on each other.

• Knowing your programs and services is important. Mr. Goodman's commanding knowledge about diamonds was an important lesson. I have been with hospital CEO's who cannot take an outside guest on a tour because they do not know where anything is . . . honest!

• Pricing programs and services and review of the charge master should be used as a strategic and tactical tool, not an assignment of drudgery. Mr. Goodman used discounts artfully. With his varied pricing strategies he built interest in his business, expanded his market share and bonded loyal customers.

• Seize new programs and services on an opportunistic basis. Mr. Goodman foresaw that the "baby boomers" would be better educated than their parents. His early jump into electric typewriters was a masterstroke. In our consulting practice, we frequently see opportunities for the hospital to meet unfulfilled needs in the community; e.g., diabetic teaching programs and hypertension screening, among others. While these are wonderful opportunities for the hospital, the impact is far greater on the citizens of the community being served.

• The appearance of any organization and its people matters. If you need a hospital and use a rest room that is dirty, the floors look terrible and the hospital personnel are attired like a "rag tag army," it does not inspire confidence in a place that will control whether you live or die.

• Community service is important. I do not know the inner recesses of Mr. Goodman's heart, but his sense of duty and service to McKeesport brought him respect that reflected well on him and his business.

• Integrity matters. Mr. Goodman's name and reputation was his most valuable asset. He nurtured and protected that asset by his predictable business practices. Many hospitals are equally vigilant regarding transparency and corporate compliance; some could learn from Mr. Goodman.

• Consistent fulfillment of commitments will lead to trust, brand name equity and repeat business.

These ten lessons should not be lost on healthcare executives. I wish Mr. Goodman were alive today to read this. I would rather he be alive so I could visit with him and get to know him better. His example meant a lot to me, and I hope it is helpful to you.

Jan Jennings, President and CEO, American Healthcare Solutions, can be reached at JJennings@americanhs.com or visit www.JanJennings.blogspot.com.

Things I'll Never Do Again When Applying for a Job

This new era of dog-eat-dog competition, where every organization is looking to get the upper hand on its competitors through whatever means available, is not restricted to the business of products and services. Increasingly, individuals looking for employment, whether it is their first job or they have extensive experience, find the competition extremely keen. As a result, some job seekers, in the name of competition, find it difficult to resist the temptation to "fudge" on their credentials or take liberties with their experience.

Reuters reports that tahe background search firm ADP Screening and Selection Services found that more than 50 percent of the people on whom it conducted employment and education checks in one recent year had submitted false information. As a result, most employers have deployed counter measures aimed at "smoking out" guilty parties by either checking for themselves or hiring professional services to verify candidates' credentials and other information provided during the interview process.

So let's look at some of the common mistakes candidates make in trying to "get over" on a prospective employer.

"I have worked for Acme Healthcare from June 2000 to Present". Exaggerating dates of employment is the #1 lie perpetrated by job applicants. Thinking, for example, that you can hide a gap in employment by listing your date of hire as June 2000 instead of November 2000 is easily exposed. Among the information former and current employers will typically verify is dates of employment, so don't be so quick to try to get by with this one. Lying on an application or resume is grounds for disqualification from consideration or termination of employment if discovered post-hire.

"I have an M.B.A. from Stanford". This is something that most of us wish we could put on our resume. However, the Stanford M.B.A. crowd is an elite group. If you have a B.A. from Stanford or an M.B.A. from Northeast Southwest Louisiana Tech, you are best off to tell it like it is. Again, more and more employers are checking on academic credentials of applicants and this fib is easy to uncover. And getting caught could mean the end of a promising job opportunity.

"I was an assistant administrator for Sunnyside Convalescent Manor". Well, you got part of it right! In reality, you were the administrative assistant but you sure feel like you did the work of an assistant administrator so you think you are entitled to anoint yourself as one. Embellishing job titles may seem innocent, but it is far from harmless. It has become such a common practice for applicants to exaggerate job titles that employers are on to this practice like nobody's business. Resist the temptation of run the risk of being eliminated from consideration for a "little white lie" because there are no "little white lies" these days.

"I was laid off from my last job due to downsizing". Because downsizing, rightsizing or whatever other term of art businesses use for cutting people loose has become so common these days, employees who have been terminated for poor performance, absenteeism, or other "willful misconduct" increasingly think they can successfully hide behind the downsizing veil. While this may have been true in previous times, applicants are less likely to get away with it in today's environment where employers tend to leave no stone unturned when checking on prospective hires. You are playing with fire when you fudge about the reason for termination. You may get away with it during the interview process but what are you going to do when someone you previously worked with who now works with the firm that just hired you tells the boss you were canned for disciplinary reasons?

"I am currently making $65,000 a year". So what if you are really only making $55,000 a year. As the saying goes, "what's a couple of bucks among friends?" The prospective employer will never know. And how are you going to make what you believe you are really worth if all you are offered by the prospective employer is a modest increase over your current pay? So you puff up your current salary, like so many other applicants, and think there's no harm in doing so. Little do you know that you may be committing fraud.

"No, I have never been convicted of a crime other than a misdemeanor or summary offense". Every employment application is likely to contain a question about prior criminal convictions. It is not a good idea to develop amnesia when it comes time to answer this question. Honesty is the best policy. If you try to skate by because you think the offense is too old to be discovered or too "innocent" to be considered relevant, you are taking a huge risk. Criminal background checks are mandated for many healthcare occupations these days and where they are not, healthcare organizations are likely to be doing them just the same. Why? Because no employer wants to face the question of why it hired the person with the DUI record as its van driver or why it hired the person convicted of larceny in the finance department.

So next time "a friend" tells you about that little white lie they told on the employment application or in the interview, remind them to play it smart and tell it like it is. Nothing good can come from embellishing the truth.

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Are Charge Nurses Supervisors?
The NLRB has Finally Spoken

BY JOHN E. LYNCHESKI, ESQ.
AND FLOYD A. CLUTTER, ESQ.

In a just-released trilogy of decisions – known as the Kentucky River cases – the National Labor Relations Board ("NLRB" or "Board") finally responded to a 2001 Supreme Court directive by providing employers with long-awaited guidance regarding whether charge nurses, and their similarly-situated counterparts in other industries, are "supervisors" or "employees" under the National Labor Relations Act ("NLRA" or "Act"). The distinction is critical because the NLRA effectively divides the workforce into "teams": supervisors, who are on management's team; and employees, who have the right to form, join and assist unions and to engage in other collective and concerted activities even when a union is not in the picture.

For an individual to be classified as a supervisor (or on management's team) for purposes of the Act, the individual must meet the requirements of NLRA Section 2(11):

… any individual having authority in the interest of the employer, to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward or discipline other employees or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment. (Emphasis added)

Accordingly, individuals are supervisors if (i) they have the authority to exercise (or effectively recommend) one of the twelve designated supervisory functions, including the authority to "assign" or "responsibly … direct" employees; (ii) their exercise of such authority "requires the use of independent judgment;" and (iii) the authority is held "in the interest of the employer." Prior to the Kentucky River decisions, the NLRB applied overly restrictive definitions of "assign," "responsibly direct" and "independent judgment" -- particularly in cases involving individuals who possess professional or technical knowledge and training, and most particularly as to charge nurses.

As a result, many individuals who directed and assigned employees were classified as non-supervisors by the NLRB. On the other hand, individuals with non-professional, non-technical knowledge and training, who exercised a comparable degree of independent judgment to carry out any of the ten other supervisory functions, typically were found to be supervisors. The Kentucky River decisions eliminate these unwarranted distinctions.

In the lead case of the trilogy, Oakwood Healthcare, which involved charge nurses in an acute care hospital, the NLRB finally clarified what it means to "assign" or "responsibly … direct" other employees using "independent judgment" as contemplated by Section 2(11) of the NLRA. Specifically, the NLRB defined "assign" as "the act of designating an employee to a place (such as a location, department, or wing), appointing an employee to a time (such as a shift or overtime period), or giving significant overall duties … to an employee."

Thus, assigning encompasses a charge nurse's responsibility to assign other nursing personnel to particular patients. With respect to the supervisory function "responsibly to direct," the Board held that "the focus is on whether the alleged supervisor is held fully accountable and 'responsible' for the performance and work product of the employees [s/]he directs." In this regard, the putative supervisor must have the authority to direct the work and to take corrective action, if necessary, and must also bear the prospect of adverse consequences for any failures.

Finally, the NLRB responded to the Supreme Court's directive in Kentucky River to assess independent judgment based on the degree -- not kind -- of discretion exercised by retiring its long-standing position that individuals who exercise a Section 2(11) function using a substantial degree of discretion do not exercise "independent judgment" if the judgment implicates "ordinary professional or technical judgment in directing less-skilled employees to deliver services."

However, the degree of discretion must nevertheless rise above merely "routine or clerical" judgment. Pursuant to these standards, assignments requiring an assessment of and match between patient or resident needs and staff competencies are indicative of supervisory status. In contrast, assignments made in accordance with the seniority provisions in a collective bargaining agreement or as set forth in staffing or procedure manuals do not entail independent judgment.

In the companion cases, the Board applied the criteria announced in Oakwood to determine the status of nursing home charge nurses and manufacturing "lead persons" in Golden Crest Healthcare and Croft Metals, Inc., respectively. The net effect of these decisions is that the Board will no longer routinely refuse to recognize the supervisory status of individuals who use "independent judgment" to "assign" and/or "responsibly … direct" other employees. In particular, the NLRB will not interpret "independent judgment" as excluding the exercise of "ordinary professional or technical judgment in directing less skilled employees to deliver services" -- an exclusion which, fairly consistently in the past, had been used to arbitrarily find numerous "supervisors" in the healthcare industry to be employees and not members of management.

These refined definitions will be applied to a backlog of pending cases, most of them involving healthcare employers, and supervisory status will be determined on a case-by-case, person-by-person basis upon the facts and circumstances in each employment situation.

As a result, before becoming involved in an NLRB proceeding, all employers along the entire spectrum of healthcare are well-advised to use the guidance in these holdings to reconsider the status of personnel who assign and direct other employees but who do not possess greater authority, and to take affirmative steps to address the status and authority of such individuals. This determination can be particularly critical if a facility becomes the subject of a union organizing drive. It will also have an impact on the composition of existing bargaining units because certain individuals, including many nursing personnel, may now be properly classified as supervisors.

However, despite the NLRB's painstaking effort to provide clear standards and numerous examples, determining whether a particular individual is a supervisor will nevertheless require a factually-intense inquiry and experienced judgment on a case-by-case and, at times, person-by-person, basis. And the stakes could not be higher.

Put simply, accurate determinations and the formulation of an appropriate strategy will be imperative to successfully respond to future union organizing campaigns and resolve the composition of existing bargaining units. But the time to act is now – before a dispute arises. Otherwise, the NLRB will get to decide who is, and who is not, on your team – like it or not.

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The Fifteen Commandments for Discharging Employees

PART II

BY LAURA A. CANDRIS

Last month we discussed a hospital or healthcare institution's inherent risk of being sued when discharging an employee. By following the 15 commandments for discharging employees, hospitals can help reduce the risk that a claim will be filed and/or increase the likelihood that a claim, once filed, will be disposed of quickly. The first seven commandments appeared in last month's article.

In this second installment, we take a look at the eight remaining commandments and focus on the steps to take once a decision has been made to discharge an employee.

1. **HAVE THE DECISION REVIEWED.** If possible, insist that all discharge decisions be approved by the decision-maker's superior and the hospital or healthcare institution's human resources professional. If your healthcare institution does not have a human resources professional, review the decision with the healthcare facility's employment law attorney. The cost of the 15 minutes you spend in having that review may save the thousands of dollars you will spend if a claim is filed.
2. **ACT ONLY FOR SOUND BUSINESS REASONS.** If you are reviewing someone else's recommendation, question the possible motivations of a supervisor or of employees who are accusing the employee of misconduct or poor performance. Question whether the real reason might be personal or unlawful. Look for patterns of negative treatment of employees in protected classes. Look for inappropriate written or oral comments by the decision-maker. Look for any recent protected activity.
3. **BE HONEST.** When you discharge an employee, give the real reason(s). Either exaggerating the problem or giving a reason that you think is less likely to offend the employee will make it very difficult to win if a claim is filed.
4. **HAVE A MANAGEMENT WITNESS.** Whenever possible, have another manager or personnel representative present at the meeting with the employee to inform him/her of the discharge decision.
5. **DON'T MAKE THREATS.** Don't threaten to file civil or criminal charges against an employee or to take other negative actions, like denying references. Additionally, don't actually take such actions without consulting legal counsel.
6. **PUT IT IN WRITING.** Take the time to prepare an accurate letter or notice to the employee confirming his/her discharge for the reasons you discussed. Write this notice or letter carefully. It is the first thing a lawyer or government agency will ask to see. Stick to the facts, i.e., describe the problem, describe the efforts made to give the employee a second chance and describe what happened thereafter.
7. **FULFILL YOUR OBLIGATIONS.** Pay the employee any wages and for any fringe benefits earned before the discharge. Fulfill any other obligations to the employee, such as, insurance conversion or COBRA rights.
8. **KEEP IT QUIET.** Don't set yourself up for a libel or slander claim. Limit your discussions of employees' problems or reasons for discharge to those who have a genuine need to know.

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Looking into the Health Care Crystal Ball

BY MARK A. PIASIO, MD, MBA

Governor Rendell hinted to it in mid-December during his end-of-the-year press conference in Harrisburg. And, all signals clearly demonstrate that healthcare will be a major discussion in 2007.

For many months now, the Governor's Office, and in particular his Office of Health Care Reform, has been meeting with various stakeholders including hospitals, doctors, nurses, business, lawyers, and others. Many anticipate a public report in January that will paint a picture of what the Governor envisions for the future of health care in Pennsylvania.

And, don't be surprised if the Governor's health care dreams are met with both cheers and jeers, depending where you fall on an issue.

But, as the Pennsylvania Medical Society pointed out in 2006 through its State of Medicine Report, a conversation on health care delivery and finance is long overdue.

Think about it. Is anyone happy with the current state of health care? Health insurance is becoming prohibitively expensive. The number of uninsured, or those without access, is unacceptable. Health care professionals are having more difficulty keeping up with escalating practice costs. And patients are becoming more frustrated every day

Last year, the Pennsylvania Medical Society released its first ever State of Medicine Report. Without rushing to judgment, pointing fingers, or drawing conclusions, the state medical society collected data and then reported upon the data to identify trends. The trends identified were disturbing and upsetting to many. Trust me. I had many tell me they didn't like what the data reported. It raised some tough questions about issues like physician supply and the future of health care.

As far as 2007 goes, we know that health care reform is near and necessary. And, as health care professionals, we all must play an active role. When reforming our current system, we'll need to answer many tough questions.

Do we move towards more or less insurance regulation? In working with the un- and underinsured population, do we look for public or private market solutions … or both? How do we deal with national competition for highly skilled health care workers, in ever shortening supply? And – maybe the most important question to be answered – how do we deal with unsustainable costs and indeterminate value inherent in our current delivery system?

To date, many people have been dealing with health care's high costs by going without insurance and thus not receiving necessary care. That's a sad statement considering the United States is one of the richest countries in the world and that we have some of the best and brightest medical minds, and world renowned healthcare facilities. We should be able to figure out how to solve this problem.

Today, in Pennsylvania, more people rely on public health care assistance than ever before. It was only this past December that Governor Rendell stated there was a 20 percent increase in the number enrolled in the Pennsylvania Children's Health Insurance Program (CHIP) since he took office in January 2003. As of December 2006, the governor says 150,819 children were enrolled.

Without a doubt, health care reform will be one of our biggest challenges of 2007.

Finally, Pennsylvania also faces challenges in cultural diversity within health care and health care manpower. And, these two issues could be interlocked.

Many reports indicate an upcoming shortage of health care professionals. Pennsylvania, if not careful, will be one of the hardest hit states since we have one of the oldest populations in the country. The older you are the greater are your health care needs, and unfortunately, costs. Thus the state can expect a higher demand for services, healthcare professional shortages, and rising costs. Historically, the majority of Pennsylvania physicians, and allied health professionals, were from or were educated in Pennsylvania

As we address future needs, shouldn't we look within our own schools by demanding more of public education in preparing Pennsylvania students for the rigors of higher education and a future in health care? And, in doing so, shouldn't we find a way to expand educational opportunities for minorities and the poor (including Caucasians)?

Knowing that there will likely be more health care jobs open than there are qualified candidates for those positions, it would be worth exploring how we prepare and encourage young students to go into health care, and succeed in healthcare careers in Pennsylvania.

Already, many parts of Pennsylvania – specifically rural and inner city locations – are considered medically underserved. It's very difficult for a multitude of reasons to attract health care professionals to those areas. As part of health care reform, a closer look at the distribution, as well as the supply of health care professionals, in light of increased demand should be further investigated.

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The Challenge of the New Year

BY THOMAS WHITE, FACHE

When I was asked to write this article, I sat back to reflect on the present state of health care. In order to fully understand what is going on in health care today, it is important that we have a general familiarity with the pressures on health care.

The news media emphasize the safety concerns and negative quality perceptions, instead of the vast improvements in care quality and the technologies that provide the populace with improved quality and health status during an increasingly lengthy life span. Access to services is perceived to be less, and the choice of providers (hospitals and doctors) is shrinking. The number of uninsured is increasing. Presently, there are approximately 43 to 46 million uninsured people in the United States. Costs are approaching double-digit increases. There are significant personnel shortages in all areas of health care, and technology is advancing faster than hospitals and other providers can afford to keep up with.

There continues to be a medical malpractice crisis in many areas of the country. There is a shift underway in providing care, from acute to more chronic, due to the significant aging of the population. We continue to see demand for more services, but at the same time, we have declining reimbursement and increased regulations, which drive up the cost of care. We are faced with the potential of a pandemic crisis, as well as more patient demand due to the shifting population demographics.

We have faced many of these pressures before; however, now they are different in many ways. This is the first time health care providers have been faced with these pressures simultaneously and the nature of these forces is more complex today.

As health care providers, we will have to meet each of these pressures and find ways to manage our organizations so that we can survive. This will require that we, as well as the public, accept some changes that will be necessary to deal with the issues. Now more than ever before, we must be willing to change and the public must be willing to accept change, if the independent health system is to remain viable.

There is no question, in the years ahead; these pressures will continue to accelerate. Because of this, we may see continued consolidation of health care providers, as well as insurance companies and physician practices. We will also see more competition for the services that we provide. Boards of Directors and hospital CEO's, as well as management and employees, must face these difficult times with a clear direction. If not, we will see a much different health system by the end of this decade.

The question that society must answer is; will a definitive health care strategy be in place, in which the community infrastructure to provide it, remains viable.

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Looking Ahead to 2007

BY PAUL MCLEOD, M.D.

The year 2007 will be another challenging year for health care providers. We have a system of care in our country with which no one is happy. Misaligned incentives and flawed economic strategies have crippled our well-meaning system. So where are we going in 2007? I don't have a crystal ball, but like many others, I have an opinion. Here is what I see as we look ahead.

No State Left Behind

As the federal government stalls under a lame duck congress, the weight of the uninsured is falling on our states. The timing is perfect for universal health care coverage initiatives. Massachusetts will require the state's 6.4 million residents—including the 550,000 uninsured—to obtain health care coverage by July 1, 2007, and their new law will subsidize premiums for people earning below 300 percent of the federal poverty level. The Vermont Legislature in May created a comprehensive health insurance plan for uninsured residents under which the state provides premium assistance to lower-income individuals to keep premiums low. And the state of Utah is using a Medicaid waiver to provide primary care and preventive services to low-income adults who otherwise would lack health insurance.

Universal coverage is an option being seriously considered by virtually every state. Why? Because they are reacting to 46 million uninsured in our country and the reality of $1,000/month premiums for those fortunate enough to have private coverage. Reactive solutions are symptom-focused and fail to address system flaws. But this one is gaining a great deal of momentum.

The "Big Boys" Make the Plunge

IBM recently joined the myriad of healthcare technology vendors with plans in the coming year to develop systems to overhaul medical payments by using small personal devices to trigger financial transactions (Smart HealthCare Payment Systems) and will make the leap into the world of electronic medical records. The timing is good. 2007 will be a breakout year for physician adoption of electronic health records. The stars have aligned and the big boys are seeing dollar signs. Microsoft has finally rolled out the Vista operating system and freed up some intellectual resources. In addition, we will see more general acceptance by physicians of decision support databases that will facilitate evidence-based medical decision making.

Employer-Driven Health Plans

If providers won't invest in health care, some employers say they will. Intel, Wal-Mart, and British Petroleum are creating a joint effort to provide their employees with portable electronic health records that they hope to link with records from hospitals and pharmacies. These three companies could be joined by several others in a CDC co-sponsored project intended to reduce medical errors and improve quality in a transparent environment that stresses performance data. Toyota is taking a different approach by building a health clinic for employees and dependents in its new factory in San Antonio. They will go a step farther than Wal-Mart and offer medical care, dental care, eye care and physical therapy services in addition to technology infrastructure.

The Medical Home Model for Primary Care

We have a daunting task before us. How do we provide high quality care to our aging population composed of chronically ill seniors with multiple and often complex medical conditions? The answer derives from the concept that medicine is now a team sport with primary care physicians serving as captains. Access to primary care in the form of a "medical home" is a concept essential to success. In addition to expertise in the chronic care model, these physicians will require the efficiencies that can only come from a systems approach supported by technology infrastructure.

Outcomes-Based Competition

Precursors for this concept abound—patient centered care, transparency, pay-for-performance, consumer-driven care and high performance networks. Through the work of groups like the Commonwealth Fund and thought-provoking books like ***Redefining HealthCare*** (by Michael Porter and Elizabeth Olmsted Teisberg), the next year will see more movement toward outcome-based competition. This is where we need to go for lots of reasons and our patients will provide the catalyst for this change as information about cost and quality becomes more available to them and more reliable. Physicians who embrace this concept now will reap the benefits while others are scrambling to catch up.

Hospitals Become Major Employers of Physician Providers

Hospitals are back in the physician employment business. This time, I think many of them will succeed. On the new list are not just primary care providers, but niche specialists (e.g., wound care, stroke centers) who support important hospital services. New physicians in training are being told that they can not be successful at starting and maintaining their own business. Most are looking for an employer that has the cash flow to support start-up and weather the lean times that may occur. The hospitals are getting the help they need from companies skilled in revenue cycle management and physician office systems. Early signs of success are encouraging.

The coming year will offer great opportunity for those who embrace change, create efficiencies, successfully implement technology and differentiate themselves based on quality. The rest will continue to swim as hard as they can against the rip current of "this is how we have always done it." Sometimes it is not safe to go into the water.

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COVER STORY: *ACMS Set to Tackle Change Under Dr. Gopal's Leadership*

Continued from page 1

Society," he recalled. “When I attended my first PMS convention and I saw the political process at work firsthand. It was a real education but something that has remained with me over the years. I learned how the democratic process works. I realized that for every concern we have there are those who have opposite concerns, and it is for us to convince our legislators to see our way. I learned how changes can occur and committed myself to working in that direction."

That commitment has included efforts that go beyond the traditional clinical role of physicians. Dr. Gopal has served on numerous ACMS committees for more than 15 years and has been a member of its Board of Directors since 2002. He also is a past president of the Medical Staff and chairman of the Department of Surgery at Jefferson Regional Medical Center and past chairman of the Patient Care Committee at Monongahela Valley Hospital. In addition to Jefferson and MVH, Dr. Gopal, a physician since 1962, also has privileges at UPMC South Side.

Through all that experience, Dr. Gopal has seen many changes that impact physicians.

"Decades ago there were only two players in the health care arena, patients and physicians," he said. "Now we have a large array of players – employers employing physicians, administrators of institutions with their corporate leaders, various personnel measuring the quality of care offered by physicians, employers who pay the premiums for patients, and the insurance industry. And everyone is asking for accountability."

Dr. Gopal said physicians, by the nature of their profession, "do not have the sophistication to wade through the myriad rules, regulations and contracts and how to reconcile with enormous data that is being churned." But physicians are not trained in these areas, he said, adding, “It is not conducive to our way of thinking, to what our primary purpose is; that is, to care for and about our patients.”

"Physicians, in many instances, have become employees of large health systems rather than choosing to open a private practice," Dr. Gopal said. "This means they are accountable to their employer, to the hospital administration and to the insurance companies. What has transpired, I believe, has driven a wedge between physicians and patients. We no longer have time to be close to our patients because of the need to be accountable to so many other entities."

Concomitant with all of this, Dr. Gopal said, is a paradigm shift in health care from earlier years when health care meant treating diseases and no attempt made to preventive measures.

"Now we see that more than 60 percent of health care costs are directed at managing the chronic illnesses, which could have been avoided if proper preventive measures had been taken," he said. "Obesity, diabetes, renal diseases and hypertension are just some examples."

Dr. Gopal said the underlying factor for the change, is rising health care costs.

"In the guise of improving quality care, various methods are deployed to reduce the costs," he said. "But none of them is really reducing costs."

He cited the following as examples: Specialists' referrals, mandatory second opinions for some types of surgery, prior authorization to certain procedures, authorization for special x-ray studies. Several of these measures have not been helpful in reducing the cost and have been rescinded.

"All of these measures add additional bureaucratic layers for administration and costs for physicians who need to hire more full time employees to comply with all of these regulations," Dr. Gopal said.

He also cited a recent push toward pay for performance, evidence based medicine, measurement of quality care, electronic health records and electronic e-prescriptions.

"All of these are being introduced under the guise of improved quality care but they are bound to cost physicians money," Dr. Gopal said.

Dr. Gopal said that while there has been a tremendous explosion" of medical technology and sophistication in medicines, "unfortunately they cost money." As examples of the advancements, he cited stem cell transplants, bone marrow replacement, gene splicing, genome projects, Gamma Knife, and transplants of various organs.

Drugs are another component of rising health care costs, Dr. Gopal said.

"Development of new drugs requires extensive research, hence the upward spiral of costs," he said, adding that various antibiotics, newer medications for immune diseases and newer chemotherapeutic drugs lead the way.

"Some of these drugs may just prolong the life of an individual without really curing them of the disease," Dr. Gopal said. "One has to be philosophical about the overall outlay of the health care expenditure. People are living longer. Studies show that 80 percent of patients in any intensive care unit are over 80 years old. They consume significant resources of both personnel and finances to care for them. After their care they are sent back to nursing homes. End of life decisions are never easy for anyone -- the patient's family, physicians or hospital staff. But we have to consider what we are really doing for the patient. Are we just prolonging life and delaying death without really doing anything beneficial for his or her well being for the sake of proving that a certain drug works? Are we doing the humane thing?"

Educating physicians in the Allegheny County Medical Society on these issues, and others, will be a top priority for Dr. Gopal this year.

"We have to face the expectations of our patients to do all that can be done for them," Dr. Gopal said. “We have to change our positions to confront the challenges we face. Change is inevitable and we must adapt, adjust and take appropriate steps to preserve the best interests of our patients and our profession."

Dr. Gopal plans to hold open discussions among the ACMS membership on such topics as medical errors.

"Errors exist, there's no getting around it," he said. "We needn't be afraid of making it in the open. We need to work to prevent medical errors. I am in favor of global sharing of information, looking at the evidence and weighing the outcomes to reduce the number of errors. Hopefully we can do this through seminars and programs that will be beneficial to everyone."

Dr. Gopal also supports reports on physicians and hospitals such as those by the Pennsylvania Health Care Cost Containment Council and other agencies, "as long as they are educational and not punitive."

"All doctors have report cards (physician profile reports)," he said. "And it is OK to disseminate that information in a useful way to consumers. The information should be analyzed in a constructive manner. The public is often overwhelmed with information from the media and on the Internet and often confused by the data. Patients do research before they come to the office. They ask more questions, they expect answers, they are more demanding."

Dr. Gopal also has concerns about the status of health care in Pennsylvania because of "a disturbing trend" in the loss of physicians.

"The average age of a practicing physician herein Pennsylvania is 54 years," he said. "And fewer than three percent of physicians are below 35 years of age. Older physicians are considering early retirement and are cutting back on complicated procedures. Pennsylvania trains the largest number of young physicians, over 5,000, but unfortunately fewer than seven percent remain in the state to practice medicine. If this trend is not reversed, health care in Pennsylvania in 10 years will be debatable."

Dr. Gopal blames two factors for this disturbing trend: Insurance reimbursement for physicians in Pennsylvania are among the lowest in the nation and medical liability (malpractice) premiums are among the highest.

Dr. Gopal said he knew at an early age that he wanted to pursue a career in medicine.

"I always had an interest in the sciences, especially biology," he said. "I remember telling my parents and my grandfather when I was in elementary school that I wanted to be a doctor. This was a rather dramatic change because we had a number of judges and lawyers in our family and no physicians. I was the first to divert from that career path."

It's a decision Dr. Gopal has never regretted.

"It has been very fulfilling," he said of his medical career. "I have seen so many changes that have improved the practice of medicine and, more important, benefited our patients."

For more information, contact Lisa M. Goetz, Communications Director, Allegheny County Medical Society, at (412) 321-5030 or lgoetz@acms.org.

2007 to Provide Career Opportunities Across Healthcare Industry

BY VANESSA ORR

As Baby Boomers continue to age, the demand for healthcare professionals in many different fields will continue to grow. And with these opportunities comes the need for properly trained professionals who have the right skills set, from nurses and pharmacists to CEOs.

J. Don Haney

Bill Lowderman

"There will be numerous career opportunities in 2007, especially in areas where we are seeing shortages, such as nursing, radiology, and pharmacy," said J. Don Haney, principal and senior partner of Haney/Lowderman, which provides career transition services to healthcare executives. "There are always opportunities at the senior executive level, whether it's a CEO moving into another CEO role at a different facility, or a COO moving into a CEO position."

"Individuals in acute healthcare administration are now finding more positions outside traditional hospitals, including in rehabilitation hospitals and LTAC (long-term acute care) facilities," added Haney/ Lowderman principal, Bill Lowderman. "We're also seeing a real proliferation of jobs for consultants in interim or turnaround management companies—not just for the CEO, COO and CFO, but in emergency, surgery, and other departments as well."

According to Haney and Lowderman, while there may be a proliferation of healthcare jobs available, candidates are undergoing a more thorough selection process than ever before. "Especially in upper level positions, employers are relying less on chemistry during the interview, and are spending more time scrutinizing potential employees' track records and references," said Lowderman. "They are using behavioral-based interviewing (BBI) related to the issues, projects and challenges the management position requires based on the belief that the best indicator of an applicant's future performance is his or her past performance." Behavioral-based interviewing is also a way of discovering an applicant's values, temperament, decision-making processes, conflict resolution style and personality.

"Employers who used to consider three candidates for a position now look at six," added Haney. "They also conduct thorough reference checking and second-generation reference checking, so candidates really need to have their acts together."

In order to help healthcare executives succeed in their employment quest, Haney/Lowderman, formerly known as Haney & Associates, provides comprehensive career transition services, which include outplacement training techniques designed to help executives minimize mistakes during the job search. Two- to three-day workshops help individuals learn how to build a powerful resume, prepare for interviews, manage references and learn to network. "We believe that it's not what you know or who you know, but who knows what you know that determines future career success," said Lowderman.

With more than 45-plus years of experience between them, Haney and Lowderman understand what skills employers require. "A candidate must have strong leadership skills, as well as strong technology skills and financial skills," said Haney. "Even non IT-managers must be more technologically savvy. And if a candidate doesn't have a thorough understanding of the financial aspects of their organization, they are at a definite disadvantage."

"Executives must have the ability to improve clinical quality ratings and customer service ratings," added Lowderman, who says that with more of this data available on the Internet, customers who are making the purchasing decision are increasingly focusing on these statistics. "The federal government and customers who are making healthcare decisions are looking for increased transparency in quality and in pricing."

Being able to work with a myriad of people is also an important skill. "An executive's physician-relationship skills must be outstanding," said Lowderman. "Physicians expect a hospital administrator to be attentive, responsive and honest. And anyone who takes this position needs to realize what a complex relationship it is—a physician can be a hospital's competitor, partner, collaborator, customer, and employee, all at the same time."

"Physicians have more power now than ever before," added Haney. "They can develop outpatient projects on their own, and there is also a trend toward more physician equity positions. To succeed as an executive requires political astuteness and savvy—not only in physician relationships, but with the hospital board, medical staff, employees, consumers and the community."

Though jobs in healthcare can be extremely rigorous, finding the right position can make it all worthwhile. "Hospital management is one of the most labor-intensive jobs in the world, and one of the most difficult industries for management due to multiple constituencies and the political skills required," said Lowderman. "Still, for people who relish a challenge, healthcare remains an exciting and dynamic field."

For more information on career transition services in the healthcare industry, visit Haney/Lowderman at www.haneyandassoc.com or call (800) 797-7388.

Nursing Challenges Continue, Growth in Profession Slow

How Nursing Educators Hope to Meet this Challenge Head On

BY ROSEMARY MCCARTHY, PH.D.

It's no secret that one of the biggest challenges facing the health care industry today is the nursing shortage – a shortage that is expected to continue for years to come. The rate of growth within the nursing profession has slowed markedly and, by virtually all accounts, is insufficient to meet the general health care needs of a growing population or the demands of an increasingly graying society. According to the Department of Health and Human Services, the demand for registered nurses will rise 40 percent by 2020, whereas the supply will only rise by 6 percent.

Given those figures, it's obvious that something must be done to encourage qualified candidates to join the ranks of the caregivers our population will rely upon for quality care. Those of us in the field of education continue to focus on offering quality programs that will prepare qualified graduate nurses who will deliver safe, compassionate care. Nursing schools are seeing a steady increase in enrollment, and we believe that's truly a welcome sight for health care systems across the country.

Continuous improvement: Finding out what nurses want

At La Roche, our philosophy on helping to overcome constraints and challenges has been to continually evaluate the way we provide education and at what level. For instance, in spring 2004, La Roche's Department of Nursing initiated the Associate of Science in Nursing (ASN) Program. This program provides a pathway for entry into registered nursing practice. Associate degree programs are designed to offer accessible, affordable, quality education to a diverse population – often within a two-year time period. With the need for nurses so great, the associate degree option provides qualified nurses to help meet this present and future need.

The initiation of the ASN program was based on a number of factors. One of the most pressing issues, of course, is the nursing shortage and the need to create avenues for nurses to enter the workforce.

The continuous improvement of the nursing program is an integral part of today's system of health care delivery to the public. Our goal for students is to actively prepare them for their role as professional nurses. As the department looks to the future of nursing, we are in the formulative stage of reorganizing our Master's of Nursing program to meet the needs of professional nurses in the area. To gain input for this program, we gathered data via a direct-mail needs assessment sent during summer 2006, and we found a tremendous interest among nurses in leadership, education, long-term care and community health. These areas have been included in our planning sessions.

Will we see a nursing education boom?

We are already seeing an increase in applicants to nursing programs. There has been quite a push for awareness in the elementary schools about what it is to be a nurse. This has helped us in planting the seed with the younger population. It is important for the public to know what options there are in the profession. Although the majority of positions in nursing will require the nurse to remain at the bedside, there are many career opportunities within the profession, such as education, research, community health, school nurse and forensic nursing. The possibilities are endless and make nursing such a viable option for people who have varied interests.

Taking those interests to the next level – as in obtaining higher degrees and continuing education credits – makes nurses more attractive to health care organizations for a number of reasons. For instance, many institutions encourage advanced degrees among nurses who seek promotions. In addition, many health care institutions are applying for Magnet status, which is a program that recognizes organizations that have exhibited a sustained level of excellence and is based on the ANA Scope and Standards for Nurse Administrators. Hospitals with this status foster a workplace that empowers and is respectful of nursing staff. It is also indicative of a hospital that supports and rewards those nurses who move toward certification and advanced degrees.

In the future, we most likely will see a higher number of nurses interested in long-term care and community care. Those are two areas where there is a void and many educational institutions are looking to develop graduate programs in these areas. In addition, we expect to see that there will be a considerable need for nursing faculty – both now and in the near future. This is because of a number of issues such as unfilled faculty positions, resignations, projected retirements and a shortage of MSN- or Ph.D.-prepared nurses needed to teach.

Our goal, collectively, must be to work toward educating and preparing nursing professionals to care for patients in the future. As we continue to evolve in a high-tech society, we must never forget that nursing is, above all, a high-touch profession – one that the public relies on, now and in the future.

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What Will The New Year Bring For Nursing?

Good Health Perspective

from ROBERT MORRIS UNIVERSITY

BY LYNN GEORGE, PHD, RN

Happy New Year. As I sit here at my desk writing this I am taking a much welcome rest from the holiday activities and looking forward to the next year. What will the New Year bring for nursing and particularly nursing education? Changes in the form of nursing education are inevitable and important for the profession. As nurses face the challenges of a health care delivery system that is experiencing workforce shortages, new educational strategies must reflect and prepare individuals for these and other changes. Support for these changes comes from national organizations such as The Institute of Medicine, Joint Commission on the Accreditation of Healthcare Organizations and others who have called for reconceptualizing health professions education. In a report titled Health Professions Education: a Bridge to Quality, the IOM Committee on the Health Professions Education (2003) states, "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics."

The healthcare team needs to work more effectively and continue to make changes that improve patient safety. Nurses, physicians and others must learn to work in teams that fully appreciate and draw on the strengths of each team member. Education should provide the opportunity to experience multidisciplinary teamwork as part of the curriculum.

While the needs of the patient have long been an essential part of the curriculum for nursing education, a focus on safeguarding the patient in the healthcare environment needs to be emphasized. Research from Drs. Linda Aiken, Carole Estabrooks and others have established a clear link between higher levels of nursing education and better patient outcomes. Education matters.

These same concerns have been the stimulus for change in nursing education at the graduate level. The rapid expansion of knowledge and complexity of patient care as well as concerns about the quality of care and demands for higher levels of preparation for nursing in practice, leadership and education have built momentum for change both at the master's and doctoral levels. Doctoral programs in nursing fall into two principal types: research-focused and practice focused. Most research focused programs grant the Doctor of Philosophy degree (PhD). The practice doctorate is not new to nursing but has evolved over the past several decades. Designed to prepare experts at the highest level of nursing practice, the Doctor of Nursing Practice degree (DNP) focuses heavily on practice that is innovative and evidence-based, reflecting the application of credible research findings. At the AACN 2006 Fall Semiannual Meeting, the membership voted to approve the DNP Essentials. This document outlines the curricular expectations that will guide and shape DNP education and is available on the aacn.nche.edu web site.

Graduate education in nursing has expanded and will continue to expand. With 101 doctoral programs and 417 master's programs in 2006, the addition of the DNP programs is beginning to add to those numbers. The AACN website lists 24 DNP programs as of the summer of 2006. Pennsylvania currently has two DNP programs listed. With more in development.

In order to prepare nurses for the changing demands of the healthcare system, appropriate high quality educational systems at both the undergraduate and graduate levels are required. These educational systems must prepare individuals to work collaboratively to provide the best and safest care. Those considering careers in nursing have many options and must plan their educational path to provide them with the best preparation for the future.

Lynn George, PhD, RN, Associate Dean, Robert Morris University, can be reached at (412) 397-3689 or george@rmu.edu.

Homecare Providers 'Treading Water' at Onset of 2007

BY GEORGIE BLACKBURN

Always a time of anticipation, the New Year promises hope, challenges and solutions. But this year many providers of homecare equipment and supplies feel ANXIETY as they keep their heads above water, awaiting the release of Medicare and Medicaid directives. What would make seasoned businessmen anxious? Specifically three initiatives:

Medicare Competitive Acquisition

Section 302 (b) (1) of the Medicare Modernization Act requires Medicare to replace the current DME payment methodology for certain items with a competitive acquisition process. In Western PA, Pittsburgh is high on the list to be one of the first ten Metropolitan Statistical Areas (MSA's) deemed a competitive bidding site. Many Pennsylvania providers are privately owned businesses and smaller than larger regional or national firms, yet they wish to be able to participate. How and if they can will depend upon two bills currently in Congress: H.R. 3559, the Hobson-Tanner Bill, Medicare Durable Medical Equipment Access Act of 2005 and S. 3920, the Hatch-Conrad Bill to Strengthen Access to Homecare, introduced September 21, 2006. Neither piece of legislation repeals the competitive acquisition process for durable medical equipment (DME), but both ensure beneficiary access to DME through mandates that include:

- Exemption of smaller rural areas (population under 500,000)
- Allow all qualified providers to participate at the selected award price
- Exempt items and services unless savings of at least 10% can be demonstrated

Recently, the Centers for Medicare and Medicaid Services (CMS) released Quality Standards by which all providers must abide and the list of accreditation organizations approved for accrediting durable medical equipment providers. Announcement of the first ten MSA's is expected sometime in January 2007. CMS' plan is that bid requests will follow, illustrating the products under bid, awardees will be announced, then Competitive Acquisition will commence the last quarter of 2007. If Pittsburgh is one of the first MSA's, beneficiaries living within its defined perimeter may ONLY receive prescribed equipment listed on the bid from contracted awardees …unless both bills pass Congress.

Medicare Rent-to-Purchase plan replaces Capped Rentals

As of January 2006, CMS determined beneficiaries renting equipment would no longer be given a choice to continue to rent or purchase their equipment after ten months of rental. Now, equipment such as wheelchairs, beds, and lifters automatically convert to purchase after 13 consecutive rental payments, with the first to commence February 1, 2007. Oxygen Concentrators currently transfer title after 36 months of rental, but President Bush is pushing hard to have that changed to 13 months.

In addition to causing increased inventory expenditures, providers are concerned about the added responsibility placed on beneficiaries to maintain equipment. Previously, if a beneficiary chose to continue to rent equipment and it subsequently needed repair, Medicare paid under a maintenance and service agreement. But for purchased equipment, Medicare will not pay for "worn" parts, only those that totally "break". And Medicare further states all equipment must last a minimum of five years before it is totally replaceable with a new product. Beneficiaries using equipment that provides function or access to activities of daily living is constantly in use.

Will patients with limited incomes pay to keep equipment in good condition so it lasts five years? Are chronically ill oxygen patients able to self-monitor respiratory equipment? So many beneficiaries live alone, do not have a caregiver and "make do". They are proud citizens. Providers are fearful of negative outcomes.

PA Selective Contracting - Medical Assistance Fee for Service Recipients

By the end of 2006, PA Medicaid was to have Selective Contracting operational throughout the state. However, planners did not envision the uproar that was initiated by advocacy groups, customers and providers. Concerns about access to care, high-end rehabilitation equipment repairs and respiratory care needs became hot topics. The clamor did not subside and Deputy Secretary James Hardy, who spearheaded the project, has recently resigned his post.

Late December 2006, Secretary Estelle Richman responded by considering a Pilot project in Zone 2, Northeastern PA, where managed care is not prevalent. While the final result is not in as of this writing, it is a much more reasonable approach than the initial plan to initiate the program statewide, encompassing ventilators to wigs. PA citizens' voices were heard. We need to keep that voice resonating.

Providers envision a very active year, maintaining levels of care and educating legislators. It could also be a year to take swimming lessons!

Georgie Blackburn, Compliance Director, BLACKBURN'S, and President, Pennsylvania Association of Medical Suppliers (PAMS), can be reached at georgie.blackburn@blackburnsmed.com.

COVER STORY: *2007 Brings Both Challenges and Opportunities to Western PA Healthcare Organizations*

Continued from page 1

record extremely time consuming," Harper said.

The alternative to outcomes measures is to look at the process of care being delivered and determine if it is evidence based and in accordance with community standards. Other employers may find measuring the employees' ability to return to work and perform at the same level of productivity prior to their medical intervention is important.

"Legislators, businesses, consumers and payers are demanding that hospitals report more information openly. Hospitals are willing to report information," Harper said, "however, at this point in time, hospitals are reporting different sets of data to different entities. We need to collectively create a common reporting mechanism which is user-friendly for the public but at the same time makes it easier for hospitals to report."

There is also a growing focus on the ability of providers across the continuum of care to share patient information electronically. "While there is some interest from the federal government in moving health information technology forward, local hospitals and physicians are in various stages of using electronic medical records. There are logical steps to creating a paperless medical system," Harper said.

Significant changes to reimbursement are expected, as Pennsylvania's Department of Public Welfare works on a proposal to redesign repayment for care. "The state would like to improve APR DRGs (all patient related diagnosis related groupings) to more accurately coordinate reimbursement with patient severity,' Harper said. "The APR DRG system has been successfully implemented across the country and should be of assistance to hospitals."

Harper added that of great concern to all hospitals in western Pennsylvania is "a total revamp of the formula used to determine the Medical Assistance base rate of payment." He said, "We are adamant about a fair methodology to determine a hospitals' base rate across the entire state."

In addition, western Pennsylvania hospitals continue to struggle with the Medicare Wage Index, which has an impact on hospital reimbursement from Medicare. "Our region has been in a downward spiral for the past six years," Harper said. "Our region's wage index has dropped from .96 to .88 dramatically affecting reimbursement." In 2007, Hospital Council will be working with all of the region's hospitals in a coordinated effort to ensure that hospital cost reports have been completed correctly and that they accurately reflect each hospital's wages, hours worked and occupational mix.

Another major issue which will continue into 2007 is a focus, regionally, statewide and nationally, on healthcare workforce issues related to recruiting and retaining workforce for hospitals and nursing homes. "I personally am excited about the team which has come together locally under the Jewish Healthcare Foundation, with the Allegheny Conference and the Workforce Investment Board to create a process which will help our region's students move from high school into a job at one of our region's health care facilities, " he said.

Harper concluded, "As is the case every year, it is an exciting and challenging time for all healthcare providers. I am confident that the work being done at Hospital Council and the Hospital and Healthsystem Association of Pennsylvania will result in our members being prepared for and thriving in the western Pennsylvania market."

For more information visit Hospital Council's website at www.hcwp.org.

"Legislators, businesses, consumers and payers are demanding that hospitals report more information openly. Hospitals are willing to report information, however, at this point in time, hospitals are reporting different sets of data to different entities. We need to collectively create a common reporting mechanism which is user-friendly for the public but at the same time makes it easier for hospitals to report."

COVER STORY: *Expanding the Role of Nurse Practitioners*

Continued from page 1

address one aspect of the issue – escalating prices.

When compared to their physician counterparts, nurse practitioners can provide primary services at lower costs, but less expensive does not necessarily mean lower quality. Patients should not expect a decline in their quality of care in exchange for a decrease in health care costs. With more nurse practitioner care, it won't be.

A large body of evidence shows that nurse practitioners have equivalent patient outcomes when compared to physicians and, typically, have better patient satisfaction. In fact, patients under the care of a nurse practitioner may actually fare better than those being treated by a physician, in some cases. Research suggests that patients with chronic conditions, like diabetes or heart disease, who require follow-up care over time, have better outcomes when their care provider is a nurse practitioner.

With the American health care system witnessing a shift toward preventive care, nurse practitioners can make valuable contributions to society's health and well-being.

In addition to Pennsylvania's health care costs, physician shortages have emerged as a problem for the Commonwealth, as well. More medical students are choosing to practice in specialty areas like dermatology or cardiology, leaving voids in primary care that nurse practitioners can help to fill. This could be particularly valuable in rural and inner-city areas, where health care consumers face the biggest hit from high health care costs and an insufficient number of primary care physicians.

Some health care consumers have been reluctant to embrace the idea of turning to nurse practitioners for their primary care needs. However, when they are educated about nurse practitioners' training and expertise, many patients overcome this hesitation.

Nurse practitioners have no desire or intent to misrepresent themselves as physicians. Rather, they hope to continue to collaborate with physicians, just as they have always done. In fact expanding the scope of nurse practitioners will actually benefit physicians, who will then be able to attend to the more complex cases that require their levels of expertise.

Do nurse practitioners present a complete solution to Pennsylvania's health care problems? Certainly not. However, they are definitely underutilized in the current system. Private industry has already recognized the promise that nurse practitioners hold for health care delivery, with retail pharmacy chains introducing in-store clinics where these professionals provide treatments for conditions ranging from the common cold to strep throat. Patients, physicians and health care systems should follow their lead.

I strongly encourage the public, Pennsylvania legislators and health professionals to promote improved access to health care services, without loss of quality, by supporting Governor Rendell's efforts to extend the utilization of nurse practitioners in the health delivery system.

Jacqueline Dunbar-Jacob , PhD, RN, FAAN, professor and dean of nursing at the University of Pittsburgh School of Nursing, can be reached at (412) 624-7838 or dunbar@pitt.edu.

A Look Ahead for 2007

BY SUSAN HECK

As we look ahead to 2007, again we see great changes on the horizon for healthcare. With continued scrutiny of the cost and quality of care from both internal and external sources, Corazon believes that hospitals will no doubt be forced to direct efforts towards ensuring high-quality care delivery in an operationally-efficient setting.

This focus on cost is most evident in CMS's gradual shift to cost-based (rather than charge-based) reimbursement. Beginning with the 2006 changes to the relative weights, many DRGs have already been impacted, most within the cardiovascular specialty. Organizations will now have to dedicate increased efforts to tracking and/or creating documentation that supports a more granular DRG system that will result in charges and payments that are matched to the complexity of patient diagnoses and condition. Appropriate documentation that drives optimal coding processes to accurately capture the severity of patient illness will continue to make CV services among the most profitable hospital specialties.

The expiration of the moratorium on specialty hospitals will also impact the healthcare industry in 2007. Though Corazon does not expect a sharp rise in the number of specialty hospitals so soon after the moratorium was lifted in August 2006, increased interest in freestanding facilities dedicated to one clinical specialty (most often cardiovascular or orthopedic care) has been a more immediate result. This issue can impact facilities of all types across the country…Those organizations not thinking of building a freestanding facility must instead consider the possibility of their competitor doing so. No matter your individual situation, the specialty hospital issue should be "top of mind" as this trend gains momentum in both urban and rural communities.

Angioplasty with off-site surgical support will likely remain a hot topic in the months ahead. Regulations are already changing in states that have traditionally restricted coronary intervention without surgery on site, while demonstration projects, clinical studies, and state-sponsored programs continually prove the safety and efficacy of this practice. Increased patient access to life-saving angioplasty in all areas of the country is the ultimate goal of this initiative. Likewise, efforts to reduce time-to-treatment to less than 90 minutes will be a benchmark that all programs will be measured against. But as the legislative debate continues, hospitals in states where regulations are poised to change can expect a surge in cardiac program expansions, triggering increased competition for cardiovascular patients.

Also, recruitment challenges will continue to plague the healthcare industry. As we find in our consulting and recruitment business, experienced and qualified administrative and physician leaders, especially for cardiovascular services, are always in high demand. Strengthened recruitment efforts and continuing development for current leaders will be increasingly necessary.

And finally, increased interest in joint ventures and partnership arrangements will likely continue, especially with heightened interest in new and innovative pay-for-performance models that facilitate hospital and physician involvement in high-quality care delivery.

Despite these general predictions for the year ahead, Corazon recommends relationship-building between hospitals and physicians; a focus on documentation; and benchmarking for clinical, financial, and operational indicators, both of which can help gauge and drive program success, no matter what the future holds.

Susan Heck, Vice President of Consulting, Corazon Inc., can be reached at (412) 364-8200 or sheck@corazoninc.com.

No matter your individual situation, the specialty hospital issue should be "top of mind" as this trend gains momentum in both urban and rural communities."

Five Resolutions For 2007

BY MARTIN KEEGAN

As Americans rang in the new year, many of them had a list of resolutions to carry with them throughout 2007. People everywhere make New Year's resolutions. If your list is a little short, or if you didn't make one, we'd like to give you a few suggested Social Security resolutions for 2007.

Social Security Resolution #1: Plan for Retirement Now. Whether you'll retire in two years or 22, it's good to know ahead of time how much you might expect from Social Security. And we provide easy ways to figure it out. Three months before your birthday you'll get your Social Security Statement in the mail. It will show your earnings record for past years and estimate your benefit amounts for disability, survivors and both full retirement and early retirement. If you just can't wait for your new Statement, visit our website. You can request that a Statement to be mailed to you, or you can use our Benefits Calculators to plug in your earnings and get an instant estimate. Visit our website at http://www.socialsecurity.gov/mystatement/ for more on the Statement. To use our Benefits Calculators, visit http://www.socialsecurity.gov/planners/calculators.htm and determine how much you'll be due.

Social Security Resolution #2: Save for Your Future. Social Security can provide a financial foundation for your retirement, but it was never intended to be your sole source of retirement income. You should do some saving in order to ensure a comfortable retirement. It can be hard to save for your future, but it is essential. Whether you're a veteran investor or you're just starting out, it's important to your financial future to put away some comfortable padding for your nest egg.

Social Security Resolution #3: Compare and Save – Your Records. Compare the number on your Social Security card to the number on your W-2s or payroll statements and make sure they're one and the same. This is especially important for people who change jobs often. If the numbers don't match, you may not be getting credit for all the Social Security and Medicare taxes you're paying. That could mean a reduction in benefits. If there is a mismatch, it can be fixed. Let your employer know, and contact Social Security at 1-800-772-1213.

Social Security Resolution #4: List All of Your Dependents. Not just your children, but all dependents need to be accounted for; they need to have their own numbers. Without a Social Security number, your dependents can not be claimed on your tax return. Social Security numbers are also important in the event that you apply for federal benefits on behalf of your children or dependent family members.

Social Security Resolution #5: Safeguard Your Social Security Number. We don't have to tell you that identity theft is a prominent crime these days, but we would like to remind you to keep your number safe. Never carry your Social Security card with you in your wallet or purse unless you know it will be needed. Be careful who you give your number to. Many places of business will ask for it, but few actually need it. When you renew your driver's license, request that your Social Security number not be shown. Shred any bills, mail or documents that contain your number before throwing them away.

Five little steps can make all the difference down the road, so we encourage you to take our 2007 resolutions to heart.

Martin Keegan is Social Security Manager in East Liberty. To learn more, visit Social Security's website at www.socialsecurity.gov, or call toll-free 1-800-772-1213 (TTY 1-800-325-0778).

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Around the **Region**

University of Pittsburgh Professor Carol Feghali-Bostwick Appointed to Board of Directors of Scleroderma Foundation

Dr. Carol Feghali-Bostwick

Carol Feghali-Bostwick, Ph.D, an assistant professor of medicine at the University of Pittsburgh Medical Center, has been appointed to a three-year term to the Scleroderma Foundation Board of Directors.

Dr. Feghali-Bostwick is a faculty member of the Dorothy and Richard Simmons Center for Interstitial Lung Diseases.

Dr. Feghali-Bostwick has been active in the scleroderma community, serving as a keynote speaker at the Scleroderma Foundation's national conference, and as a member of its peer review committee that oversees the awarding of research grants.

In addition to her teaching, Dr. Feghali-Bostwick is an accomplished researcher, having won several grants, and has authored over 36 publications in her specialty.

She is a member of the American College of Rheumatology, American Association for the Advancement of Science, International Society for IGF Research and the American Thoracic Society.

Duncan Tapped for CEO of Blair Medical Associates

Dr. David J. Duncan

David J. Duncan, Ph.D., FACHE, senior vice president and chief information officer, has left his position at Altoona Regional to accept the chief executive officer role with Blair Medical Associates, a system-affiliated corporation. Duncan will replace current BMA CEO John Brown, who is relocating to Virginia.

Duncan has provided administrative oversight for the Altoona Family Physicians' Residency Program, Behavioral Health and the outsourced Information Management department, as well as being instrumental in facilitating the system's master facility planning process.

Amy L. Davison, R.N., Joins Celtic Hospice & Palliative Care Services as Executive Director

Amy L. Davison

Amy L. Davison, R.N., recently joined Celtic Hospice & Palliative Care Services as Executive Director

Amy has served in various management positions throughout the hospice industry. Amy is an active member of the National Hospice and Palliative Care Organization (NHPCO) as well as the Coalition for Quality at the End of Life (CQEL). Amy is using her knowledge and passion for hospice to develop a unique and compassionate hospice and palliative care program at Celtic. Amy is a graduate of West Penn Hospital School of Nursing.

Ken DeFurio Named President & CEO of Butler Health System

Ken DeFurio

The Board of Trustees of Butler Health System has named Ken DeFurio President & Chief Executive Officer of the system. DeFurio had been serving in an interim CEO capacity with the health system since the retirement of former CEO Joseph A. Stewart.

DeFurio began his career at Butler Memorial Hospital in 1986 as a respiratory therapist. He then left for the University of Maryland Medical System in Baltimore where he served as assistant director of respiratory therapy, supervising a staff of 90 in a large healthcare system that served as the shock-trauma center for the entire state of Maryland.

He returned to BMH in 1989 as assistant director of respiratory therapy; he was promoted to director of rehabilitation and respiratory care services in 1990. In 1996 he joined the administrative team of the hospital as Vice President of Outpatient Services and was then promoted to Senior Vice President and Chief Operating Officer in 2003.

DeFurio is a Fellow of the American College of Healthcare Executives, a member of the American Hospital Association's Society for Healthcare Strategy and Market Development and the COO affinity group of the national Voluntary Hospitals of America (VHA) Shareholders group.

Laura Jones Heads Milan Puskar Health Right

Laura Jones

Laura Jones, who joined the staff of Milan Puskar Health Right in 2000, recently assumed the post of executive director.

Jones began at Health Right as a social worker and counselor, and was promoted to assistant director in 2002. She has been responsible for several innovations, including an intensive diabetes clinic that has earned widespread attention.

Jones came to Morgantown in 1981 as a student and has remained ever since. Prior to joining Health Right she worked for the WVU Center for Excellence in Disabilities, Valley Comprehensive Community Mental Health Center in Kingwood, and the Coordinating Council for Independent Living.

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Around the **Region**

University of Pittsburgh Nursing Associate Professor Elected to Board of Directors of Leading National Nursing Association

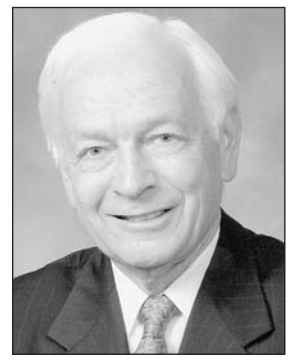
Susan Albrecht

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) recently announced that Susan Albrecht, Associate Professor of Maternal-Child Health Nursing and Associate Dean for Student/Alumni Services and Development of the University of Pittsburgh School of Nursing, has been elected to serve on the 2007 AWHONN Board of Directors.

Albrecht has served on the faculty at the University of Pittsburgh for 30 years and is also a staff nurse in the Emergency Department of the South Hills Health System in West Mifflin, PA.

Albrecht serves on the Board of Directors for the American Academy of Pediatrics Cleaner Air for Healthy Children and on the Governing Board for the University of Pittsburgh Office of Child Development Early Head Start/Family Foundations. She also chairs the American Academy of Nursing, Adolescent and Young Adult Expert Panel.

Melvin D. Rex Elected Chairman of St. Clair Hospital's Board of Directors



Melvin D. Rex

St. Clair Health Corporation has announced the election of Melvin D. Rex as Chairman of the St. Clair Hospital Board of Directors.

Rex has held various leadership positions with the Duquesne Club over the past 40 years, including general manager, secretary, executive director and chief operating officer. Currently, he serves as the Duquesne Club's secretary emeritus and is a consultant to various private clubs throughout the United States.

Rex serves as a board member for many community and professional organizations throughout the western Pennsylvania region, including the National Aviary, the Pittsburgh CLO, the Duquesne Club Charitable Foundation, and others. He had also served as a board member of the St. Clair Hospital Foundation from 2001-2006.

Simon McGuire Appointed Managing Director, Respironics' Respiratory Drug Delivery UK Ltd.

Simon McGuire

Respironics, Inc., recently announced that Simon McGuire has been appointed Managing Director of Respiratory Drug Delivery (RDD) UK Ltd., the European base of Respironics' Respiratory Drug Delivery business unit headquartered in Cedar Grove, NJ. In his new role, McGuire will be responsible for leading all RDD activities in the UK including manufacturing operations, quality assurance and regulatory functions and the Profile Pharma business. He will also oversee the move to a new state-of-the-art facility in Tangmere, Chichester, UK and the establishment of a Center of Excellence in Aerosol Research providing aerosol testing and analysis services to pharmaceutical and biotech companies.

PHC4 Executive Director Re-elected as Chair of National Data Organization

Marc P. Volavka

Marc P. Volavka, Executive Director of the Pennsylvania Health Care Cost Containment Council (PHC4), was re-elected Chairman of the Board at the 21st Annual Meeting of the National Association of Health Data Organizations (NAHDO).

"I am honored to be re-elected to this position as NAHDO is one of the strongest voices in the national dialogue on quality improvement in health care," said Volavka. "I look forward to working with all of NAHDO's partners and members to further expand its role in health data leadership."

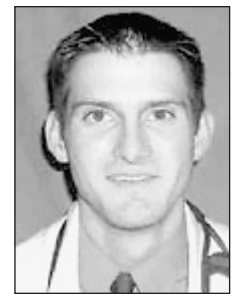
MAKING ROUNDS

PHYSICIAN ANNOUNCEMENTS, APPOINTMENTS AND AWARDS

New Physicians Join Altoona Regional Medical Staff


Dr. John A. Baker


Dr. Matthew T. Sabol


Dr. Ryan R. Ridenour


Dr. Roberto Gonzalez


Dr. Emmanuel A. Osagiede


Dr. Danny R. Fijalkowski


Dr. Thomas E. Covaleski

John A. Baker, D.O., has joined the Altoona Regional Health System medical staff in the department of Emergency Medicine. Dr. Baker is affiliated with the Department of Emergency Medicine, Bon Secours Hospital Campus. He is board eligible with the American Osteopathic Board of Family Practice.

Matthew T. Sabol, D.P.M., has joined the Altoona Regional Health System medical staff in the department of Orthopedics/Podiatry. He is affiliated with Advanced Regional Center for Ankle & Foot Care. Dr. Sabol is board eligible with the American Board of Podiatric Surgery.

Ryan R. Ridenour, D.O., has joined the Altoona Regional medical staff in the department of Family Medicine. Dr. Ridenour is affiliated with Blair Medical Associates. He is board certified with the American Osteopathic Board of Family Practice.

Roberto Gonzalez, M.D., has joined the Altoona Regional medical staff in the department/clinical service of Specialized Surgery/Plastic & Reconstructive Surgery. Dr. Gonzalez is an associate with Blair Plastic Surgery. He is board eligible with the American Board of Plastic Surgery.

Emmanuel A. Osagiede has joined the Altoona Regional Health System medical staff in the department of Radiology. He is board certified with the American Board of Radiology.

Danny R. Fijalkowski, D.P.M., has joined the Altoona Regional Health System Medical Staff in the department of Orthopedics/Podiatry. Dr. Fijalkowski is board qualified by the American Board of Podiatric Surgery and the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. He received his residency training from Dayton Veterans Affairs Medical Center, OH, and graduated from the Ohio College of Podiatric Medicine, Cleveland.

Thomas E. Covaleski, M.D., has joined the Altoona Regional Health System Medical Staff in the department of Internal Medicine. Dr. Covaleski is board certified by the American Board of Internal Medicine. He received his residency training and graduated from the College of Medicine, Pennsylvania State University, Hershey.

Jameson Hospital Appoints Emergency Department Medical Director

David Anderson, M.D., FACEP, has been appointed Medical Director of the Jameson Emergency Department. Dr. Anderson attended medical school at the Medical College of Ohio and completed an emergency medicine residency at MetroHealth Medical University in Cleveland, Ohio. He is board certified in Emergency Medicine and has been practicing for 12 years including the past two years at Jameson Hospital.


Dr. David Anderson

Pathologist Joins UPMC Northwest Medical Staff

Pathologist Sophie Tynski, M.D., is the newest addition to the UPMC Northwest medical staff.

Dr. Tynski specializes in cytopathology, which involves evaluation of human cells to diagnose disease and measure the effectiveness of treatment.

Dr. Tynski graduated from medical school and completed an internship in her native Poland, and completed a pathology residency program at Saint Vincent Hospital and Medical Center in New York and the State University of New York at Buffalo.


Dr. Sophie Tynski

Richard A. Young, D.P.M., Named as Medical Director at MVH's Center for Wound Management


Andrea Russo, RN, BSN, Center for Wound Management (left) and Richard A. Young, D.P.M., Medical Director, review a patient's care plan.

Richard A. Young, D.P.M., was appointed as Medical Director of the Center for Wound Management at Monongahela Valley Hospital.

Dr. Young is a podiatrist with Advanced Foot and Ankle in Monessen. He completed his Podiatric Surgical Residency at Bryn Mawr Hospital in Bryn Mawr, PA from 1994-1996 and a Medical Podiatric Residency at the Medical College Hospitals, Elkins Park Campus, Elkins Park, PA from 1993-1994 and graduated from the Pennsylvania College of Podiatric Medicine in Philadelphia. He is a Diplomat of the American Board of Podiatric Surgery, a Fellow of the American College of Foot and Ankle Surgeons, a Fellow of the American Professional Wound Care Association and is active in state and national Podiatric Medical Associations.

ACMS Slates Numerous Awards

The Allegheny County Medical Society is honoring member physicians and individuals in the community with a variety of awards. These honors include:

- **Karen Henderson**, Wexford, Benjamin Rush Individual Public Health Award, which is given in appreciation of outstanding contributions to public health by a volunteer. Henderson is a volunteer and educator with the Center for Organ Recovery and Education and is being recognized for her devotion to elevating organ donation awareness.
- **Community Human Services Corporation**, Pittsburgh, Benjamin Rush Community Organization Health Service Award, which is given in appreciation of outstanding contributions to public health by a lay volunteer organization. CHSC is being honored for the gifts of time, self and service that it has devoted to developing health care programs for poor and at-risk individuals.

Meanwhile, several awards also will be presented at the Society's annual Installation of Officers and Physician Awards Presentation on Saturday, January 27 at the Westin Convention Center and Hotel. The event will begin at 6 p.m.

New ACMS officers for 2007 are Krishnan A. Gopal, MD, president; Adam Gordon, MD, MPH, president-elect; Douglas Clough, MD, vice president; John F. Delaney Jr., MD, secretary; Leo McCafferty, MD, treasurer, and Terence W. Starz, MD, chair of the Board of Directors.

The following honors will be presented at the event:

- **Loren H. Roth, M.D., MPH**, UPMC Health System, Physician Workplace Diversity Award, which is given to a physician or physician group in recognition of outstanding contributions to fostering workplace diversity within the field of medicine in western Pennsylvania. Dr. Roth is being recognized for her commitment to diversity at UPMC. He serves as Senior Vice President, Quality Care and Chief Medical Officer at the University of Pittsburgh Medical Center and Associate Senior Vice Chancellor for Health Sciences at the University of Pittsburgh.
- **Andrew Russell**, Executive Vice President, Western Pennsylvania Market Manager, PNC Bank, Community Workplace Diversity Award, which is given to a person, group, or organization from the community who has made an outstanding contribution in fostering workplace diversity in Western Pennsylvania.
- **Bernard I. Cohen, D.D.S., M.D.**, Gibsonia, Frederick M. Jacob Outstanding ACMS Service Award, which is given to a physician in tribute to his or her outstanding dedication to the society. Dr. Cohen is being recognized for his devotion to the ACMS and extraordinary commitment to Pittsburgh patients and physicians.
- **Donald B. Middleton, M.D.**, Pittsburgh, Nathaniel Bedford Primary Care Physician Award, which is given to a primary care physician in tribute to his or her outstanding dedication to the physical and psychological needs of patients.
- **Edward M. Barksdale Jr., M.D.**, Children's Hospital of Pittsburgh, Medical Society Physician Volunteer Award, which honors a physician who donates significant amounts of time and expertise towards the provision of medical care on a volunteer basis. Dr. Barksdale is a volunteer with Every Child.
- **Chandrappa S. Reshmi, M.D.**, Pittsburgh, Ralph C. Wilde Award, which recognizes a physician who exemplifies the personal and professional characteristics – physician, teacher, leader and human being – of the late ACMS president for whom this award is named. Dr. Reshmi is being recognized for combining dedication to patients here and in India, knowledge dispensed to students and colleagues and time volunteered to the Indian community in Pittsburgh.

The following physicians will be honored at the dinner for 50 years of service to the medical profession):

- **Lawrence N. Adler, MD, Morton I. Berkowitz, MD, Stanley H. Bushkoff, MD, Peter J. Citrone, MD, Richard E. Easler, MD, Anas A. Elattar, MD, Stanton B. Elias, MD, Morton L. Goldstein, MD, Joseph F. Hakas, MD, Robert J. Hartsock, MD, John B. Hill, MD, Stanley A. Hirsch, MD, Eugene Z. Hirsch, MD, Peter J. Jannetta, MD, Roland T. Keddie, MD, Sricrishna B. Kenkre, MD, Barbara K. Kolmen, MD, Philip R. Levine, MD, J. Robert Love, MD, MS, CMD, Joseph A. Marasco Jr., MD, Edward J. McClain Jr., MD, George R. McCollum, MD, Fenton M. Mitchell, MD, John P. O'Connor, Murray V. Osofsky, MD, James A. Raub, MD, Murray Sachs, MD, John C. Scarmucci, MD, Robert G Selker, MD, Margaret C. Sharrer, MD, Norbert J. Weikers, MD.**

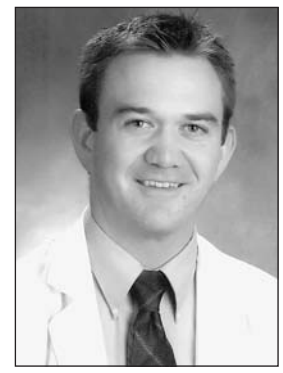
And these physicians will be recognized for 25 years of ACMS membership:

- **Frank B. Artuso, MD, Parviz Baghai, MD, Frederick W. Crock, MD, FACC, Robert J. Donofrio, MD, Martin M. Fenster, MD, Thomas W. Forbes, MD, Marc E. Garfinkel, MD, Barbara M. Harley, MD, Neil J. Hart, MD, Leticia Q. Jariwala, MD, Chester R. Jarmolowski, MD, Hae Dong Joh, MD, Thomas B.Julian, MD, Gerald I. Kaufer, MD, Paul J., Killian, MD, Kotayya KONDAVEETI, MD, James V. Kunkel, MD, John C. Maher, MD, James W. Marcucci, MD, James J. McCague, MD, Harshad Mehta, MD, Sudhir K. Narla**, MD, E. Douglas Newton, MD, George W. Poutous, MD, Harold Z. Scheinman, MD, Samuel T. Simone, MD, Basilio Starunko, MD, Edward Teeple Jr., MD, Christopher A. Troianos, MD, Karl E. Williams, MD.

MAKING ROUNDS

New Physicians Join UPMC Horizon Medical Staff

Dr. James Liszewski



Dr. Curtis Jantzi

James Liszewski, M.D., has joined UPMC Horizon's medical staff and Greenville Medical Center – UPMC.

Dr. Liszewski specializes in family medicine. He completed a residency in family practice at Latrobe Area Hospital, Latrobe, PA in 1999 where he served as chief resident. After completion of his training, Dr. Liszewski remained at Latrobe Area Hospital as an attending physician and full-time faculty until accepting his new position in Greenville.

Curtis Jantzi, D.O., has joined UPMC Horizon's medical staff and Hermitage Community Medicine – UPMC, formerly known as Micchia and Snyder Family Practice. He completed an internship and residencies in pediatrics and family practice at Mercy Hospital of Pittsburgh, where he served as chief resident.

Physician Joins UPMC Northwest Medical Staff

Dr. Steven Ferguson

Hospitalist Steven Ferguson, D.O., is the newest member of the UPMC Northwest medical staff. He is practicing full-time with John Graham, M.D., medical director of UPMC Northwest's hospitalist program, and Kathleen Filiaggi, M.D.

Dr. Ferguson holds a bachelor's degree in medical technology from Thiel College in Greenville and a degree in osteopathic medicine from the University of Health Sciences College of Osteopathic Medicine in Kansas City, MO. He completed an internship at the University of Medicine and Dentistry of New Jersey and an internal medicine residency at Mt. Sinai Medical Center and MetroHealth Medical Center in Cleveland.

Ophthalmologist Retiring After 45 Years of Practice in North Hills

After more than 45 years of practice, ophthalmologist Dr. Stanton Elias, a native of Pittsburgh, is retiring from practice.

Dr. Elias completed his undergraduate degree at the University of Pittsburgh in 1953 and obtained his medical degree from the University of Pittsburgh in 1957. Following a one-year internship at Montefiore Hospital, he completed his residency in ophthalmology there in 1961. Shortly afterwards, the doctor practiced ophthalmology in the United States Navy. His initial position was Chief of the Department of Ophthalmology at Portsmouth Naval Hospital, Kittery, Maine, in June of 1961, having the rank of Lieutenant Commander. It was here that he was awarded the National Defense Medal.

Dr. Elias returned to Pittsburgh and joined the staff of UPMC Passavant in 1963, when the hospital was located in the Hill District. In March 1964, Dr. Elias performed the first cataract surgery at UPMC Passavant's new location in McCandless. Dr. Elias' practice grew and thrived over the next four decades. In addition to working at UPMC Passavant, he also operated at Suburban General Hospital, Montefiore Hospital, and Eye and Ear Hospital. He obtained the title of clinical assistant professor of ophthalmology at the University of Pittsburgh School of Medicine.

Allegheny General Physician Appointed to NIH Council

Dr. Sharon C. Kiely

The National Institutes of Health (NIH) has recruited Sharon C. Kiely, M.D., M.P.M., medical director of Quality and Patient Safety at Allegheny General Hospital (AGH), to join an elite group of U.S. healthcare professionals responsible for overseeing activities of the National Institute of Allergy and Infectious Disease (NIAID).

Dr. Kiely is one of 12 health or science experts who will serve on the NIH's National Advisory Allergy and Infectious Disease Council for a four-year term.

Board certified in internal medicine and a Fellow of the American College of Physicians, Dr. Kiely also serves as an Associate Professor of Medicine for the Drexel University School of Medicine and is a former vice chair of AGH's Department of Medicine. She received her medical degree from Georgetown University and earned a Master of Public Management from the H. John Heinz School of Public Policy and Management at Carnegie Mellon University.

Rajiv Jain, M.D., Appointed Acting Director of VA Pittsburgh Healthcare System

Dr. Rajiv Jain

Dr. Rajiv Jain, VA Pittsburgh Healthcare System (VAPHS) Chief of Staff, was appointed by the VISN Director to serve as the Acting Director of the VA Pittsburgh Healthcare System. Dr. Jain will serve as Acting Director during the search, recruitment, and selection process for a new VAPHS Director. Michael E. Moreland, former Director of VAPHS, was promoted to serve as Director of the VA Stars & Stripes Healthcare Network on December 24, 2006.

Rajiv Jain, M.D., FACP, has been the senior clinical leader for VAPHS since November 2000, overseeing the clinical management of three campuses as well as five community based outpatient clinics, with 692 operating beds distributed among medicine, surgery, psychiatry, intermediate care, nursing home care and a domiciliary. Dr. Jain also serves as Assistant Dean for Veterans Affairs at the University of Pittsburgh School of Medicine.

General Surgeon Joins Wetzel County Hospital Staff

Jeffry J. Pilney, M.D., a physician certified by the American Board of Surgery, has joined the Wetzel County Hospital medical staff as a general and trauma surgeon. Dr. Pilney recently opened his private surgical practice in New Martinsville.

In addition to his Board Certification in Surgery, Dr. Pilney is also certified by the National Board of Medical Examiners. He is a member of the American Medical Association and the West Virginia State Medical Association.

Dr. Pilney served on the academic staff of the West Virginia University School of Medicine as a staff surgeon and clinical instructor for medical students and residents, where he specialized in trauma surgery. He also served the West Virginia University School of Medicine as the Medical Director for the Surgical Stepdown Unit; Interim Director of the Jon Michael Moore Trauma Center and on various committees of the hospital and Department of Surgery.

He continues to be an instructor in Advanced Trauma Life Support (ATLS) for the West Virginia University's Center for Rural Emergency Medicine.

West Penn Hospital Nurses Are First in Region to Earn Prestigious 'Magnet' Designation

West Penn Hospital has earned designation as a "Magnet" hospital from the American Nurses Credentialing Center (ANCC), the highest recognition a hospital can receive for excellence in nursing.

West Penn is now one of just 231 hospitals worldwide, out of approximately 6,000, to achieve this honor, placing West Penn among the top 3 percent in the nation. In addition, West Penn is western Pennsylvania's first and only facility with Magnet status. The ANCC notified the hospital of its achievement on Dec 7, 2006, following a rigorous and comprehensive three-year effort that reviewed and documented every aspect of nursing, from direct patient care to professional development.

"We are so proud of our nurses. Everyone has worked hard and this means so much," said Sherry Zisk, RN, MNEd, CNAA, chief nursing officer and vice president for West Penn. "The scope and intensity of the Magnet appraisal is enormous, but for all of us, it was a completely positive process that I wish every hospital could experience."

"For me, it solidified my vision to achieve and to be recognized for true nursing excellence here at West Penn. For the staff, it validates what they already knew – that they are excellent nurses and our care is second to none. It is the ultimate seal of approval that gives the consumer a strong message that West Penn offers excellent care."

The Magnet Recognition Program is administered by the ANCC, a subsidiary of the American Nurses Association. The ANCC developed the Magnet Program and Standards to recognize hospitals that demonstrate sustained excellence in nursing services.

In this era of severe shortages and competition for nurses, the Magnet designation indicates an exceptional professional work environment and the opportunity to provide state-of-the-art, excellent care. Magnet hospitals consistently show lower nurse turnover and vacancy rates, improved patient outcomes, lower patient mortality rates, shorter lengths of stay and higher satisfaction ratings from patients and staff.

West Penn began the lengthy and detailed Magnet application process in 2003, measuring its performance against the ANCC's gold standard in 14 areas, including leadership, quality of care, and professional development, known as "The Forces of Magnetism." This meticulous self-assessment explores every aspect of nursing operations and identifies areas for improvement. Hospitals submit extensive documentation in support of their applications, and undergo a site survey in which Magnet appraisers, as they say, "clarify, verify and amplify" the documentation.

"The standards reach deep into the organization's culture," Zisk says. "It is really about having a culture of excellence on every level that is ingrained and genuine. You have to be able to demonstrate that the nursing staff at the bedside has the expertise, resources, support and autonomy to deliver the highest quality care."

Zisk credits the entire West Penn staff for the achievement but has special praise for Jackie Collavo, RN, BSN, Magnet Recognition Program Director, and a team of Magnet "ambassadors," clinical nurses who facilitated the effort among all nursing departments. "Jackie played a significant role. She had to become the in-house expert on the Magnet Program standards and processes. She provided the guidance, the stamina and the perseverance to succeed."

Sherry Zisk

Jackie Collavo

Barb Lion

> "The scope and intensity of the Magnet appraisal is enormous, but for all of us, it was a completely positive process that I wish every hospital could experience."
>
> – Sherry Zisk

"It was a monumental challenge to pull this together," Collavo says, "and was truly a journey. It was a learning experience for all of us. For me, it was a reminder of why nurses become nurses in the first place – to give excellent care to patients."

The entire process was staff nurse-driven, she says, with separate task forces composed of nurses at all levels for each of the 14 Forces.

Barbara Lion, R.N., Clinical Nurse III, served as a Magnet ambassador. "I'm proud to say that I work at a Magnet hospital; it validates that we are among the very best. The journey to Magnet designation was eye-opening for me and I enjoyed the whole process. I believe that Magnet recognition defines us; it makes a statement about who we are and has given us both recognition and greater confidence."

Lion has worked at West Penn for 38 years, including the last 19 in the Ambulatory Surgery Center. In her role as an ambassador, she served as a liaison between her department and the Magnet task forces, keeping her colleagues informed, motivated and educated.

"At first, I wasn't fully aware of what it meant to seek Magnet Recognition status. I discovered that once I got involved, it became infectious. It was wonderful to see the growing enthusiasm of the staff nurses, many of whom worked on special projects throughout the Magnet journey.

"In a hospital, we are all so busy with our own units that we can become cloistered and forget that there is a bigger picture, but the Magnet program brought us all together. I feel that it also told the staff that the administration believes in us and that meant a lot. West Penn is a large hospital with a small town feel, and our administrators are very visible. This is exciting for all of us, for the nurses and for the whole hospital."

Lion served as an ambassador/escort for the ANCC appraisers, but in keeping with ANCC policy, was not among those interviewed. The appraisal team visited every department and conducted interviews with staff members at random, assuring the integrity of the process. In addition to inspections and interviews, the appraisers invited about 280 nurses, throughout the three-day visit, to share meals with them, giving them an opportunity to talk with as many staff nurses as possible.

Magnet Recognition Status, Zisk emphasizes, is an achievement for the entire West Penn community, not just for the nurses. "Although the Magnet program is about nursing excellence, it is also an interdisciplinary process; nurses don't do it alone. Every department participated and it is their achievement, too."

"This is a big honor for the hospital and it boosted everyone's morale, said Maribeth Fischer, RPH, Senior Pharmacist, who answered survey questions for the ANCC appraisers. "Every department was involved in the effort. It's a great feeling to know that you achieved something really difficult. My hope is that it will bring more recognition to West Penn and that patients will realize that the care here is the highest quality."

Magnet designation verifies what physicians have known for a long time – that West Penn nursing is outstanding, said John Guehl, D.O., Medical Director of West Penn.

"The medical staff is pleased that the nurses are getting the recognition that we always felt they deserved," Guehl said. "The fact that this has happened through the Magnet program demonstrates that, on a level playing field, when held up to the highest possible standards, our nurses demonstrate excellence."

In addition to Magnet designation's numerous internal benefits, it also benefits the community. For consumers, it means that West Penn has a proven record of excellence and a professional accreditation that very few hospitals have earned. Consumers are aware of the problems confronting hospitals – the shortages of health care professionals, the medical errors crisis and the rising rate of hospital-acquired infections, among others – and they need information they can trust about which hospitals offer care of the highest caliber.

For more information, contact Jackie Collavo, RN, BSN, Magnet Recognition Program Coordinator, at (412) 578-5205.

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