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Hospital Council Seeks Solution to Medicare Wage Index Issue

BY PATRICIA J. RAFFAELE

Hospitals in Pittsburgh and in western Pennsylvania receive less reimbursement than hospitals in other parts of the state and across the country due to how hospitals are reimbursed for their labor costs under a formula called the Wage Index. This in turn, affects how much hospitals can pay their employees and how many employees they can add to their staff. Since 2001, the cumulative impact to the Pittsburgh CBSA alone has been a loss of more than $300 million. The wage index continues to cycle downwards each year, in what some experts call a "death spiral."

"The wage index system is broken," said A.J. Harper, president of Hospital Council of Western Pennsylvania. "Pittsburgh and western Pennsylvania hospitals need short term relief and a long term fix to stop this chronic and fundamental problem."

This issue really only affects hospitals in the Pittsburgh and western Pennsylvania area, including Altoona, Butler, DuBois and Johnstown, Harper said. For example, hospitals in Pittsburgh, Johnstown and Altoona have seen a 13.9 percent decline in their wage index over the past eight years, while hospitals in Pennsylvania and across the country have seen steady increases.

"Add this issue to the other unique challenges faced by our region's hospitals and we have a perfect storm," Harper said. "Hospitals in western Pennsylvania operate under a unique and challenging market which is different from other parts of the country—and the wage index is one of these factors."

For example, besides dispari-

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A.J Harper

PROFILES IN MANAGEMENT

DR. STANLEY MARKS: *Making Life Better for People With Cancer*

David K. Miles

BY DANIEL CASCIATO

When Dr. Stanley Marks began his medical career, specializing in oncology in 1978, cancer care was only available in the city Pittsburgh and not the surrounding communities.

"At that time, I saw a tremendous need for these communities," recalls Dr. Marks, director of clinical services and chief medical officer for UPMC Cancer Centers. "Over the years, we have developed one of the largest cancer delivery networks in the country. As a result, I think we have improved the health of families throughout the region."

Dr. Marks, currently residing in Shadyside, has also helped the UPMC Cancer Centers become one of the largest cancer delivery systems in the United States. Additionally, UPMC Cancer Centers is ranked 10th in the country in terms of annual funding for research.

"We're not happy there," says Dr. Marks. "We want to be in the top five in terms of funding and clinical delivery. We should get there within five years. That's a goal of ours."

Ask Dr. Marks about these accomplishments and you can hear the pride in his voice. After all, making life better for people with cancer is something he's been working for his entire career.

As an undergraduate and a medical student at the University of Pittsburgh, Dr. Marks knew he wanted to be in a career where he could help people. He later trained in hematology and oncology at Harvard.

"I love interacting with people and what I wanted to do is help people in their greatest time of need," he says. "Oncology has been an area where there have

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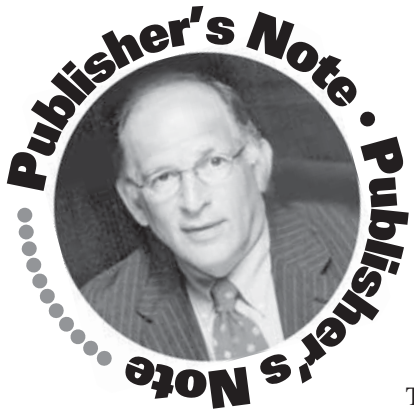

"Just Be Happy You Have A Job"

I'm sure it's heard even in good times, but it reaches a crescendo during an economic downturn. Those who are spared the unemployment ax are reminded constantly to "Just be happy you have a job."

Some people mean it innocently enough, a secular version of "There but by the grace of God go you." But when spoken by others, there's an undercurrent of smugness, even threat, as if to say no matter how unfair or frustrating your work is, you should suck it up, accept it, and be grateful you're not reduced to filing biweekly unemployment claims and scouring the want ads in a desperate search to find something, anything, to stave off bankruptcy, poverty, or homelessness.

But the healthcare industry, like every other industry in America today, needs to tread cautiously here. Today, employers have employees right where they want them: frightened. Many individuals live paycheck to paycheck. They come to work every day anxious, one ear continuously connected to the office grapevine. Some have been reduced to praying for reduced hours, or mandatory time off without pay, or even a loss of some salary if it means at least still having a job to go to.

But I would offer a word of caution to all employers. If history teaches us anything, it's that what goes around does indeed come around, and the economic downturn will someday reverse direction. And when it does, employees with long memories will recall how they were treated when times were bad. When employers find themselves needing good people to join their organizations, they may find that their biggest challenges are not in recruitment, but retention, as some of their best employees decide to leave in search of a more humane, more compassionate work environment.

If we learn nothing else from these times we currently struggle through, it should be that we are all in them together. As tough of a reality that it is to face, Americans understand that in a recession jobs will be lost and those who remain will be asked to do more, often with less. But that shouldn't be an excuse to treat people as if they should grovel and cower while in the workplace. In good times and bad, there should be more to a job than a paycheck. To the extent possible, it should bring fulfillment, satisfaction, and a sense of pride.

Sure, it's great to have a job. But it's even more important to have a life.

Harvey Kart

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Health Information Technology – Incentives for Rural Health Facilities

BY JENNIFER E. CIDILA, CPA

Over the past few years there has been an increased focus placed on electronic health records. This process allows for easier access from multiple medical facility locations, but it also brings with it many security issues. Through the Health Insurance Portability and Accountability Act (HIPAA), many rules and regulations have been established to protect patient health information and privacy.

The American Recovery and Reinvestment Act of 2009 established state grants to promote health information technology and assist health care providers with its adoption and implementation. The incentives are for meaningful electronic health record uses which would include use of certified electronic health records technology, information exchange, reporting on measures using electronic health records, submission of claims with appropriate coding, and survey response data.

There is a Medicare incentive which is spread over a five year period. The incentive is limited to the lower of 75% of allowed Medicare charges for professional services for a payment year or $18,000 the first year decreasing to $2,000 by the fifth year. The Medicare incentive is for eligible professionals (doctors of medicine or osteopathy, doctors of dental surgery or of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors). An eligible physician practicing in a designated health professional shortage area can receive a 10% increase in incentive payments.

In addition to physician incentives, there are incentives for other provider types. By 2011, if a critical access hospital is a bona fide electronic health record user, then they are eligible for four years of enhanced Medicare payments. In addition, they can immediately depreciate certified electronic health record costs, including undepreciated costs from previous years. The enhanced Medicare payment is calculated by taking the total enhanced health record costs multiplied by Medicare share plus 20%. The Medicare share is the estimated number of inpatient bed days with payment under Part A plus estimated number of inpatient bed days for those enrolled with Medicare Advantage

Part C divided by estimated total number of inpatient days times percentage of an eligible hospital's total charges that are not charity care.

Professionals are eligible for either Medicare or Medicaid incentives, but they cannot receive both. However, critical access hospitals are eligible for both Medicare and Medicaid incentives. There are Medicaid incentives for non hospital-based professionals who practice in a federally qualified health center or rural health clinic with at least 30% patient volume attributable to individuals who either receive Medicaid, receive assistance under Title XXI (State Children's Health Insurance Program), who are furnished uncompensated care by a provider, or who receive reduced charges by the provider on a sliding scale basis based on the individual's ability to pay. The incentive payments will cover up to 85% of net allowable costs for electronic health record technology, support services, maintenance, and training for a provider to adopt and operate the electronic health record technology. The net average costs for the first year cannot exceed $25,000 and the first year cannot be after 2016. The net average costs for subsequent years cannot exceed $10,000. There will be no payments after the year 2016 and a professional cannot receive payments for more than five years.

> "In addition to physician incentives, there are incentives for other provider types. By 2011, if a critical access hospital is a bona fide electronic health record user, then they are eligible for four years of enhanced Medicare payments. In addition, they can immediately depreciate certified electronic health record costs, including undepreciated costs from previous years."

The Medicaid incentive for critical access hospitals, with at least 10% Medicaid patient volume, is equal to the electronic health record costs multiplied by the Medicaid share. This amount is then multiplied by 50% for one year or it can be multiplied by 90% for a two year period. The electronic health record cost is the sum of four years of payments with a four year transition factor.

Transitioning from the "paper" system of the past to the electronic based system can be challenging for many small rural facilities that already have cost challenges. However, based on the above incentives, it is beneficial for professionals and facilities to comply with the regulations early on to receive the maximum five year incentive available.

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Rural Providers: Stark Law Exceptions and Anti-Kickback Law Safe Harbors

BY JESSICA A. ELLEL, ESQ.

High costs and poor payor mixes generally result in health care providers in rural communities struggling to provide innovative technologies and services to their patients. Federal laws designed to prevent unlawful referrals further constrain health care providers in their attempts to innovate by thwarting certain ventures which would help health care providers work together to provide these technologies and services. Fortunately, exceptions to the federal Stark Law and safe harbors in the federal Anti-Kickback Law have been designed to assist providers in rural areas to address these concerns.

The Stark Law

The federal Stark Law prohibits physician referrals to any entities in which the referring physician maintains a direct or indirect financial relationship with the entity. However, the federal government has also created a multitude of exceptions to this general prohibition to permit certain types of ventures that have been shown to have a low risk for actual fraud or abuse. One such exception is the Rural Provider Exception, which states that ownership or investment interests in a rural provider do not constitute a "financial relationship," as defined under the federal Stark Law. Therefore, physicians may participate in a joint venture with the hospital, and refer to that entity, in a rural community, despite such relationship being prohibited in an urban setting.

In order to qualify as a rural provider under the federal Stark Law, a joint venture must meet certain requirements. First, a rural provider is defined as an entity that furnishes at least 75% of its designated health services to residents of a rural area. A rural area is defined as any area that is not defined as urban by the United States Census Bureau. This definition encompasses many health care providers across the country who may not be aware of their status.

The Anti-Kickback Law

The federal Anti-Kickback Law provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business reimbursable under any federal or state health care program. The types of remuneration under the Anti-Kickback Law include kickbacks, bribes, rebates and other payments, whether made directly or indirectly, overtly or covertly, in cash or in property. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration intended to induce the purchasing, leasing or ordering, or arranging of any good, facility, service, or item paid for by federal or state health care programs. In addition, in order for there to be a violation of the Anti-Kickback Law, there must be intent on the part of the individuals involved to pay or receive improper remuneration. Thus, a business arrangement that does not completely meet one of the safe harbors for the Anti-Kickback Law may still be legal, so long as the parties involved do not intend to pay or receive remuneration in order to induce business.

Because the federal Anti-Kickback Law is so broad, safe harbors have been developed due to recognition of certain ventures that provide a low risk of actual fraud or abuse. Although the federal Anti-Kickback Law does not contain a safe harbor specifically addressing rural providers, the Investment Interests Safe Harbor provides enhanced flexibility for rural health care providers practicing in medically underserved areas.

Pursuant to the Investment Interests Safe Harbor, returns on investments in small entities are not considered improper remuneration if, among other requirements, no more than 40% of all the investment interests in the entity are held by referring investors (i.e., investors who are in a position to refer patients to the entity) and no more than 40% of the venture's revenues come from business referred from investors. In the case of health care providers practicing in medically underserved areas, the Investment Interests Safe Harbor permits a more flexible ownership threshold. If a joint venture is located in either a medically underserved area or is serving a medically underserved population, then referring investors in those areas can own up to 50% of the venture and the venture may derive an unlimited amount of its revenue from those referring investors. In exchange for these relaxed provisions, the Investment Interests Safe Harbor mandates that the entity must derive at least 75% of its dollar revenue from services provided to patients that live in a medically underserved area or are members of a medically underserved population.

Conclusion

With the Rural Provider Exception and the Investment Interests Safe Harbor, the federal government has provided rural health care providers with opportunities to collaborate with large health care entities, such as hospitals, to bring innovative technologies and services to communities that would otherwise need to do without. Rural health care providers should be aware of these options when planning future ventures.

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Foundation Radiology Group and Vital Images' Partnership Formed

Foundation Radiology Group (FRG) and Vital Images have partnered to bring Vital Images' advanced visualization software to FRG's customer base. FRG will utilize Vital Images' full suite of software exclusively with its customer base of over 20 non-university affiliated, suburban and rural healthcare institutions.

"We are proud to partner with Vital Images to provide a full suite of advanced visualization technology to our growing customer base," said Brandon W. Chan, chairman and chief executive officer at FRG. "It enables us to deliver state-of-the-art technologies to small community hospitals and their patients, who would otherwise not have access to these types of care options."

Becoming a Leader Through Mentorship

BY CRYSTAL MACOM

John Quincy Adams is quoted as saying, "If your actions inspire others to dream more, learn more, do more and become more, you are a leader." I have found that the most effective way to become a good leader is through mentoring. If you are lucky enough to encounter a supervisor or co-worker who inspires others to succeed and achieve, you are well advised to learn from that person's techniques. A truly effective leader enlists the help of others to accomplish goals. In the workplace, when a team focuses on an objective together something special happens.

At Bethany Hospice, we have developed a set of professional standards called the "Team Bill of Rights" by working together as a team, led by our Executive Director, Diane Mead. Diane knew that by allowing staff to help create policy, the policy will be effective. Over several months, any staff member who wished to participate was encouraged to attend a meeting to develop our "Team Bill of Rights." What emerged from those meetings was a list of standards to which all employees of Bethany Hospice are committed. The "standards of excellence" are things such as Respect, Honesty, Understanding, Professionalism, Competence, and Accountability to name a few. We also established a standard of Unconditional Positive Regard which is our formal terminology for our practice of maintaining an upbeat, positive work place. Employees are empowered to address concerns with our open door supervisory methods. Because the team drafted these standards together, we are all committed to the company culture that we are achieving. These methods have paid off. This year Bethany Hospice was chosen as one of the Western Pennsylvania Best Places to work largely due to responses from an employee satisfaction survey.

Diane's leadership was essential in the development meetings. We have used this teamwork approach to draft many other standards and policies since then. Having worked with Diane for many years, I have learned to value teamwork and have implemented those concepts successfully in my own job. Diane has been an asset to my career, giving me real guidance toward becoming a professional, helping me to overcome my weaknesses and learning to appreciate my strengths through positive feedback.

Here are some tips for finding a good mentor:

- Choose a mentor who garners the respect of people both within his or her own company as well as the community.
- Approach your would-be mentor honestly and ask for help in your career development.
- Make a plan to discuss your progress on a regular basis depending on your schedule availability and that of your mentor.
- Develop career achievement goals for yourself. You may find it helpful to write these down and post them somewhere you can see them on a regular basis.
- Be professional and courteous in your relationship with your mentor.

The Webster Dictionary defines a mentor as a trusted counselor or guide. In my experience, I have definitely found this to be true. As the first person to graduate from college in my family, I had a lot to learn in my professional growth. I am grateful to every single person who showed me the right path to tread. I look forward to my ongoing growth as a leader with Bethany Hospice. As I do that, I plan to continue to learn from Diane and other professionals like her. After all couldn't we all use a little guidance here and there?

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Leadership: Two Principles – and a Nuance

BY DAVID K. MILES

I have always believed that effective leaders practice two fundamental principles: leading through example and accepting ultimate responsibility.

Leaders set the tone for any organization – its culture, its ethos, the way it's perceived by its stakeholders, both internal and external. Directives don't work – if a leader says integrity is valued but doesn't practice it, integrity will never be a characteristic of the organization. It's the leader's actions that matter – the day-to-day behaviors that staff, patients, volunteers, students and others can observe, and whose effects they can see.

Truly effective leaders, I believe, try to exhibit the best in human nature. Certainly everyone has "off" days – leaders are human, after all – but being as consistent as possible in qualities including integrity, humility, vision, patience and good communication will go a long way toward gaining the trust and respect of stakeholders – and inspiring in them the commitment necessary for organizational excellence.

A word about communication: it's easy for leaders to think that the most important aspect of communication is sending the message. But I've learned that receiving the message – listening – is at least as important; that's how leaders can best know what is happening within their organizations. I think often of this Winston Churchill quote: "Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen."

The second fundamental principle of leadership is accepting ultimate responsibility; the leader's desk is truly where "the buck stops."

Stepping up and accepting responsibility is particularly important when situations go awry, or the news is not good. That's when effective leaders calmly say, "We will deal with this" – and do so, marshalling whatever resources are necessary. It doesn't matter who or what caused the situation; it's the leader's job to accept responsibility and focus on producing the best possible solution for the organization. There is time later to work on preventing recurrences.

But while leaders should accept ultimate responsibility, it's equally important that, when good things happen, they share credit with their staff members and others responsible for the achievements. Whatever those achievements are—patient satisfaction, quality, financial results or anything else—it's impossible to overestimate the strong (and long-lasting) motivational effects when credit is given where it's due.

Any leader—novice or veteran—can successfully practice the principles of leadership by example and acceptance of responsibility. But there is one more essential quality of effective leadership, and it's one that tends to develop with experience. Some leaders develop it quickly and others more slowly—but, at least as far as I have seen, few people come to leadership with the quality in evidence.

That quality is the ability of a leader to know when decisions should be made by the leader himself or herself and when they should be made by staff or other key stakeholders.

Even when a leader knows it's appropriate to delegate a decision, the line between treating others as capable professionals and attempting to control their performances can be a fine one; it's not always easy for a leader to provide adequate guidance and information – and then have enough patience and trust to step back and let someone else determine and implement the suitable action.

Knowing when and how to delegate is, I believe, a nuanced ability – subtle and sensitive and to a degree intuitive – but it's a key one for any leader who wants her or his staff to grow in responsibility and capability.

When you combine that ability with the willingness to lead by example and to accept ultimate responsibility, you have a highly effective leader – and a highly effective organization.

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> I read once that the greatest challenge a leader faces is not simply allowing people to speak the truth, but actually being able to hear it. Sometimes our deafness comes from being too busy, or being too arrogant. But if we listen closely we will hear the voices of leadership coming at us from every position.

Leading from Any Position

BY GAIL WOLF, DNS, MSN, BSN, FAAN

My initial plunge into leadership came when I was 21 years old and assumed a job as Director of Nursing for a small 60 bed rural hospital. There I was – one year out of college, green as could be, scared to death, and too dumb to know what I didn't know. Over the next few years the nurses and the patients taught me how to be a leader; sometimes by example, sometimes through a good idea, but mostly by listening to folks talk about what wasn't working well and trying to fix it.

Over the years that followed, I went back to school to learn more about leading. I studied all the great theorists, read endless numbers of books and articles, and was promoted to a variety of leadership roles. I learned how to lead people to where they didn't want to go, but needed to be; and I learned that sometimes you lead by following. I made my share of mistakes, and hope I did a few things right. But I never forgot that first lesson: leadership can come (and often does) from any position.

Today I work in an industry that's in a mess. Pick up any newspaper, turn on any TV and you are bound to hear about how broken health care has become. But I am encouraged. "Good grief -- why?" you might ask. Well, in addition to teaching about leadership, I also Chair the Commission on Magnet – a designation bestowed by the nursing profession on hospitals that have great work environments, and even better patient outcomes. Granted there aren't a lot of them – only around 5% of all hospitals in this country have Magnet designation – but about 75% of the *U.S. News and World Report* top rated hospitals are Magnet hospitals.

Their secret? Magnet hospitals have people leading from every position. Yes, they have good leaders at the "top", but they also value the leadership that comes from those closest to the work. They have created work environments where it is not only okay to take the lead, it is expected. Staff who do the work are accountable for making sure it is of high quality. They are expected to use the latest scientific knowledge in delivering care. They work together and respect each other. And if it isn't that way? That same staff is given the support to lead initiatives to fix it. The results? Engaged employees, excellent patient care, and good outcomes. Imagine that – just what we are looking for in health care.

I read once that the greatest challenge a leader faces is not simply allowing people to speak the truth, but actually being able to hear it. Sometimes our deafness comes from being too busy, or being too arrogant. But if we listen closely we will hear the voices of leadership coming at us from every position.

Gail Wolf, coordinator of the nursing administration and leadership program and professor in the Department of Acute and Tertiary Care at the University of Pittsburgh School of Nursing, can be reached at (412) 648-3047 or wolfg@pitt.edu.

Embracing Medical Leadership Critical for Community-Based Hospitals and Health Systems

BY KIRK L. MILLER, FACHE

As hospital administrators struggle with the challenges of the nation's health care landscape, the need for community-based hospitals and health systems to embrace physicians in medical leadership roles is more important now than ever before.

Hospitals and physicians alike face increasingly complex hurdles ranging from funding stream changes and quality mandates, to keeping abreast of technological innovation in patient care and record-keeping, while responding to mounting market pressure for integration and physician alignment. Physicians are seeking ways to defer the risks of private practice through alignment with larger organizations and facilities. Such risks include increasing shortages and costs of financial capital, increased regulation on equipment and ownership of health related enterprises, restricting and complex reimbursement from payors, and malpractice cost pressures. Alignment with other physicians or hospitals is a necessity for survival and will become even more so as Centers for Medicare and Medicaid Services (CMS) and third party payors look toward bundling payments and pay-for-performance incentives. Gone are the days where a doctor can come out of medical school, set up a solo practice and succeed.

Similar forces have made it increasingly critical for community-based hospitals to have physician leaders and physician peer representation in their governance. While physician leadership has been common in academic and research institutions, it's a relatively fresh concept in community-based medicine, where business expertise traditionally dominated. The trend now is more toward a shared governance model between business leaders and physicians.

As many community-based organizations work to shape a governance structure that best suits the needs and dynamics of their individual organizations, in nearly every case, it is evident these new types of structure require physician leaders who possess a broader understanding of business and management principles. This makes the investment in and cultivation of medical leadership critical to their success.

Some health care organizations are using a hospital-based council model, which brings together the business expertise of the health care administrators and the clinical knowledge of physicians. This model fosters joint decision-making and ownership, as well as joint responsibility for outcomes. For example, if cost constraints require $300,000 to be cut from a service-line budget, having physician leaders involved as active participants in the process for selecting how and why programs, supplies or services would be cut will provide physicians better understanding of the financial and economic constraints that drive a particular decision. At the same time, physicians might advise administrators on pros and cons of a particular equipment purchase and how it affects their clinical practice and thus avoid cost-cutting without consideration of long-term qualitative aspects of purely economic-based decisions. Such a shared process of decision making affords joint ownership in the eventual outcomes.

Another type of shared governance used by health systems, particularly in clinical service lines, is the "dyad" model. A dyad leadership model pairs an administrative leader with a physician leader to manage day-to-day issues of patient care, patient and referrer satisfaction, budget management, and strategic direction for a clinical area or service. Typically, this includes inpatient, outpatient and ambulatory services.

Regardless of approach, a successful Medical Leadership Development program is crucial. Career tracks and succession planning for physician leaders are also key. In essence, these are the same tools and approaches that have been in place at the administrative level for years. Management by partnership eliminates compartmentalization, streamlines communication and provides a systematic focus which means better coordination of services and cost efficiencies.

Community-based hospitals that successfully establish a medical leadership development program will also reap a competitive advantage in recruiting physicians. Physicians looking for opportunities to grow as their career progresses will be more apt to choose a position where they are afforded such opportunities.

While not all physicians have the desire to participate in leadership roles, having respected peers and contemporaries at governance and executive levels is attractive for those seeking a place to practice. Doctors like to work for doctors and having colleagues who can serve as mentors is important to most physicians.

It's an exciting time for community-based hospitals and health systems to forge partnerships with one another and the physicians who practice with them. There is greater opportunity for all involved, professionally and clinically. Most importantly, at the end of the day, patients have access to the care they need from hospitals and qualified physicians close to home who share a common concern for their well-being.

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> Community-based hospitals that successfully establish a medical leadership development program will also reap a competitive advantage in recruiting physicians.

Management
By the Heart

BY NORMAN J. RISH

> "The most important are openness, acceptance, and integrity or credibility. This trust is not easy to accomplish and remains an ongoing task. However, the overall health of the organization depends upon it!"

As I reflect back on greater than 10 years of working in the health and sciences for Fortune 25 Companies and 30 years as the President of Family Home Health Services, Inc. and Three Rivers Hospice, I have gained numerous insights of effective management techniques and leadership.

I have been fortunate to have participated in many management training programs over the years, and to have had the opportunity to attend seminars and meet a number of noted management consultants and authors on these subjects. The information, attitudes, and mores that I was able to glean from these experiences and bring to my individual management style is of prime importance.

Leading in this climate of change has never been more challenging than it is now. This being said, how does one maintain the leadership edge? Challenges abound.

I have always "Managed by the Heart" – it is my solution. Management by the Heart serves as a method to inspire, motivate, and encourage staff to perform their duties as needed and directed. It helps to develop a loyal staff, builds a winning team, and helps to increase the levels of trust within the organization.

There are many components to building trust within the organization. The most important are openness, acceptance, and integrity or credibility. This trust is not easy to accomplish and remains an ongoing task. However, the overall health of the organization depends upon it!

Developing a mission statement is also key. This should be created by a team. Whereby I would create the vision statement, my managers create the mission statement, which is strictly adhered to. It is not always easy to adhere to these statements, but it is imperative to do so, to attain a spiritual quality within the organization. Of equal importance and tying all of these factors together is the development and empowerment of a true Corporate Compliance Program. The Mission Statement, Vision Statement, and Corporate Compliance Program taken together thus define the Organization.

Today we are on the verge of a paradigm shift in healthcare. It is most interesting that in my professional career, I am experiencing my fourth or fifth paradigm shift. The term Paradigm Shift was first introduced by Thomas Kuhn when he demonstrated how a breakthrough in the field of scientific endeavor is really a break with old ways of thought. Or, suddenly everything takes on a different meaning or interpretation. When I began my professional career years ago, this term was not used. Now it is an integral part of day to day operations and management. Of course, a part of the difficulty is that many staff do not fully recognize paradigms. In the past, there were those old "conventional wisdoms" and "rules of thumb" that we could use to roughly measure effectiveness. Those are all gone now and it seems that those old adages are harder and harder to replace and invent with each ensuing paradigm shift.

Robert Ballard states that, "We are all explorers." I agree! His idea of an epic journey; dreams, preparation, teamwork, embarking and overcoming obstacles, finding truth and sharing new knowledge are the same steps that any business person must utilize to be successful. Dreams, vision and mission statements all flow together. They form the "HEART"!

Norman J Rish is President/CEO, Family Home Health Services, Inc. and Three Rivers Hospice. For more information, call 1-800-692-2738 or visit fhhs.com or call 1-800-282-0306 or visit threeriversshospice.com.

PAM SCHANWALD –

Filling the Gaps in Specialized Pediatric Health Care

BY LAURIE BAILEY

While she was working as a young nurse, a supervisor told Pam Schanwald that she needed to find a way to channel her energy for wanting to improve hospital logistics. "I didn't have a great appreciation for bureaucracy and wanted to affect change in the simplest way possible," she now admits.

Today, the Chief Executive Officer of the Children's Home of Pittsburgh and Lemieux Family Center directs an organization founded on hope and functioning on expert specialized care. At the organization's helm since 1993, Schanwald has and continues to work toward change and advancement, compassionately dedicated to filling unmet community needs.

Since 1893, the non-profit organization has served families in the areas of specialty health care and day care and adoption services. In their new "home" on Penn Avenue for two years, staff members are a family, genuinely courteous to one another and to those entering through the facility's wide automatic doors.

Moving from two buildings less than half its current size, the center now boasts 63,000 square feet on three floors of inviting, attractive space. Schanwald and her staff worked closely with Perkins Eastman architects and designers to establish a working environment with a home-like atmosphere. Every detail is deliberate, from the soothing hues of purple, orange and green in the 28-bed Transitional Infant Care (TIC) hospital to the spacious floor plan of Child's Way, the day care center for medically fragile children.

Child's Way encompasses most of the first floor of the building, and at naptime, the only light in the rooms is the overcast daylight coming in through the windows. Toddlers and infants sleep or quietly look at books or toys, a professional staff member nearby. It's an amazingly relaxing place, considering the children here have extraordinary health issues. Many have feeding tubes and tracheotomies, cardiac and seizure disorders or rare genetic abnormalities. Tending to their needs are pediatricians, registered nurses and other expert childcare staff members.

"She (Pam Schanwald) makes it her point to know the kids and their parents. She truly knows which families have special needs," expresses Carolyn Brickley, the director of Child's Way for the last 9 years.

When Schanwald visits Child's Way, just down the hall from her own first floor office, staff members look up from their work and greet her as welcome company - with everyone's attention automatically drawn to the special children in the room. Age appropriate toys, artwork and educational materials are in abundance. In the event that they are needed quickly, gas and oxygen hookups are evident in all areas of the facility.

Brickley admits the director-CEO relationship she has with Schanwald is ideal. A hands-on leader, Schanwald doesn't micro-manage.

"She could be giving a tour and notice a look on my face and sense there's an issue," explains Brickley. After the tour, Schanwald will be sure to follow up, she adds.

"She's very intuitive," says Brickley

Schanwald is credited with spearheading a move to gain licensing for Child's Way as a Pediatric Extended Care Center (PECC), the first in Pennsylvania. As a PECC, the facility can receive reimbursement from third party payors for the medical care it provides. But getting to that point wasn't easy. For eighteen months, Schanwald lobbied for a special day care program status.

The largest obstacle, explains Schanwald, was that she was suggesting a program that didn't look like any other in the state.

"The focus had always been on having (special needs) children in the home. We were going beyond the societal norm," says Schanwald. Her struggle - along with a community of physicians, board members and health care companies - was to convince legislators in Harrisburg that a PECC was a viable option for special needs families.

In reality, because of its specialized care, trained staff and unique clients, it is a truly unequaled center.

"We're not replicating what someone else is doing … we look for the gaps (in what is already available for families)," says Schanwald.

"She can hurdle adversity in a way that would be daunting to many others," comments Ranny Ferguson, colleague, friend and president of the board of directors for the Children's Home.

Finally, in November 1999, after Schanwald's testifying at a subcommittee hearing to examine granting full licensure to Child's Way, Act 54 was passed and licensure was granted.

Two floors above Child's Way is the fully functioning pediatric hospital, divided into three spacious units with clusters of partitioned areas - private enough for families to gather yet open for constant monitoring by nurses. A team of doctors in a variety of specialties, registered nurses, a social worker and developmental specialist provide acute care for infants and children who are transitioning from hospital to home.

George Mazariegos, M.D., director of pediatric transplantation in the Hillman Center for Pediatric Transplantation at Children's Hospital of Pittsburgh of UPMC, says the Children's Home offers an extremely high level of commitment to the overall care of transitioning of patients.

"It starts with her (Schanwald) direction and enthusiasm and continues to nursing and other individual teams," he emphasizes.

In September of 2008, the hospital received its first transitional transplant patient from Children's Hospital. Two-year-old Zachary Johnson, who had multivisceral organ transplant, moved from his bed at Children's Hospital to the Children's Home for the last of his seven and a half weeks of hospital recuperation. Realizing the complexity of the toddler's health issues, Dr. Mazariegos says Schanwald was proactive in mobilizing the various personnel to ensure every detail was addressed.

With the move to the new facility, the hospital also gained the capability to provide pediatric specialty care to children from birth to age 21. From 1984 to 2006, care was provided to infants only. Ranny Ferguson credits Schanwald with having the vision for that expansion.

"She could see we needed to expand that … to care for those (children of all ages) in intensive care not quite ready to go home. It's almost like she can see the next need for children and family," she says.

After earning her bachelor of science degree from Syracuse University, Schanwald practised nursing at Suburban Hospital in Bethesda, Maryland for one and a half years. To make the move into administration, she attended George Washington University in Washington, D.C. While there, she also took a job as an information specialist with the national Healthcare Group of Ernst and Young.

Balance in her life remains a priority. "I like to get as much sleep as I can, honestly," she admits. She usually arrives at work about 7:45, after taking her 11-year-old daughter, Sarah, and 13-year-old son, Sam, to school. She attempts to be flexible with her schedule, striving to be present at important family events, like school choral concerts. And she understands the same need for balance in lives of her staff – "to the extent it doesn't stop getting the work done," she says.

> "A leader can't be effective without a great staff."

"A leader can't be effective without a great staff," she adds.

Schanwald insists on following a strategic plan. On the surface, the Children's Home of Pittsburgh is calm and relaxed, but behind the scenes it is fast-paced and ever changing. Schanwald is always examining ways to serve new kinds of patients.

In addition to the increasing numbers of referrals for transplant patients, another new population of patients includes those with cystic fibrosis. The staff, Schanwald adds, is also growing to include endocrine expertise as well.

Increasing community support, fundraising and awareness are among Ms. Schanwald's current priorities for the Children's Home. Unfortunately, "people aren't aware about it unless they need more support ... when a family needs it, they're usually in a crisis," she says.

Always willing to accomplish a task that she would expect of any of her staff, Ms. Schanwald has on occasion shoveled snow, changed batteries and moved cars in the old building's parking lot. She admitted to having once climbed into an open window to retrieve keys in the locked building.

Schanwald remembers board director Ranny Ferguson describing her best as a swan…above the surface she is calm and steadfast, but below the water she is paddling "like hell" to get to where she is going.

"And she never, for one moment, forgets one child," says Ferguson.

Pam Schanwald, CEO, The Children's Home of Pittsburgh and Lemieux Family Center, can be reached at (412) 441-0700.

Biondo Leads Kane Regional Centers

In his more than five years as Executive Director of the John Kane Regional Centers, Dennis R. Biondo has led the four facilities through a series of upgrades, renovations and improvements that have enhanced the quality of life for residents in the skilled nursing care and rehabilitation centers. The Kane Regional Centers are owned and operated by Allegheny County and provide nursing home care to more than 1,000 residents daily.

Allegheny County Executive Dan Onorato said that Biondo has provided direction and leadership instrumental to Kane's development and expansion.

"When I became County Executive in 2004, the Kane Regional Centers were carrying a deficit and in need of a new direction," Onorato said. "I asked Dennis to come on board, and with the help of industry experts and community leaders, we developed the Kane Action Plan, a first-of-its-kind public undertaking in Pennsylvania that will give Allegheny County residents access to a continuum of care. We will provide home-based care, adult daily living services, independent living units, personal care units, dementia units, rehabilitation services and skilled nursing. Through Dennis' leadership, we are restructuring the Kanes and erasing the operating deficit."

Each of the four Kane centers provides 24-hour skilled nursing care, a full rehabilitation program and specialty medical clinics.

"Long-term care is an important issue for every family," Biondo said. "I am committed to ensuring that the Kane Centers meet the ever-changing healthcare needs of our community."

"In the constantly evolving healthcare field, and particularly in a governmental setting, an effective leader needs to be able to adapt to changes and lead the organization through the changing environment," Biondo added. "Leading the organization through change will often include involvement of the entire workforce and an effective leader will evidence his or her commitment to the evolving needs or direction of the organization while communicating how the changes will result in a stronger organization to the betterment of the community being served as well as the organization itself."

Among the most high-profile improvements at Kane in the past year has been the $2.1 million Transitional Care Unit (TCU) at the Scott Township Center. The TCU opened in January 2009.

In May, plans for a four-phase project to construct a Senior Living Complex on the Kane Ross Township campus were announced. Phase 1 is expected to cost approximately $13 million and will result in the addition of 60 independent living apartments. The goal is to increase the type of housing available to residents 62 and older.

At Kane McKeesport an unused former smoking room has been transformed into a modern, spacious game room and activity center for the residents. At Kane Glen Hazel, an older portion of the building has been demolished to make way for a new independent living center that is expected to open in 2010, providing 12 units for an additional 16 residents.

Biondo brought to Kane an extensive background in serving Allegheny County's long-term facilities. He was named acting executive director in January 2004 and officially assumed the post as executive director two months later.

He had served as Kane's solicitor from 1986 through 2004. Biondo previously had served as acting executive director from 1996-1999. A licensed nursing home administrator, Biondo holds a juris doctorate from Duquesne University and a bachelor's degree from Pennsylvania State University. He joined the Allegheny County solicitor's office in 1977.

COVER STORY: DR. STANLEY MARKS:

Making Life Better for People With Cancer

Continued from page 1

been major success stories and improvements in treatments over the last three decades. What I do everyday makes a huge difference in people's lives. It's very rewarding for me. I enjoy treating patients more than anything and helping them deal with life threatening diseases which nowadays are often curable and treatable."

After leaving Harvard, Dr. Marks was in practice at Allegheny General Hospital (AGH) for nearly 20 years. In 2000, UPMC decided to build the Hillman Cancer Center.

"They were building this beautiful center and AGH was going through bankruptcy and had no money or vision," he says. "I was recruited to come over to lead the clinical and cancer program and to bring my large practice which at the time consisted of 30 oncologists throughout the area."

One of the greatest changes he's seen in his career has been a paradigm shift in the treatment of patients. It's becoming more personalized now.

"The development of many new agents in the treatment of cancer, which we call targeted agents, helps us identify which patients will respond to what treatments so we can personalize the therapy," Dr. Marks says. "There are now tests that we can take on the genetic makeup of a tumor and predict how a patient will do in the long term, whether they will benefit from chemotherapy or other therapies. We could focus more on the tumor and not kill any other cells. This leads to a more effective treatment and less side effects."

Despite his hectic schedule, Dr. Marks is active in the local health community. He is the honorary chairman of the Lymphoma and Leukemia Society Golf Outing. He was also president of the organization twice. He was one of the founders of the Cancer Caring Center. One of his greatest passions is the Juvenile Diabetes Foundation in Pittsburgh, the local chapter which he founded. Dr. Marks' son was diagnosed with diabetes when he was 15 months old.

"Now he's 24 and doing well," he notes.

As he looks ahead to the future of UPMC Cancer Centers, Dr. Marks remains focused on recruitment.

"We have a new cancer director in place and she and I are working closely to recruit several full-time faculty members in key areas where we have had some exodus," says Dr. Marks. "Some of those areas include hematological malignancies, gastroenterological cancers and lung cancers. In addition to that there's a major effort underway to recruit more top-notch researchers."

Dr. Marks remains concerned about funding for cancer centers, not only locally, but across the country.

"I think some of the proposed reforms in healthcare have a direct impact on us, particularly in terms of proposed cuts in reimbursements which could impact our cancer centers in a major way," he says. "We're concerned about being able to operate major centers throughout the region and if we are forced to downsize, this could compromise care in some of the local communities. We're very concerned about continued funding in cancer research and with a lot of the budgetary issues nowadays, we're worried about overall funding, because our success is dependent on our research efforts."

When asked for advice on how to prevent cancer, Dr. Marks says to simply lead a health lifestyle.

"Most cancers are preventable," he says. "If you look at all the cancers across the board, more than 2/3 of them are preventable, such as quitting smoking and reducing sun exposure. The other third are caused by obesity and bad diet. So if you avoid tobacco products, obesity, sun, and you eat a healthy diet low in fats and high in fruits and vegetables, you can reduce your risk of cancer by about 75 to 80 percent. In addition, regular exercise at least three hours per week can also reduce cancer risk. However there are certain cancers that we can't control. But I think a healthy lifestyle and exercising weekly clearly prevents most cancers."

For more information, visit www.upmccancercenters.com.

Coro Pittsburgh Inspiring and Advancing Leaders

Of all the qualities and skills desired by employers, leadership ranks among the top. Unfortunately, leadership is rather nebulous; it's a bit like love - you know it when you see it, and when there is a lack of it, its absence is felt most deeply. In a recent Washington Post column addressing the debate on the state of health care and the epidemic of obesity in the United States, guest commentator, Joe Moore, CEO of International Health, Racquet & Sportsclub Association appealed for the need of leadership, stating:

Leaders must emerge from all industries, sectors, and corners of the country, while existing leaders must make the health of their followers, employees and students a priority. And while it's important that political leaders create supportive public policies and legislation to make exercise and healthy living affordable for all Americans, including economic incentives like appropriate tax incentives, it's equally important that everyday leaders figure out ways to affect healthier schools, workplaces, and local communities.

While the need for leadership is established, the larger issue is: From where does leadership come? For 10 years, Coro Pittsburgh has been addressing the dearth of leadership and inspiring and advancing leaders to make a difference in every segment of society including health care.

Coro, a nonprofit, nonpartisan organization, whose mission is to advance ethical and effective leaders who share a commitment to civic engagement, is celebrating its 10th anniversary. Through its numerous programs, Coro has been building a leadership pipeline for Pittsburgh's business, health care, nonprofit and government sectors.

"The goal of Coro is to better prepare our region by providing well-trained leaders from our area to stay in our area," said Sala Udin, president and CEO of Coro Center for Civic Leadership. Udin, former City of Pittsburgh councilman and noted civic leader, has been at the helm of Coro since May of 2006 and says that most employers are frustrated that college graduates are not ready to lead. "Coro fills that gap by providing talent that is ready to lead in any sector. They are ready to grab a task and get it done," Udin said.

Coro provides an experiential approach to leadership development through it numerous programs. Coro equips leaders with the tools they need to transform the world. The Fellows Program in Public Affairs enables fellows to complete consulting work in government, health care, nonprofit and business organizations. The Regional Internship Center of southwestern PA brokers connections between internship seekers and employers throughout the region.

Public Allies, an AmeriCorps Program, partners with Coro to identify talented young adults from diverse backgrounds and prepare them for careers working for community and social change. Leaders in Learning participants learn about the Pittsburgh Public School system, create an educational team project, and network with and interview local leaders. Women in Leadership participants work with a personal coach to create a Personal Strategic Plan, create a group project, network with and interview local leaders. The Running for Public Office program strengthens participation in public elections.

Coro Pittsburgh also has an Alumni Council for those who wish to stay involved with Coro after their programs are completed. Alumni are responsible for continuing communication with current program participants, maintaining data and networking with businesses and professionals just to name a few.

"With our magnificent talent pool from Pitt, Duquesne, CMU and the other colleges and universities in the area we shouldn't have to rely as much on bringing in talent from other countries to fill these positions." Udin said. To rectify this situation, Coro recruits from local colleges and universities, and students are shown how to gain a competitive edge through leadership development.

On November 7th, Coro will celebrate its 10th Anniversary.

For more information about Coro, visit the website at www.pittsburgh.coro.org.

Consortium Ethics Program: Educating Leaders in Health Care

Jeanne Graff

Maryanne Fello

Dr. David Orenstein

Health care ethics is typically regarded as a body of literature consisting of principles, cases, policies and legal precedents. While this information is used by clinicians to identify and resolve specific patient care issues, it can also serve to educate health care professionals to take on leadership and management positions within their institutions. The Consortium Ethics Program (CEP) at the University of Pittsburgh has provided a continuum of education for front-line health care professionals since 1990.

Over 400 nurses, social workers, physicians and others have been trained in language and methods of health care ethics and many have continued in the program for over six years. At our 20-year mark, we interviewed a few of our long-term members--a social worker, nurse and a physician regarding their long-term participation with the CEP and inquired how the program influenced their professional lives.

Libby Moore, LSW, DHCE, served as a social worker for Sewickley Valley Hospital's Critical Care Unit when selected by administration to serve as a CEP representative in 1990 and when her hospital became part of the Heritage Valley Health System in 1996, Libby's knowledge of health care ethics earned her the position of ethics resource person for the system. In 2003, she left the CEP to pursue a Doctorate of Health Care Ethics at Duquesne University and is now the advanced illness coordinator for the System. She facilitates end-of-life care, provides education and in-service on ethics and palliative care, and supports the ethics committees within the system's service area. "My involvement in the CEP influenced my decision to obtain a higher education degree," says Moore. "The CEP was very supportive in my endeavor, being a source of assistance and guidance."

Maryanne Fello, RN, BSN, MEd, had been a nurse for 20 years when she became a representative. She sparked an interest in ethics in 1972 when she was a "new" nurse on the neurology unit at Presbyterian University Hospital; the same year the Karen Ann Quinlin case occurred. Now the Director of Forbes Hospice and faculty for the CEP, Fello says the CEP education was the foundation of her learning. "The Hospital and Hospice bring that learning to life in everyday clinical practice and I am able to offer the ethical principles by which many issues can be framed," says Fello. "Mediation skills learned within the CEP curriculum have also become vital to not just my clinical, but also to my management responsibilities."

Five years ago, David Orenstein, M.D., Director of the Antonio J. and Janet Palumbo Cystic Fibrosis Center at Children's Hospital of Pittsburgh of UPMC, was asked to re-start and chair the hospital's ethics committee. After accepting the opportunity, he enrolled in Pitt's Master's program in bioethics and enrolled his institution in the CEP. "I decided I wanted to do it the right way," says Orenstein. "I wanted to feel that my efforts would have credibility, both to myself and to any outside observers who might wonder what qualified me to take on this role." Last year, Orenstein was faced with starting a new in-house consultation service at the hospital and turned to the CEP for education and guidance. "With its long record of ethics education and its stellar cast of ethics experts, including some of the most well-known nationally in the field of what it takes to be an ethics consultant, the CEP was the obvious place to turn," says Orenstein.

These scenarios provide some insight into how the CEP model recognizes that ethics education is a combination of classroom instruction and applied learning in the clinical setting. Teaching in this way can contribute to training frontline caregivers to become leaders and role-models within their own institutions and local community. "With the knowledge gained from CEP classes and then applying that knowledge to real life 'practice,' I believe that I not only became a better ethics consultant but also a better leader in general," says 20-year veteran representative Jeanne Graff, RN, MSN, MBA, Vice President of Patient Services at ACMH Hospital. "I definitely learned skills that I continue to use every single day in many situations at work and in every day life."

More information about the CEP can be found at www.pitt.edu/~ cep or by calling (412) 647-5834.

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E-mail editorial submissions to judy@ hospitalnews.org

Vantage® Holding Company, LLC

A For-Profit Company that Forms Health Care Partnerships to Create Revenue, Savings and New Services

Vantage® Gets Aggressive

Expands Sales Operation Nationally

In today's hyper-competitive business environment, having a better product or service may not be enough. In fact, companies all over the country are struggling with getting their products in front of the right people. Not Vantage®. As a leading company in the healthcare field, Vantage® has distinguished itself as a force to be reckoned with. They have taken the steps necessary to continue what has already proven to be a successful business model by getting more aggressive in getting their message out. With the help of Defiant Sales Consulting, Vantage® has created a literal sales machine. By using space already owned by Vantage®, Defiant has built a call center that does much more than telemarketing. This center is designed to reach a much broader spectrum of potential clients using cutting edge sales methods. Through education and high contact rates, they are better able to understand the needs and desires that potential customers have for their line of products. This allows them to not only talk to more companies, but to also talk to them about what matters to them. Through a greater understanding of client needs, Vantage® will be better able to deliver the kinds of products and services their market demands.

While competitors continue to talk about the same things they have for years, Vantage® discusses solutions that are relevant to today's market conditions. Delivering market relevant services is the key to a successful business model and Vantage® is doing just that. Defiant Sales Consulting from northeast Ohio first approached Vantage® two months ago with the project. After building this sales machine, Defiant Sales expected a 30-60 day turn around time for the this process to become fruitful; however, not with the Vantage model. Defiant's President, Jason Wood, said about Vantage®, "I have never seen results this quickly. Most companies struggle to get everyone on board, but the Vantage® management team is phenomenal".

Vantage® decided to use its Franklin facility as the hub of their new multi-tiered sales operation. Deb Logan, Vantage's Sr. Vice President of Sales stated, "This expansion has created new jobs in the western Pennsylvania region and will be a vital sales and communication link to rural healthcare organizations across the country that could use our services. This sales structure promotes an aggressive career ladder, in spite of the current economic times. Since 1985, Vantage® has practiced and perfected its strategy by seeking out health care organizations who want to take charge of their own future. Over the past 25 years we have brought cost effective, high quality services to rural health care communities and now we are taking this model nationally." Mary Tartaglione, Vantage® Director of Sales added. "The talent pool in this region is exemplary. There is a reason for our success over the past 25 years, It's like baking a cake on a much larger scale. You pull together the best ingredients, and provide the optimal conditions and the chance for success is greatly increased. In Vantage's case the ingredients are the quality health care services Vantage® offers and the conditions are the sales people that deliver on a timely and cost effective basis."

The Vantage model is quite unique. The hospitals, physician groups and other healthcare organizations that use Vantage actually become partners and control their own future. In 1985 a small group of community hospitals decided to form a holding company which they individually would own and use the company to create services they need to thrive. The company would then sell these same services to the market place to generate profits. The partners would save money for themselves by outsourcing to a business they created and by generating new profits for themselves as investors. This became the Vantage model for success.

To obtain a complete list of Vantage services, contact Mary Tartaglione at Maryt@vhcn.com or call (887) 415-6993 or go to www.vhcn.com.

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The Journey to Improve Hospice Care in America

Health Care Reform:

Planning Ahead for the Sake of the Patient and Caregivers

BY RAFAEL J. SCIULLO, MA, LCSW, MS

From town halls to coffee shops, the debate rages on about the government's health care reform bill. While many facets of the proposed legislation are stirring debate, one item in particular, end-of-life care, is at the center of some of the most heated arguments.

It's fair to say that some opinions expressed about the initiative are downright startling.

Section 1233 of the original bill calls for voluntary "advanced care planning consultations", which would offer Medicare recipients the opportunity to have informed discussions with their doctor about future care planning options, has unfortunately been labeled by opponents as "euthanasia" and even "genocide."

This debate has given rise to some misconceptions, so it is important first to understand what exactly end-of-life care entails. Once a person has been diagnosed with a life-limiting illness, hospice is often considered the best option for ensuring the patient's comfort, care and quality of life in his or her final months. Hospice and palliative care are considered to be a model for quality, compassionate treatment, involving a team approach that along with medical care, includes pain management, and emotional and spiritual support, tailored to the person's needs – and to the person's family.

At press time, there are reports from the White House that the end-of-life provision may be removed from the bill, which is terribly disappointing. In the end, it is designed to provide higher quality care to more Americans, while keeping costs down. Part and parcel to this is the opportunity to plan your advance care directives, without it costing you. Some lawmakers are instead proposing health care cooperatives, which many experts say would pose difficulty in achieving lower rates from doctors and hospitals.

At Family Hospice and Palliative Care, we are committed to providing education along with care. We feel that the more informed a patient and family are about their options, the easier it is to make decisions. While it may not be the most comfortable conversation to have with your physician, end-of-life care is certainly a necessary one.

Indeed, hospice and palliative care needs to be an essential part of any health care reform discussion. When understood correctly and utilized at the right time, hospice and palliative care is part of the solution, as a model of top quality and cost-effective health care delivery. In fact, a study released earlier this year by Harvard University directly associated practical end-of-life counseling with lower health care expenses and better quality of life for patients with advanced cancers. Thoughtful pre-planning for this difficult time can only help the process. A proactive approach will ease the transition to hospice care and allow the family to focus on care giving.

At a recent town hall meeting hosted by the AARP, President Obama explained that the intent of this provision of the bill is to guarantee that patients are provided with the information and options they want, with the process simply being covered by Medicare. "It strikes me that that's a sensible thing to do," he said.

Sensible? Absolutely. Euthanasia? Not even close. Again, allowing the patient and family to experience the end-of-life journey in a dignified way is at the crux of this issue. While there are surely other portions of the overall health care reform plan that deserve debate and revision, this is not one of them. When all is said and done, deliberate planning for end-of-life care is practical, wise, and a necessary step in ensuring the patient's wishes are met. Labeling such actions as "genocide" is nothing but a knee-jerk reaction from those who have not taken the time to review and consider the facts of this legislation.

After all, careful review, consideration and planning are the first step in making informed decisions. And it's the first step in understanding how hospice and palliative care can be one of the answers to health care reform.

Rafael J Sciullo, MA, LCSW, MS, is President and CEO of Family Hospice and Palliative Care and Past Chairperson of the National Hospice and Palliative Care Organization. He may be reached at (412) 572-8800 or rsciullo@familyhospice.com or

> "In fact, a study released earlier this year by Harvard University directly associated practical end-of-life counseling with lower health care expenses and better quality of life for patients with advanced cancers."

Integrating Medicine As a Tool In Treating Opioid Addiction

BY NEIL A. CAPRETTO, D.O., F.A.S.A.M., AND CARA M. RENZELLI, PH.D.

From the misuse of medications contributing to the death of Michael Jackson to the record number of drug overdose deaths in western Pennsylvania, the devastating effects of opioid addiction are widespread. The National Institute on Drug Abuse (NIDA) recently reported that an estimated 48 million people (ages 12 and older) have used prescription drugs for non-medical purposes throughout their lifetimes. This represents approximately 20 percent of the U.S. population.

On a local level, the latest autopsy reports from the Allegheny County Medical Examiner's Office revealed that 67.6 percent of the 254 overdose deaths in Allegheny County in 2007 involved the use of prescription drugs—with 80 percent of the prescription drugs being opioids. Opioid addiction often starts with a doctor prescribing medication for pain management and develops into a dependency, or it may begin as recreational drug use that quickly spirals out of control into addiction. A vast amount of research has shown that addiction to any drug (illicit or prescribed) is a chronic disease with biological, psychological, sociological and spiritual components.

The FDA approved medicine buprenorphine-naloxone — more commonly known as Suboxone® — has emerged as an effective method for treating the biological component of opioid addiction. Today, opioid medications are available in stronger doses and illicit opiate-containing substances such as heroin have greater purity, meaning that people can become dependent on the drug faster and with greater severity. A course of traditional substance abuse treatment without medication could be extremely difficult or nearly impossible to complete without initially treating the biological component.

Suboxone provides a safe withdrawal from opioids and paves the way for treatment by allowing patients to better engage in individual and group therapy sessions and the overall recovery process. NIDA asserts that the longer patients stay in treatment, the greater chance they have for entering and maintaining recovery. Research indicates that many individuals who are addicted to opioids are likely to relapse following treatment or are at risk of leaving treatment early. The severe withdrawal experience may be one factor underlying early treatment discharge. However, when Suboxone is given to opioid addicted patients during detoxification and subsequent treatment, results show a decrease in the number of patients leaving against medical advice.

We conducted a study at Gateway Rehabilitation Center with 170 patients titled "Less Pain, More Gain: Buprenorphine-Naloxone and Patient Retention in Treatment." Published in the *Journal of Addictive Diseases,* the study reported differences between patients who received Suboxone and those who did not. The most significant finding was that 97.6 percent of the patients who received Suboxone transferred to inpatient treatment following their stay in the detoxification unit. In contrast, among the patients who did not receive the medication, only 44.7 percent transferred to inpatient treatment. Those who received the medication had longer total lengths of stay than those who did not receive it.

Moreover, a recent NIDA study indicated that extended use of Suboxone throughout treatment substantially improved outcomes for opioid-addicted young adults. Researchers at Johns Hopkins University state that a major benefit of using Suboxone throughout treatment is that it helps patients remain alert and function throughout the day.

Even though strong evidence from multiple studies shows that for properly selected patients certain medications including Suboxone may significantly enhance their chances of recovery, medicine alone is never sufficient for good recovery. Whether or not a patient is on medication, obtaining good recovery should be the main goal of treatment, which will require an individual to be actively working a total mind-body-spiritual recovery program.

> "Moreover, a recent NIDA study indicated that extended use of Suboxone throughout treatment substantially improved outcomes for opioid-addicted young adults."

Despite the destructive and pervasive impact of opioid addiction, medication assisted treatment—when integrated into an addiction treatment program that holistically treats the biological, psychological, social and spiritual needs of a patient—can serve as a source of hope for opioid addicted individuals seeking recovery.

Dr. Neil A. Capretto is Medical Director, Gateway Rehab and Dr. Cara M. Renzelli is Director of Research and Evaluation, Gateway Rehab. For information about treatment options available for opioid addiction and other chemical dependencies, call Gateway Rehabilitation Center at (412) 766-8700 or visit www.gatewayrehab.org.

CMS Proposes to Relax Controversial Physician Supervision Requirements for Hospital Outpatient Services

INSIDE Washington

BY KARL A. THALLNER, ESQUIRE

Hospitals received some welcome news recently when the Centers for Medicare & Medicaid Services ("CMS") proposed to relax its controversial position concerning physician supervision for hospital outpatient services. This change in Medicare policy was proposed as part of CMS's Hospital Outpatient Prospective Payment System ("HOPPS") rule for 2010, which was released on July 1. If the change is adopted, hospitals will have more flexibility to meet Medicare physician supervision requirements for outpatient services, thereby avoiding some of the high costs that have been incurred. However, concerns remain about certain aspects of the supervision requirements, which may be addressed in the final rule.

The controversy concerning the level of physician supervision that is required for hospital outpatient services arose a year earlier with the publication of CMS's HOPPS rule for 2009. In the 2009 HOPPS rule, CMS "clarified" that direct supervision by a physician is required for outpatient hospital therapeutic services furnished "incident to" a physician's services – not only when those services are furnished at an off-campus hospital-based location, but also when furnished in the main hospital building or an on-campus department. To meet the 2009 HOPPS rule requirements, a physician must be present in each provider-based department of a hospital when these services are furnished.

While styled as a "clarification", most hospitals saw CMS's position in the 2009 HOPPS rule as a significant change from prior CMS guidance. Specifically, in the 2000 HOPPS regulations, while CMS required that services furnished at a location designated as a department of a provider under the Medicare "provider-based" rules must be furnished under the direct supervision of a physician, CMS also stated that it "assumed" that the direct supervision requirement would be met when the services are furnished on a hospital's campus. Thus, before the 2009 HOPPS rule, many hospitals had not considered it necessary to ensure that a physician was present in every part of a hospital's main buildings in which outpatient therapeutic services were furnished.

After publication of the 2009 HOPPS rule, the hospital industry became quite vocal in its objection to CMS's new position. Leading industry trade associations, including the American Hospital Association and the Federation of American Hospitals, urged CMS either to reconsider or to delay enforcement of the new guidance.

Responding to these and other comments, in the 2010 HOPPS rule proposal CMS articulated three new proposed policies for physician supervision for hospital outpatient services that would go into effect January 1, 2010.

- First, non-physician practitioners (physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives) would be permitted to directly supervise all hospital outpatient therapeutic services that they are permitted to perform themselves in accordance with state law and scope of practice, hospital-granted privileges, and other Medicare requirements.
- Second, for outpatient services furnished in the hospital or in an on-campus outpatient department of the hospital, the "direct supervision" requirement would be met if the physician or non-physician practitioner is present on the same campus, in the hospital or on-campus provider-based department, and is immediately available to furnish assistance and direction throughout the performance of the procedure.
- Third, for hospital outpatient diagnostic services, the physician supervision requirements attributable to each particular test under the Medicare physician fee schedule would have to be satisfied, whether the test is performed directly or under arrangements. While the same definition of "direct supervision" applicable to therapeutic services would also apply to diagnostic tests, non-physician practitioners would not be permitted to supervise diagnostic tests.

These changes would allow hospitals significantly more flexibility in meeting the supervision requirements for hospital outpatient services, and would represent a relaxation not only from policy in CMS's 2009 HOPPS rule, but in some respects also from CMS's policy prior to 2009. In particular, for example, non-physician practitioners would be able to supervise therapeutic services furnished in off-campus provider-based departments.

While the 2010 HOPPS rule proposal does reflect a relaxation, some questions and concerns remain. For example, the requirement that the supervising physician or non-physician practitioner must be "immediately available" could impose challenging practical limitations in some cases. CMS has said a practitioner who is performing another procedure or service that cannot be interrupted is not "immediately available"; nor is a practitioner who is at such a far distance that he could not intervene right away.

Furthermore, since CMS maintained in the proposed 2010 HOPPS rule that the guidance in the 2009 HOPPS rule did not constitute a change in policy, hospitals could be subject to continuing enforcement risks, including through qui tam actions brought by whistleblowers, arising from outpatient therapeutic services furnished prior to 2010.

Hopefully, some of these concerns will be addressed in the final 2010 HOPPS rule, which is likely to be released in December 2009. Hospitals should monitor regulatory developments in this area, in order to adjust physician and non-physician staffing and scheduling of hospital outpatient services accordingly.

Karl A. Thallner is a partner in the law firm of Reed Smith LLP. He is a member of the firm's Life Science Health Industry group, focusing his practice on providing business and regulatory advice to hospitals, health systems and academic medical centers throughout the United States. Karl can be reached at kthallner@reedsmith.com.

COVER STORY: *Hospital Council Seeks Solution to Medicare Wage Index Issue*

Continued from page 1

ties in what the region's hospitals get paid through Medicare, there are disparities in the payment system in Pennsylvania related to Medical Assistance. Pennsylvania is already one of the lowest paying states for Medical Assistance, and western Pennsylvania hospitals get paid significantly less than other hospitals across the state for Medical Assistance.

And, on top of those payment issues, western Pennsylvania has one dominant insurer. "In a market with limited competition among insurers, there is little ability to cost shift and both small and large businesses shoulder the burden."

The wage index for the Pittsburgh CBSA is one of the lowest in the country and is actually lower than 23 rural wage indexes across the country. For example, rural hospitals in such states as Iowa, North Carolina and Wyoming are paid more than Pittsburgh hospitals.

Since 2001, the Pittsburgh CBSA average hourly wage rate increased 21 percent—and yet the wage index dropped more than 12 percent. Nationally, the average hourly wage increased nearly 40 percent during the same period. "It is clear," Harper said, "that the current formula disproportionally rewards hospitals that are able to grant larger increases."

In addition, hospitals in Pittsburgh and western Pennsylvania provide specialized care to patients—this becomes part of the hospitals' "case mix." Some of the hospitals in the region have a relatively high "case mix index." In some other areas of the country, there are CBSAs with few hospitals and a lower "case mix," yet those hospitals receive a higher reimbursement than hospitals in western Pennsylvania. Specifically, hospitals in North Dakota and in Lawton, Oklahoma, have higher wage indexes than those in the Pittsburgh area.

What have hospitals done about this issue?

"A few years ago, we decided we need to work on this issue as a group," said Harper. "Through Hospital Council, we asked each hospital in the Pittsburgh CBSA to work with a consultant and examine the data they were submitting in detail." Every hospital and healthsystem in the Pittsburgh CBSA participated in this "data scrubbing" exercise and were able to improve the wage index. Subsequently, the hospitals in Altoona and Johnstown now participate in the annual "data scrubbing" exercise. This resulted in bringing back more than $15 million to Pittsburgh-area hospitals alone.

"Although this has really helped us with our wage index issue, it does not ultimately solve the problem," Harper said.

Some Potential Solutions

Last year, Hospital Council's Board of Directors identified the "wage index" issue as one of the top priorities for the region's hospitals. Hospital Council formed a Medicare Wage Index Steering Committee comprised of chief executive officers, chief financial officers and government relations executives from throughout the region. Hospital Council also contracted with wage index specialists to help address the issue. Hospital Council's staff, the wage index specialists and hospital executives are working with their federal representatives and senators to address this issue, potentially through health reform.

One possible solution, Harper said, is for Congress to adopt a proposal made through the Medicare Payment Advisory Committee (MedPAC). The proposal would make changes to the wage index system which would benefit many Pennsylvania hospitals and those in western Pennsylvania as well. A recent study, released by Acumen, also supports the MedPAC proposal.

Another possible solution would be an interim measure which would establish a "floor" for the wage index to prevent further erosion of the wage index in western Pennsylvania and in other regions across the country affected by this issue.

"These are some examples of potential solutions," Harper said. "We don't know the exact answer yet, but Hospital Council is committed to helping its members find a solution to this issue."

Patricia J. Raffaele is Vice President, Advocacy and Communications, Hospital Council of Western Pennsylvania. For more information about Hospital Council, visit www.hcwp.org.

"The Clinic at Walmart" Operated by Heritage Valley ConvenientCare Opens

Walmart and Heritage Valley Health System announced the North Hill's newest offering of healthcare services – "The Clinic at Walmart" operated by Heritage Valley ConvenientCare. The clinic recently opened in the Walmart store in Cranberry Twp and provide fast, affordable access to basic healthcare services such as check-ups, immunizations, screenings and treatment of minor injuries. The walk-in health clinic is the first in a Pennsylvania Walmart, and the first to be owned and operated by Heritage Valley in a Pennsylvania Walmart

For busy customers who are seeking affordable, accessible healthcare, especially during evening hours or on weekends, the Clinics at Walmart play a key role today's healthcare environment. These clinics can also help keep people out of overcrowded emergency rooms – 10 to 15 percent of clinic customers surveyed said they would have used an emergency room had the Clinic at Walmart not been available, while another 5 to 10 percent would have gone without treatment entirely, potentially leading to more serious complications down the road.

BY RON CICHOWICZ

Dr. Bernard Grimes, retired endocrinologist, with patient "JT." and Autumn Runyon, Pharm.D , Faculty Member, Duquesne University Mylan School of Pharmacy.

CATHOLIC CHARITIES: The MIRACLE *on 9th Street*

Maybe it's not readily noticeable to the scores of people who pass by the corner of 9th Street and Liberty Avenue downtown, each day. But just a couple of floors above them, something amazing is going on.

Hoping to help meet the basic medical needs of individuals who do not have employer-sponsored health coverage, cannot afford private insurance, or who do not qualify for Medicaid or other assistance, in November, 2007 Catholic Charities of the Diocese of Pittsburgh opened its Free Health Care Center on the 2nd and 3rd floors of its main building at 212 Ninth Street, downtown.

The Free Health Care Center—operating with just a handful of paid staff and scores of volunteers—has filled a void the magnitude of which few could have predicted.

Initially, the Center operated three days a week and its volunteer medical staff saw about 40 patients per month. Today, the Center is open five days a week, including some evenings, it treats nearly 600 individuals each month, and its waiting list continues to grow.

"The Catholic Charities Free Health Care Center is a 'perfect fit' with Catholic Charities' mission to provide services to individuals at a time of greatest need," said Catholic Charities Executive Director Susan Rauscher. "It is an opportunity to watch 'good Samaritans' changing the lives of their neighbors every day."

"I don't think we were ever unaware that there were people who had to do without medical or dental care because they were not able to access medical or dental insurance to help defray expenses, but we never anticipated the actual depth of the need. As a region, we are all stronger when our neighbors are healthy."

One such neighbor is Mary, a 52-year-old Pittsburgh resident who found herself without health insurance after she broke her arm at work.

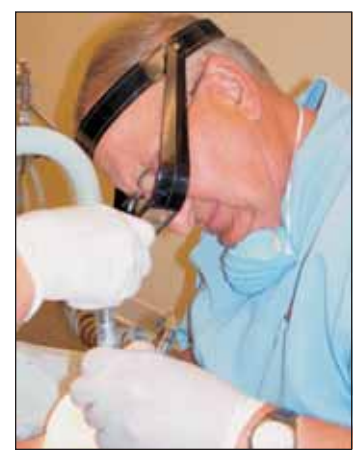
"I applied for public assistance and was denied," she recalled. "Catholic Charities came to my aid. I have somebody around to bless me. My entire life has turned around."

Through the Free Health Care Center, Mary has had access to a general physician, endocrinologist, gynecologist, pharmacist, physical therapist, podiatrist, and nurse practitioner. Besides her shoulder injury, she is now being treated for diabetes.

What is perhaps most astounding about the Catholic Charities Free Health Care Center is that is was begun, and continues to exist, largely on the compassion and generosity of others.

According to administrator Diane Redington, the Center operates daily with six employees and 10 to 15 medical, dental and administrative volunteers. While Catholic Charities provides professional support services and helps underwrite operational costs, the much needed program costs are funded from government grants and corporate donations, as well as a growing list of individual contributors. She cited in particular clinical and financial support from such organizations as UPMC, West Penn Allegheny Health System, and Highmark.

"We are trying to fill a gap in society, said Redington. "Those we see are often described at the 'working poor'—the individuals without private insurance yet who are not eligible for government help. But to offer them some level of care, we need the help and support of volunteers."



Dr. Carmine Mastandrea, Volunteer Dental Director

Anyone interested in learning more about the Catholic Charities Free Health Care Center – either for treatment, to volunteer, or donate money or equipment – should call (412) 456-6911 or visit www.ccpgh.org.

Catholic Charities assists all of its volunteers in obtaining any licensing or clearances they need. Free parking is provided and the Center staff accommodates any scheduling needs.

What the volunteers find when they arrive is a state-of-the-art facility with a spacious reception area, four medical examination rooms, four dental suites, a dental lab, a physical therapy treatment suite, and an electronic medical records system.

According to Redington, to date the generosity of nearly 150 active clinical and non-clinical volunteers has enabled the Center to offer medical services that include primary care, chronic disease management, and health screenings. Specialty care provided includes dermatology, endocrinology, ophthalmology, gynecology, psychiatry, and physical therapy.

Dental services include exams and x-rays, cleanings, fillings, extractions, periodontal treatment, and selected restorative care.

"We added dentistry almost as an afterthought," Redington said. "And within a week we had more than a 1,000 calls from people seeking dental care. Consequently, our demand for dentists is huge—our waiting list is now nine months to a year."

Dr. Carmine Mastandrea was one of the dentists who heard the call and responded.

"Since 1960, I've had a good career, with a practice serving Peters Township and the surrounding area," Dr. Mastrandrea said. "I saw the notice about the Free Health Care Center in my parish bulletin and decided it was an ideal time for me to give something back to the community. I started by volunteering one day a week; now I'm doing two. The staff is great to work with and there is such a need for this work. But this is a different world for me. There's a side of people's dental needs I didn't realize.

"About 60 percent of those I see have let their problems go. The exceptions are those who had dental insurance and kept up with their care until the insurance went away."

"This is very rewarding for me. We get notes back from people who came to us with no teeth or who needed to have them all removed and replaced. Now they are more confident as they look for work or just smile at their friends. We literally put the smile back on their faces."

"I never experienced anything like this before. I intend to keep doing it as long as my health and skills allow."

Another individual for whom the Center has meant a world of difference is George, who at age 55, suffers with diabetes and a multitude of other health problems that made him unable to work. Like Mary, George was seen by a number of medical professionals. Included in his care was treatment for an infected tooth and, because he had no lower teeth, a set of dentures.

"I needed tests but couldn't afford them," George said. "But Catholic Charities put me right through. It has been remarkable what they did for me. I never before had doctors like this. This has meant everything to me."

Rauscher summed it up this way: "At Catholic Charities, we strive to make a positive difference in the lives of each of our clients and our Free Health Care Center is perhaps the most visible example of that commitment."

Some might call it fulfilling a commitment. But others might call it a miracle.

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Healthcare Professionals in the News

ALLEGHENY GENERAL HOSPITAL


DR. JAMES E. WILBERGER, JR.

James (Jack) E. Wilberger, Jr., M.D., has been named chairman of the Department of Neurosurgery at Drexel University College of Medicine. Dr. Wilberger is professor and chairman of the Department of Neurosurgery at Allegheny General Hospital, the western regional campus of Drexel University College of Medicine. He is also director of the hospital's neurosurgical residency training program and director of neurosurgery for the West Penn Allegheny Health System, where he also serves as vice president for graduate medical education and co-director of the Comprehensive Epilepsy Program.


DR. PETER J. JANNETTA

The World Federation of Neurosurgical Societies has awarded its distinguished Medal of Honor to **Peter J. Jannetta, M.D.**, vice-chairman of the Department of Neurosurgery at Allegheny General Hospital (AGH), in recognition of his contributions to the advancement of medicine. Dr. Jannetta's research into the pathology and treatment of cranial nerve compression syndromes is regarded as one of the most important modern day breakthroughs in the field of neurological disease.


DR. H. KENNETH WILLIAMS, JR.

Allegheny General Hospital (AGH) announced that general surgeons **Sheri Mancini, M.D., FACS**, and **H. Kenneth Williams Jr., M.D.**, FACS, have joined Allegheny Surgical Associates (ASA). Dr. Mancini recently served as a surgeon in the U.S. Navy, providing routine, emergency and trauma care for more than 5,000 military personnel as the only surgeon for an aircraft carrier and its associated destroyers. She was also deployed to Iraq as a field trauma surgeon for the U.S. Marines.


DR. SHERI MANCINI

Dr. Williams served as Assistant Professor of Surgery for the MCP Hahnemann School of Medicine from 1997 to 2002 in the divisions of General and Vascular Surgery.

ALLEGHENY GENERAL HOSPITAL – SUBURBAN CAMPUS

Allegheny General Hospital – Suburban Campus (AGH – SC) and West Penn Allegheny Health System (WPAHS) announce that **Michael D. Felix, M.D.,** FACS, and **Geoffrey H. Wilcox, M.D.**, FACS, both of the Surgical Associates of Sewickley, Ltd., have joined the staff at AGH-SC.

ALLE-KISKI MEDICAL CENTER


DR. JOHN HOWER

Alle-Kiski Medical Center (AKMC) is pleased to welcome general surgeon **John Hower, D.O.**, from Alle-Kiski Surgical Associates, to its medical staff.

CANONSBURG GENERAL HOSPITAL

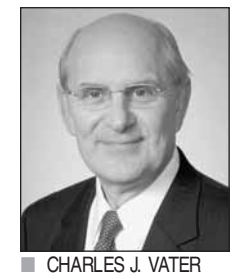

DR. ALEX SENCHENKOV

The Board of Directors of Canonsburg General Hospital recently appointed **Alex Senchenkov, M.D.**, to their medical staff. Dr. Senchenkov is a board-certified surgeon with experience and fellowship training in Plastic Surgery, Microsurgery, and Head & Neck Surgical Oncology. He received his medical degree with honors from the Ukrainian State Medical University and completed a residency in Surgery at the Medical College of Ohio at Toledo.

CHILDREN'S HOME OF PITTSBURGH & LEMIEUX FAMILY CENTER


MARIANNE DAYHOFF

The Children's Home of Pittsburgh & Lemieux Family Center has appointed **Marianne Dayhoff** as Respiratory Therapist. Dayhoff acts as The Children's Home's first on-staff respiratory therapist.


CHARLES J. VATER

The Children's Home of Pittsburgh & Lemieux Family Center announces the election of new officers to its board of directors. Elected as incoming president of the board is **Charles J. Vater.** He has been a board member since 1999. Other officers include **Eric Boughner**, who will serve as vice president and treasurer. Boughner is a vice president of wealth management for BNY Mellon and has been a board member since 2007.


MAUREEN OEHRLE

Maureen Oehrle will serve as the board's secretary. Oehrle is a stay at home mother with expertise in event planning.

CONCORDIA LUTHERAN MINISTRIES


LYNN MCKINNIS

Lynn McKinnis, PT, OCS, a physical therapist with Concordia Lutheran Ministries, was recently recognized by the American Physical Therapy Association (APTA) for her literary contributions to the field. In addition to McKinnis' employment with Concordia, she is an adjunct professor at the University of Montana and St. Francis University in Pennsylvania. Her prior academic affiliations include University of Maryland, Arcadia University, St. Louis University and Slippery Rock University, among others.

DUQUESNE UNIVERSITY


DR. LENI RESICK

Dr. Leni Resick, associate professor of nursing at Duquesne University, was recently inducted as a Fellow of the American Academy of Nurse Practitioners (AANP) at the AANP's national conference. Resick serves as director for both the Family Nurse Practitioner (FNP) Program and the Nurse-Managed Wellness Center for Duquesne's School of Nursing. She is a key leader for the school's online FNP program and was a consultant to the FNP program developed at the University of Puerto Rico.

EXCELA HEALTH

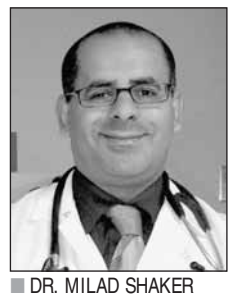

DR. KELLY DEVOOGD

Two physicians specializing in obstetrics and gynecology join the medical staff at Excela Health: **Carolyn Chambers, M.D., FACOG, and Kelly DeVoogd, D.O**. Board certified, Dr. Chambers comes to Excela Health from the West Penn Allegheny Health System where she was in practice at Alle-Kiski Women's Health for the past five years.
A graduate of the Philadelphia College of Osteopathic Medicine, Dr. DeVoogd has extensive training in minimally invasive surgery, including robotic surgery.

Two recent graduates of the Excela Health Latrobe Hospital Family Medicine Residency Program will continue to practice in the area, joining the Excela Health medical staff.

Jill Murray-Kielbiowski, M.D., will remain with Norvelt Family Medicine where she was assigned during her three-year residency. **Milad Shaker, M.D.,** is establishing a new family medicine practice in Mount Pleasant.


DR. JILL MURRAY-KIELBIOWSKI


DR. MILAD SHAKER

The Excela Health Board of Trustees has elected officers for the 2009-2010 year.
Paul Mongell will serve as board chair. Mongell is president of Penn Line Service, Scottdale, where he has been employed for more than three decades.
The Honorable **John J. Driscoll** has been elected vice chair. Judge Driscoll, Westmoreland County Court of Common Pleas, Juvenile/Family Court.
Scott Gongaware continues as board treasurer. He has been with the Richard K. Mellon and Sons' family office for more than 10 years.
Barbara Wang, M.D., FACP, is the new board secretary. An internal medicine specialist with added qualifications in geriatrics, Dr. Wang has been in practice for more than 25 years, caring for patients with Diagnostic Associates of Latrobe and Greensburg.


PAUL MONGELL

FAMILY HOSPICE AND PALLIATIVE CARE

Stacy Carbaugh has joined Family Hospice and Palliative Care as the Manager of Marketing and Customer Relations. Formerly an Officer in the United States Army, Stacy also brings over six years of healthcare sales and sales management experience. He has worked extensively in the health care industry of Western Pennsylvania while serving as a pharmaceutical sales representative for Eli Lilly and more recently, as the senior community relations liaison for another local Hospice.


STACY CARBAUGH

Eric Horwith has joined Family Hospice and Palliative Care as Community Liaison for the Center for Compassionate Care. Eric is a licensed Social Worker who previously served as Director of Social Services for HCR-ManorCare Skilled Nursing, and as Regional Community Liaison for Heartland Hospice and Home Care.


ERIC HORWITH

Greg Jena has joined Family Hospice and Palliative Care as the Public Relations Coordinator. Greg brings years of experience in local media and communications, having spent nearly 20 years at KDKA Radio as News Editor, Talk Show Producer, Assistant Program Director and Director of Marketing and Promotion. More recently, Greg worked as a media relations specialist with Children's Hospital of Pittsburgh and for a local PR agency.


GREG JENA

Family Hospice and Palliative Care has promoted **Suzanne Kimmick** to Social Work Supervisor. Suzanne had served as a Family Hospice Community Liaison since 2001. Prior to that, she worked as a Social Worker in the Skilled Nursing Unit at Mercy Hospital.


SUZANNE KIMMICK

Greg Lewandowski has joined Family Hospice and Palliative Care as Clinical Supervisor. Greg has spent the majority of his nursing career in long-term care. Prior to joining Family Hospice, he worked for Alterra Personal Care Home and Presbyterian Senior Care.


GREG LEWANDOWSKI

Family Hospice and Palliative Care has promoted **Kathy Little** to Senior Liaison. Kathy joined Family Hospice in the spring of 2008. She has over 15 years of sales and marketing experience, including hospice, pharmaceutical and transportation & logistics. Kathy was recipient of Johnson & Johnson's Business Development Award in 2006 and 2007.


KATHY LITTLE

Peter Reinhart has joined Family Hospice and Palliative Care as Clinical Supervisor at Anderson Manor, which serves patients in Beaver and Butler counties. He has worked in health care most of his life; the last ten years as a registered nurse. His experience is in medical-surgical, behavioral health, long term care, and hospice nursing. Peter has worked at several UPMC hospitals and most recently was employed by VA Hospital in Aspinwall. This is his second employment with Family Hospice and Palliative Care; having previously worked as an extended hours RN.


PETER REINHART

FOUNDATION RADIOLOGY GROUP

Erik Richter, M.D., has joined Foundation Radiology Group (FRG) as a staff radiologist. Prior to joining FRG, Dr. Richter completed a Fellowship in Thoracic Radiology at the University of Pittsburgh Medical Center.


DR. ERIK RICHTER

Mark G. Brown, M.D., has joined FRG as a staff radiologist. Most recently, Dr. Brown served as Section Chief of both Nuclear Medicine and Vascular and Interventional Radiology at Jeanes Hospital of the Temple University Health System in Philadelphia.


DR. MARK G. BROWN

Foundation Radiology Group is pleased to announce the addition of **Jim Yamshak**, Senior Vice President of Sales, to the FRG team. Most recently, Yamshak served as Senior Vice President of Sales for Emageon, Inc. Yamshak began his career at Emageon in 2002, as Senior Director of Sales for the Midwest Region.

Foundation Radiology Group welcomes **Gretchen Connelly**, Director of Marketing, to the FRG team. Most recently, Connelly served as a Project and Program Manager for The Abreon Group. Prior to her work with The Abreon Group, Connelly spent several years working as a Project Manager for Blattner Brunner (now Brunner).

KINDRED HOSPITAL PITTSBURGH - NORTH SHORE

Kindred Hospital Pittsburgh - North Shore welcomes the following physicians to its medical staff: Genesis Medical Associates, Inc. - **Harry Heck III, M.D.,** Internal Medicine and **Nita Heck, CRNP**; Renal Endocrine Associates, P.C. - **Meera Bajwa, M.D.**, Nephrology, and **Bryan Krull, D.O.**, Nephrology; Allegheny Center for Digestive Health - Gastroenterology - **Geanina Anghel, M.D., Michael Babich, M.D., Manish Dhawan, M.D., Katie Farah, M.D., Abhijit Kulkarni, M.D., Paul Lebovitz, M.D., Robin Midian-Singh, M.D., Suzanne Morrissey. M.D., Jose Oliva, M.D., Shyam Thakkar, M.D., Shira Spilman, PA-C,** and **Meredith Wisniewski, PA-C**; Pulmonary Consultants UPMC - **Charles Atwood, M.D.**, and **Steven Duncan, M.D**.

More Healthcare Professionals in the News continued on the next page.

Healthcare Professionals in the News

LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE


DR. ABIR KAHALEH

Abir Kahaleh, Ph.D., Director of Experiential Education, was promoted to Associate Professor of Pharmacy Practice. Dr. Kahaleh earned a Bachelor of Science in Pharmacy from the University of Damascus, a master's degree from the University of Toledo, a master's degree in Public Health from the University of Michigan, and a doctoral degree from the University of Michigan in Ann Arbor, MI. In addition to her administrative responsibilities, she teaches courses such as Introductory to Health Care Delivery, Pharmacy Management, Independent Research Study, and a capstone course.


DR. SEHER KHAN

Seher Khan, Ph.D., was promoted to Associate Professor of Pharmaceutical Sciences. Dr. Khan received a Bachelor of Pharmacy (Honors) degree and a master's degree in Pharmacy from the University of Dhaka in Bangladesh. He completed his doctoral degree in Pharmacology at East Carolina University School of Medicine. Following a postdoctoral appointment at Penn State University, he joined LECOM in 2003.


DR. RICHARD ORTOSKI

Richard Ortoski, D.O., was promoted to Professor of Family Medicine. He has been a faculty member at LECOM since it opened in 1992. He serves as the Chair of the Department of Primary Care Education and the Clinical Director of the Primary Care Scholars Pathway. Dr. Ortoski has been the director of many courses at the college and represents LECOM while serving on various national professional committees and the Erie County Board of Health.

MONONGAHELA VALLEY HOSPITAL


DR. CHRISTOPHER E. EMOND

Sports Medicine Specialist **Christopher E. Emond, M.D.**, has been appointed to the Medical Staff at Monongahela Valley Hospital. He joined the hospital staff in the Department of Surgery. Dr. Emond received his Medical Degree from New York Medical College in 2003. He completed his internship in general surgery in 2004 and his residency in orthopedic surgery in 2008 both at Boston University Medical Center. Dr. Emond completed his fellowship in orthopedic sports medicine at Thomas Jefferson University Hospital in Philadelphia in 2009.


DR. MARK F. SULLIVAN

Mark F. Sullivan, M.D., has been appointed to the Medical Staff at Monongahela Valley Hospital. He is board certified in General Surgery and Thoracic Surgery and has joined the hospital staff in the Department of Surgery. Dr. Sullivan received his Medical Degree from Georgetown University School of Medicine in 1983.

OHIO VALLEY GENERAL HOSPITAL


DR. ALEX SENCHENKOV

Ohio Valley General Hospital (OVGH) is pleased to announce the addition of **Alex Senchenkov, M.D.**, to its medical staff. Dr. Senchenkov earned his medical degree with honors from the Ukrainian State Medical University in Kiev, Ukraine. After his graduation, he worked as a staff surgical oncologist in the Division of Musculoskeletal Oncology (Sarcoma and Melanoma) at the Kiev Research Institute of Oncology.

SHARON REGIONAL HEALTH SYSTEM


DR. DAVID MILLER

Sharon Regional Health System is pleased to welcome **David Miller, M.D.**, emergency medicine, to its medical staff. He joins Sharon Regional's Emergency Care Center team. Dr. Miller received his medical education from the University of Pittsburgh School of Medicine and has just completed a residency in emergency medicine at Geisinger Medical Center in Danville, PA.


DR. RAJA CHADALVADA

Sharon Regional recently welcomed **Raja Chadalvada, M.D.**, a specialist in Gastroenterology to its medical staff. He completed a fellowship in Gastroenterology

at MetroHealth Medical Center/Case Western Reserve University in Cleveland, a Clinical Nutrition fellowship at Cleveland Clinic, and a fellowship in Advanced Hepatology and Transplant medicine at the University of Pittsburgh Medical Center.


DR. BRANDON M. MIKOLICH

Brandon M. Mikolich, M.D., interventional cardiologist, recently joined the medical staff of Sharon Regional Health System. He received his medical education from the Medical College of Pennsylvania (MCP) Hahnemann School of Medicine in Philadelphia.

SHRINERS HOSPITALS FOR CHILDREN—ERIE


DR. JOHN D. LUBAHN

John D. Lubahn M.D., has been named Chief of Staff of the Shriners Hospitals for Children—Erie. Dr. Lubahn has been serving as the Interim Chief of Staff since December, 2007. Dr. Lubahn has been a member of the Erie hospital's medical staff since 1981. In addition, he has been on staff at Hamot Medical Center in Erie since 1981, and has been affiliated with Hand, Microsurgery and Reconstructive Orthopaedics of Erie since 1987.

UPMC HORIZON


DR. JORGE MERCADO

Jorge Mercado, M.D., pulmonologist, has joined UPMC Horizon's medical staff. Dr. Mercado earned his medical degree from the University of Buenos Aires School of Medicine. He completed an internal medicine residency at UPMC Presbyterian and UPMC Shadyside and a pulmonary/critical care fellowship at Drexel University College of Medicine, Philadelphia.


DR. DAVID BRENNAN CLINE

David Brennan Cline, M.D., a radiologist, has joined UPMC Horizon's medical staff. A retired Lieutenant Colonel in the United States Army Medical Corps, Dr. Cline earned his medical degree from the Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine in Bethesda, MD. He completed an emergency medicine internship and residency at Darnall Army Community Hospital, Fort Hood, TX, and a radiology residency with Bethesda Naval Hospital and Walter Reed Army Medical Center, Washington, DC. He most recently served as chief of radiology at Moncrief Army Community Hospital, Fort Jackson, SC.

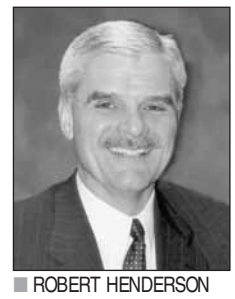

DR. HERNAN ALVARADO

Hernan Alvarado, M.D., urologist, recently joined UPMC Horizon's active medical staff. Dr. Alvarado most recently served as a staff urologist at Kaiser Permanente Medical Center, Walnut Creek, CA, and had a private practice in Roseburg, OR.


DR. JEFFREY RESPECKI

Jeffrey Respecki, D.O., recently joined UPMC Horizon's Emergency Department staff. Dr. Respecki earned his medical degree from Lake Erie College of Osteopathic Medicine, Erie, PA. He completed an internship and emergency medicine and internal medicine residencies at Henry Ford Macomb Hospital, Warren, Mich.

UPMC PASSAVANT


ROBERT HENDERSON

Robert Henderson of UPMC Passavant has been appointed by Dr. Patrick Gallagher, Deputy Director of the Commerce Department's National Institute of Standards and Technology (NIST), to the 2009 Board of Examiners for the Malcolm Baldrige National Quality Award.

UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE


DR. WILLIAM P. FOLLANSBEE

William P. Follansbee, M.D., professor of medicine and radiology at the University of Pittsburgh School of Medicine and director of Nuclear Cardiology at the UPMC Cardiovascular Institute, has been selected the inaugural Master Clinician Chair in Cardiovascular Medicine at the UPMC Cardiovascular Institute.
Named in his honor, the William P. Follansbee, M.D., Master Clinician Chair in Cardiovascular Medicine was established to recognize a faculty member who is both an outstanding academic clinician and educator.

WINDBER MEDICAL CENTER


DR. BARBARA CLIFF

Barbara Cliff, Ph.D., FACHE, recently started as the President/CEO at Windber Medical Center. She has a Bachelor of Science Degree in Nursing and also holds masters degrees in public administration and health services administration.

Predicting the Future?
The Impact of the 2010 IPPS on Heart, Vascular, & Stroke Services

BY KRISTIN TURKOVICH

Since CMS issued the final 2010 Inpatient Prospective Payment System, we at Corazon have been working to help our cardiac, vascular, and stroke program clients plan for the October 1st, 2009 implementation. Corazon strongly believes that all organizations must prepare by allocating appropriate resources, scheduling necessary training, and keeping clinical and financial teams apprised of required policy and/or procedure changes necessary to proactively tackle any issues and ultimately protect the profit margin of the cardiovascular specialty.

A Note on Final Changes

Once the proposed update was released on May 1st, hospitals feared the negative coding adjustment of 1.9%, but welcomed the 2.1% market basket update. However, when the final rule was published on July 31st, hospitals were pleased to see that CMS ruled to postpone the negative coding adjustment while keeping the market update of 2.1%. Although this may relieve some potential decreases in the short term, hospitals must realize that CMS is mandated by law to conduct a full analysis of case-mix changes in order to make the appropriate coding adjustments for FY2011 and FY2012.

Even though hospitals have squeaked by the coding adjustments for the upcoming fiscal year, hospitals still have to accurately document and code in order to receive the higher paying MS-DRG (if appropriate) especially when reimbursement hasn't changed all that much.

The Impact on Reimbursement

CMS has slightly adjusted the relative weights assigned to each MS-DRG, some increasing and some decreasing. Overall, a 1% increase for cardiac and vascular services and a 2% increase for stroke services resulted.

The subsequent table provides a comparison of the 2009 to 2010 reimbursement impact for some of the most common cardiac, vascular, and stroke MS-DRGs. Depending on an organization's patient mix and ability to document and code the severity of illness, reimbursement could vary across a sometimes broad range, mostly based on the MS-DRG under which the patient is categorized.

Service Category	MS-DRG	FY09 Pymt.	FY10 Pymt	Pymt % Change
Cardiac	MS-DRG 247 – PCI w/DES w/o MCC	$10,620	$10,810	2%
Cardiac	MS-DRG 293 – Heart failure w/o CC/MCC	$4,009	$3,923	-2%
Vascular	MS-DRG 253 – Periph. vasc w/CC	$12,518	$12,899	3%
Vascular	MS-DRG 254 – Periph. vasc w/o CC/MCC	$8,565	$8,883	4%
Stroke	MS-DRG 062 – Ischemic stroke w/TPA w/CC	$10,848	$10,905	1%
Stroke	MS-DRG 065 – Hemorrhage or infarct w/CC	$6,530	$6,547	0%

Strategies for Success

Given that reimbursement rates have changed only slightly, hospitals need to stress the importance of reducing costs and maximizing payment. When approaching this issue, Corazon recommends the following strategies:

- Focus on detailed and accurate documentation, better information on the incidence of disease, and code ALL complications and co-morbidities. Don't stop at one code that qualifies for a higher-paying DRG, and make sure to code all secondary diagnosis, which can increase the case mix index.
- Move the coding query and clarification process from the back end to the front end. Most of the oversight for the documentation and coding process occurs after the patient is discharged. Consider options to move this to the front end by working with case management to clarify documentation prior to discharge. This approach will help with the coding turnaround-time and physicians will find the process less frustrating because the patient is still top of mind.
- Modify forms, such as pre-procedure forms and progress notes, to create pick-lists that give options for the physician to capture patient information in a standardized format. Be careful not to prompt the physician for a specific code, especially if that code will result in a higher severity level.
- Consider having a third party to audit and monitor processes and make recommendations. Limiting the scope of services to be evaluated, such as diagnostic caths, coronary interventions, etc., can result in a focused effort to create and sustain change.
- Manage operating costs and length of stay. Program margins erode every additional day over the geometric mean length-of-stay set by CMS. A cost reporting system can be used to review each case category (e.g., Cath, PCI, etc.) and the MS-DRG split on a regular basis to track and trend changes. Such a process will allow programs to identify which costs are increasing or deceasing, investigate why, and then develop plans to address them.

As CMS makes updates every year, organizations must react and quickly adapt to an ever-changing reimbursement structure. Although implications will be across the full spectrum of acute care, Corazon believes organizations must be particularly vigilant for cardiac, vascular, and stroke cases, which typically are resource-intense with high-cost devices and complex patient conditions. Programs must work now to strategize and form action plans to be more prepared for next month's implementation.

Kristin Turkovich is a Consultant at Corazon, a national leader in consulting, recruitment, and interim management for the heart, vascular, and stroke specialties. For more information, call (412) 364-8200 or visit www.corazoninc.com. To reach Kristin, e-mail kturkovich@corazoninc.com.

Heart Failure Disease Management

Physicians and Hospitalists Teaming with Celtic Healthcare for Heart Failure Disease Management

Any healthcare professional knows how great a need today's healthcare arena has in regard to heart disease education and care – and physicians can't do it alone. Unless a heart disease patient experiences a critical or significantly life-threatening health problem, the patient spends most of their time outside of a hospital or a physician's direct care.

How do we tackle this problem when a heart disease patient spends a lot of their time at home?

One effective way to start the process toward heightened awareness and self-care: Celtic Healthcare's Heart Failure Disease Management Program. The Heart Failure Disease Management Program is a patient-centric, multidisciplinary approach to reducing avoidable re-hospitalization, including reducing 30-day hospital readmission rates and promoting patient self-management.

Celtic Healthcare teams with the physician or hospitalist as soon as a hospitalized patient with heart failure is identified as a candidate for possible discharge in order to formulate effective, patient-centric goals.

What are the benefits for the patient? Implementing Celtic Healthcare's Heart Failure Disease Management Program into a patient's care plan empowers the patient. It teaches the patient vital self-management tools to ensure they have control over their own condition. By increasing the patient's knowledge over their own signs and symptoms, early steps can be taken to reduce major problems and health issues. Celtic Healthcare's step-by-step program focuses on preventative and proactive measures, such as instructions on diets and nutrition, knowledge of signs and symptoms, proper medication management, exercise and fitness tips and assistance, and poor health habit elimination. This effective Heart Failure Disease Management Program focuses on the needs of heart failure patients across the full healthcare continuum and provides programs such as the Rapid Response Team and Smoking Cessation Counseling.

Celtic Healthcare's Heart Failure Disease Management Program involves all healthcare professionals working in an integrated, team-oriented manner for the patient.

The results of this program include an ultimate decrease in unnecessary re-hospitalizations, a happier, healthier patient and superior patient outcomes and streamlined hassle-free care coordination that meets the needs of the most challenging patients.

Dr. Elbert Acosta and Marianna Rand, Nurse Liaison

Celtic Healthcare's Heart Failure Disease Management Program uses tools such as Telehealth, which enables delivery of health-related services remotely. Due to the intensive homecare strategy, in the 1st quarter of 2008, only 1 CHF patient was readmitted to the hospital. This represents a 1% re-hospitalization rate, which is unheard of in our industry! In the 2nd quarter of 2008, there were ZERO CHF re-hospitalizations, representing a 0% re-hospitalization rate – this is truly an unprecedented statistic!

For more information on this unique heart disease management program and using it as a step towards lowering re-hospitalizations, contact Celtic Healthcare at 1-800-355-8894.

PROFILES IN: Cardiology

WEST PENN ALLEGHENY HEALTH SYSTEM

The Western Pennsylvania Hospital

Walter E. McGregor, M.D.

Walter E. McGregor, M.D., joined The Western Pennsylvania Hospital in 2009 as Chief of the Division of Cardiac Surgery.

He earned a record of excellence in clinical practice and teaching at Riverside Methodist Hospital in Columbus, Ohio, where he served on the Attending Teaching Staff of the Department of Cardiothoracic Surgery since 2003.

Dr. McGregor was a two-time recipient of the British Journal of Surgery Award from Western Reserve Care System. Previously a member of Mensa, Dr. McGregor also was awarded the Shermann and Francis Battle Scholarship for NEOUCOM and the Academic Foundation Scholarship for Youngstown State University.

He has lectured, presented and published on a wide variety of topics in his field, including minimally invasive cardiac surgery, surgical wound closure and aortic aneurysm repair in patients with severe pulmonary disease.

Allegheny General Hospital

Stephen Bailey, M.D.

Stephen Bailey, M.D., was appointed Director of the Division of Cardiac Surgery at Allegheny General Hospital in 2007. Under his leadership, the McGinnis Cardiovascular Institute at Allegheny General is working to develop state-of-the-art surgical technologies for end state heart failure, a new generation of heart assist devices and less invasive options for valvular and coronary heart disease.

Dr. Bailey joined Allegheny General in 2006 from Columbia University Medical Center. Dr. Bailey has expertise in the surgical management of heart failure, including heart transplantation and cardiac assist technology. He specializes in complex coronary revascularization, valve repair and aortic surgery.

Indu Poornima, M.D.

Indu Poornima, M.D., serves as Medical Director of Nuclear Cardiology and Director of The Women's Heart Center of the Gerald McGinnis Cardiovascular Institute at Allegheny General Hospital.

Dedicated to addressing the heart care needs of women, Dr. Poornima is currently serving as principal investigator in a study to determine the relationship between vascular calcification and osteoporosis in postmenopausal women.

Dr. Poornima serves on the American Heart Association's Council of Clinical Cardiology and Cardiac Imaging and is a member of the American Society of Nuclear Cardiology and the National Lipid Association.

The Western Pennsylvania Hospital – Forbes Regional Campus

Michael Culig, M.D.

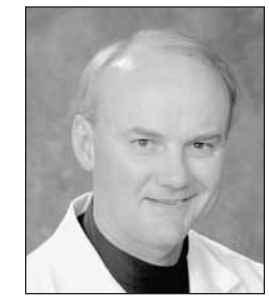
Michael Culig, M.D., serves as Chief of the Division of Cardiovascular Surgery and Medical Director of the Ed Dardanell Heart & Vascular Center, part of the Gerald McGinnis Cardiovascular Institute, at The Western Pennsylvania Hospital – Forbes Regional Campus.

Dr. Culig has special interest in innovations in beating heart surgery and arterial vascularization, coronary artery bypass surgery, cardiac valve reconstruction and replacement, and complex reconstruction of the thoracic aorta.

Dr. Culig is involved in research focused on improving the delivery of healthcare in Pittsburgh and beyond. He is President of Pittsburgh Cardiovascular Aid International and was Co-chair of the Pittsburgh Regional Health Care Initiative's Cardiovascular Working Group.

He served as American Director of Project Coronary, a philanthropic medical mission in western Ukraine, and is principal investigator of Redefining Chronic CARE, a three-year program funded by the Highmark Foundation, which analyzes the impact of Toyota Production System-based quality principles aimed at perfecting heart care at The Western Pennsylvania Hospital – Forbes Regional Campus.

Bradley Heppner, M.D.



Bradley T. Heppner, M.D., has been practicing cardiology with a special emphasis in adult consultative and interventional cardiology, at The Western Pennsylvania Hospital since 1992.

A fellow in the American College of Cardiology, Dr. Heppner is board-certified in cardiovascular diseases and interventional cardiology by the American Board of Internal Medicine.

Dr. Heppner is active in the teaching program at The Western Pennsylvania Hospital. He has participated in various clinical trials in the field of cardiology. He also serves as Director of the Quality Assurance Program for the Division of Cardiology and Director of the Electrocardiography Department. He is presently a member of the Medical Executive Committee and has served as Vice President of the West Penn Hospital medical staff.

During his tenure, The Western Pennsylvania Hospital was named three times to the prestigious list of the nation's 100 Top Hospitals for cardiovascular care. In 2008, West Penn was one of just 30 teaching hospitals with cardiovascular residency programs in the United States named to Thomson Reuter's Top 100 list.

FAMILY HOSPICE AND PALLIATIVE CARE

Stacy Mullen, R.N.

Quality of life serves as daily motivation for Stacy Mullen, R.N., who has been on staff at Family Hospice and Palliative Care since December, 2008. Stacy is part of a team of nurses pioneering Family Hospice's new cardiac initiative, Pathways: A Specialized Heart Failure Program, which instructs clinical staff to look for subtle signs of change and discomfort in cardiac patients. "The training allows us to focus on the patient's comfort level," explains Stacy. Before joining Family Hospice, Stacy worked for five years as an ICU nurse in a local hospital, and before that, spent about four years working in Myrtle Beach, Las Vegas and Baltimore. She's happy to be back in her native Pittsburgh – and proud of the work she and other hospice nurses do every day. Stacy says that her desire to ensure patients' comfort is what brought her to Family Hospice. "In the ICU, of course we worked to keep patients comfortable, but the focus was on quantity of life, rather than quality of life," says Stacy. "Now, I appreciate the opportunities I get to sit with a patient and family and explain how hospice care will allow them to experience the end-of-life journey in a dignified way." She embraces the process, seeing it as a chance to educate both patients and caregivers, all while administering quality care. Stacy lives in the South Hills and is planning an October wedding.

Pam Rodondi, R.N.

Pam Rodondi is a registered nurse who sees patients and families followed by the Hermitage office of Family Hospice and Palliative Care. Pam had worked for many years as a machinist and welder in tool-and-dye repair when the plant's closing led her to pursue a nursing degree at Penn State. This second career has allowed her to remain in and serve the community she calls home. When she worked on the cardiac unit at St. Elizabeth's Hospital in Youngstown, Ohio, Pam saw many patients and families at end-of- life and gained an appreciation of the clinical and psychosocial needs unique to cardiac disease. This understanding informed her decision 2 years ago to pursue hospice nursing. With the benefit of her experience, Pam has taken on an educational responsibility in support of Family Hospice's Pathways: A Specialized Heart Failure Program and fields questions from patients, families and health care professionals about how timely assessment, intervention and/or the application of certain medications can allow the patient and family to remain at home comfortably and confidently. Serving rural Western Pennsylvania, Pam and the rest of the interdisciplinary team bridge the physical distance between families isolated by location and their means of securing quality health care. She values the opportunity to be creative in problem solving in the many ways that community-based nursing requires. Pam believes her greatest reward is to be a privileged witness to the intimacy of a loving family on a peaceful journey with someone they treasure.

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Western Pennsylvania
Hospital News

Cardiovascular Disease Prevention Could Modulate Heath Care Costs

BY LEWIS H. KULLER, MD, DRPH, AND DANIEL EDMUNDOWICZ, MS, MD, FACC

Coronary heart disease (CHD) is preventable. The incubation period; the time from the development of atherosc1erosis to the clinical CHD event; is very long, beginning in childhood or young adult life and is directly related to the traditional cardiovascular (CV) risk factors. The time to the event, i.e. a heart attack or sudden CHD death, is obviously very rapid and is a culmination of the long term development of atherosclerosis (the total plaque burden) and subsequent change in plaque morphology and thrombogenesis. Focusing only on the short period before the clinical event or after a clinical event has occurred will not reduce the rates of CHD to those of the lowest risk populations. This should no longer be the primary focus of preventive cardiology.

Studies evaluating coronary calcium, a measure of atherosclerotic burden, have shown that both men and women who have zero coronary calcium or low coronary calcium scores < 10 have an extraordinarily low risk of both clinical CHD and total mortality over at least the next four or five years. CV risk factors are the primary determinants of presence and amount of coronary calcium.

Individuals with low levels of cardiovascular disease (CVD) risk factors have both low coronary calcium scores and risk of heart attack. The focus of the prevention of CHD must change to 1) prevention of the development of CV risk factors from childhood onward; and 2) the prevention of the development and progression of coronary atherosclerosis.

Prevention of elevated risk factors in childhood and young adult life should be the primary focus of our efforts. However, in spite of all of our good intentions, it is unlikely that we are going to succeed in substantially modifying the current distribution of LDL, ApoB or cholesterol in the population or the high prevalence of elevated BP for most adults. For the majority who remain unsuccessful in maintaining very low risk factors, pharmacological approaches are required.

One approach known as the "polypill" would provide a combination of lipid lowering, antihypertensive and aspirin therapy to most of the adult population as an initial approach without screening for risk factors, i.e. an over-the-counter low dose pill, cheap, safe and effective.

A second approach would be to use measures of coronary calcium at middle age – perhaps 45 in men and 55 in women as a baseline to identify individuals who have established subclinical vascular disease and as such, will likely be at increased risk of CHD events during their remaining lifetime. A small percentage of the population, maybe up to 20%, have very low risk factor levels and are unlikely to have high coronary calcium scores or to be at risk of CHD events.

The remaining 80-85% of the population, however, are at risk. Initial screening for coronary calcium will discriminate individuals who should begin aggressive pharmacological and nonpharmacological therapy, even though asymptomatic, to reduce their CV risk factors to very low levels.

The presence of coronary calcium as a marker of an increased atherosclerotic burden almost guarantees that there will be increasing amounts of atherosclerosis and coronary calcium over time. There is little value of waiting to begin aggressive therapy until the coronary calcium scores and associated atherosclerotic burden are very high. The cost of drug therapy is modest and the risk of sudden death as the initial manifestation of coronary heart disease remains of great concern.

Therefore, among men and women who have coronary calcium scores of over 10; probably close to _ the population at age 45 in men or 55 in women; aggressive pharmacological intervention, much like proposed for secondary prevention of CHD, should be considered. For the population in which the coronary calcium scores are zero, risk of CHD events and total mortality is very substantially reduced, at least over the next five or 10 years. Coronary calcium studies should be repeated perhaps every five to 10 years among such individuals at least until the age of about 65-70. Electron Beam CT scanners or improved image acquisition techniques with multislice CT scanners have substantially reduced radiation dose. Measurement of coronary calcium should be considered as a screening test rather than a diagnostic examination and as such, should be made affordable. Currently calcium scans can be obtained for less than $100.

Currently in the United States practically all men over the age of 65 and women over the age of 70-75 have a significant atherosclerotic burden as evidenced by a substantially increased coronary calcium score and other measures of subclinical CVD that puts them at high risk of clinical events. This accounts, in large measure, for the continued high incidence and mortality and cost of CHD in the United States.

Accordingly, practically all men over the age of 65 and women over the age of 70 or 75 should be considered to be very high risk unless proven otherwise, perhaps by demonstrating the absence of coronary calcification and treated as we now propose for secondary prevention of CHD, i.e. with substantial lipid lowering, control of BP, aspirin therapy and exercise. This preventive approach could be less expensive than repeating a litany of laboratory and diagnostic tests until the individual has a heart attack.

Finally, after the many years of research we still cannot predict, or measure in the population the determinants of the conversion of the underlying atherosclerotic plaque to a clinical event, i.e. plaque rupture and myocardial infarction. Development of new oral drugs which are safe and efficacious in modifying the risk of thrombogenesis may be the next major breakthrough in the prevention of CVD, especially for older individuals who already have extensive atherosclerosis. We will not reduce health care costs for CVD unless we embark on a much more aggressive prevention effort.

Dr. Lewis H. Kuller, Distinguished University Professor of Public Health, can be reached at (412) 383-1895 or kullerl@edc.pitt.edu.
Dr. Daniel Edmundowicz, Associate Professor of Medicine, University of Pittsburgh School of Medicine, Director, Cardiovascular Medicine, UPMC Passavant Hospital, Director, Preventive Cardiology and Lipid Management Program UPMC Cardiovascular Institute, can be reached at (412) 802-3014 or edmud@upmc.edu.

AGH Researchers Explore Use of Heart Wrap Device To Improve Cardiac Function

Cardiovascular disease researchers at Allegheny General Hospital (AGH) in Pittsburgh are exploring the use of a novel cardiac device that is wrapped around the heart to improve cardiovascular function and exercise capacity in patients with advanced heart failure.

Called the HeartNetTM Ventricular Support System, the new technology is made of an elastic nickel titanium mesh that is designed to reinforce the walls of the heart and slow or stop its enlargement. By augmenting the heart's pumping chambers, or ventricles, the device has shown the potential to help the heart work more efficiently and decrease the debilitating symptoms of heart failure, said Srinivas Murali, M.D., Director of AGH's Division of Cardiovascular Medicine and Medical Director of the hospital's Gerald McGinnis Cardiovascular Institute.

Under the direction of Dr. Murali and cardiovascular surgeon, Stephen Bailey, M.D., AGH is one of up to 30 U.S. medical centers investigating the safety and efficacy of the HeartNetTM device in a randomized clinical trial called the PEERLES-HF study (Prospective Evaluation of Elastic Restraint to Lessen the Effects of Heart Failure).

University Wellness Committee Focuses on Heart Disease Prevention

THE STATISTICS ARE STAGGERING:

- In 2005, 652,091 people died of heart disease in the United States, accounting for approximately 27 percent of all deaths.
- Approximately 47 percent of all cardiac deaths occur before the person ever makes it to a hospital.
- Including medications, health care services and lost productivity, heart disease is projected to cost more than $304.6 billion in 2009.

BY KATRINA A. PYO, MS, RN, CCRN

As these facts and figures from the Centers for Disease Control and Prevention show, heart disease walks with all of us through every aspect of life. It is the leading cause of death for both men and women in the United States, and also is a major cause of disability. We all know someone who has been afflicted by this silent killer.

In an effort to promote health and well-being among the community of employees and their families, Robert Morris University formed a Wellness Committee, made up of administration, faculty and staff members, with a purpose of providing education and support for creating healthy behaviors. In 2007, the Wellness Initiative Program was set into motion by the Wellness Committee, along with a partnership with Highmark. A major focus of the initiative is to reduce risk factors for heart disease through various programs.

Exercise programs, such as strength and conditioning, are offered to employees and family members at the RMU Health Club and the Island Sports Center. Exercise sessions include spinning, yoga and Pilates.

There are other physical activities as well. There are indoor walks at the Sewall Center throughout the winter months, and neighborhood walk routes and routes around the city of Pittsburgh that are posted on the RMU intranet to encourage walkers on the Moon campus, as well as the Downtown campus.

The second annual 12-week, 10,000 Steps Challenge Program took place this past December. Pedometers were supplied by Highmark, along with "Steps to Success" articles for tips on making the most of your steps and creative ways to keep stepping, to watch your diet and to keep motivated.

The number of heart-disease deaths that occur before the person makes it to a hospital is profound. The need for education is the No. 1 force in fighting this unnecessary statistic. Robert Morris offers CPR classes in an effort to increase education and awareness for the need for immediate intervention in a cardiac emergency. Dr. Carl Ross, University Professor of the School of Nursing and Health Sciences, is the certified CPR instructor who leads the once-a-year instruction and certification process for the RMU community.

In an effort to expand the initiative's services, the RMU School of Nursing and Health Sciences provides free blood pressure screenings for the campus community at on-campus locations, the Island Sports Center and the downtown Pittsburgh RMU location. This service has even been expanded to the greater Pittsburgh community through a partnership with the Port Authority Transit system, in which the school conducts blood pressure screenings for the Port Authority Transit employees.

The Wellness Committee extended its work internationally by conducting the first conference ever in Nicaragua focusing on men's health and the importance of exercise, weight control and managing risk factors. Dr. Ross, a committee member, initiated steps to reach out to the international community by conducting educational seminars on various heart-health topics in Nicaragua.

What started as a community effort is growing larger than imagined. The Wellness Committee has done a wonderful job coordinating and implementing programs for the health of many, both close to home and with the global perspective.

Katrina A. Pyo is clinical assistant professor in the School of Nursing and Health Sciences at Robert Morris University. She can be reached at pyo@rmu.edu or (412) 397-3798.

Good Health Perspective
from ROBERT MORRIS UNIVERSITY

Construction Zone: Federal Building Code Officer Ruling Impacts Hospital Projects

BY CHAD MICHAELSON

A recent ruling by the Supreme Court may affect the construction and renovation of hospitals throughout Western Pennsylvania.

In the lawsuit, independent contractors claimed it was against the law for smaller municipalities to make exclusive contracts with building code officials (BCOs) to conduct the inspections required when a commercial or residential property owner builds, expands or makes extensive renovations.

Modern advancements in medical technology and the delivery of care require hospital accommodations like new family and senior facilities, increased outpatient care capacity and updated emergency and treatment rooms. As a result, hospitals throughout the region have construction projects that require approval of a BCO.

The Pennsylvania Construction Code Act (PCCA) requires Pennsylvania municipalities to adopt uniform construction codes and appoint a BCO to enforce those codes on behalf of the municipality. Typically, larger municipalities will hire a full time BCO to work on their behalf, while smaller municipalities will rely on contracting with outside vendors.

Because many municipalities do not have enough construction activity to justify employing a full-time BCO, they often decide to engage a private building inspection agency to act as the municipality's exclusive BCO. This practice excludes other agencies from the business of administering inspections and enforcing construction codes within the boundaries of the municipality.

In 2005, several building inspection agencies filed lawsuits against two municipalities, alleging that the municipalities' exclusive BCO arrangements violated the PCCA. The courts initially held that the exclusive contracts were permissible under the PCCA. When the decision was appealed, the Commonwealth Court reversed the initial ruling, finding that the municipalities were not permitted to exclude other inspection agencies from performing work within their borders. The municipalities appealed this decision to the Pennsylvania Supreme Court.

The Supreme Court ultimately ruled in favor of the municipalities, agreeing that the PCCA does not require a municipality, or its appointed BCO, to accept inspections performed by any building inspector or inspection agency. This means municipalities can chose to contract with an outside BCO, which can save tax dollars but also allows for better control over the inspection and enforcement process.

The new ruling shields BCOs from being forced to accept inspections by potentially unqualified building inspectors, a protection that contributes to the overall safety of any construction project. It also prevents builders from employing a "captive," and potentially biased, building inspector to perform all inspections of that builder's work.

The effects of the Supreme Court's decision to uphold exclusive BCO arrangements will impact building owners as much as contractors and construction companies. And as Western Pennsylvania hospitals continue to make plans to modernize, expand and construct new facilities, they will undoubtedly feel the impact too.

Chad Michaelson, partner at Meyer, Unkovic & Scott LLP, can be reached at cim@muslaw.com.

(l-r) David Fenoglietto, president and chief executive officer of Lutheran SeniorLife; Cindy Hamorsky, program officer for the Campbell Foundation; and Dr. J Robert Graham, chairman of the Embracing Abundant Life Capital Campaign, pose in front of an artist's rendering of the new assisted living facility.

LUTHERAN SENIORLIFE BREAKS GROUND FOR NEW ASSISTED LIVING RESIDENCE

June 14, 2009 marked another step towards a new era in care for elderly when Lutheran SeniorLife officially broke ground for its Assisted Living Alzheimer's Residence on the St. John Specialty Care Center campus.

The 27,000 square foot assisted living Alzheimer's Residence will have a home-like feel, with single rooms featuring private baths and bright bay window-like seating areas. Colors, finishes and other design features in this warm environment are tailored to the needs of Alzheimer's residents. David Fenoglietto, president and chief executive officer of Lutheran SeniorLife, noted that the 30 private room residence will combine a dedicated staff with the newest technology including a wireless wandering alert system that gives residents maximum choice is a safe environment.

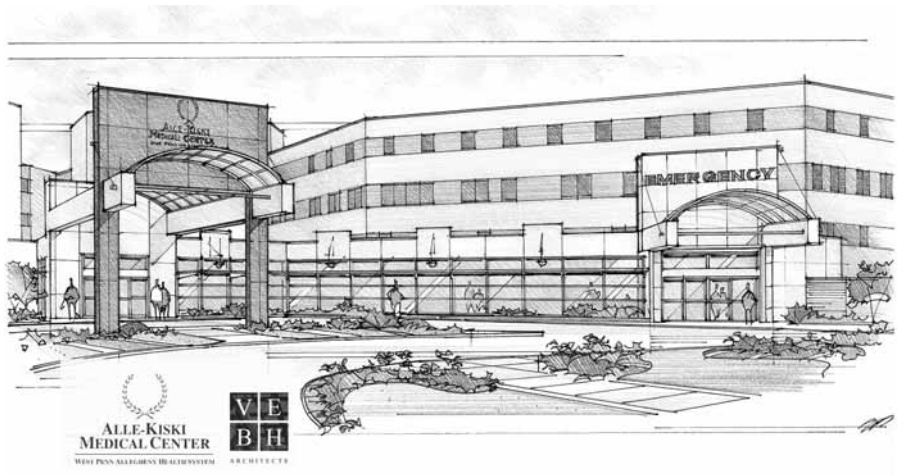
Fenoglietto led the groundbreaking ceremonies that included special guests Rev. Kurt F. Kusserow, bishop, Southwestern Pennsylvania Synod, ELCA; Rev. Dr. Ralph E. Jones, bishop, Northwestern Pennsylvania Synod and Rev. Ralph W. Dunkin, bishop, West Virginia-Western Maryland Synod. Other attendees included Ronald J. Coombs, chairman, Lutheran SeniorLife Foundation; Cindy Hamorsky, program officer, the Campbell Foundation and J. Robert Graham, PhD., chairman, Embracing Abundant Life Capital Campaign.

"I wish to thank the volunteers and staff who have made the capital campaign such a resounding success," said Graham. "We offer our sincere appreciation to the many donors, including individuals, businesses, churches and foundations for their generous support. More than $2.5 million in pledges and gifts has been donated so far to construct this residence."

PHYSICAL THERAPY PROVIDER OPENS NEW OUTPATIENT CENTER IN BUTLER

WESTARM Physical Therapy of Lower Burrell, PA is proud to announce the opening of their new facility located in the former WISR radio station building in Butler. Services will be provided by experienced and licensed physical therapists, Michael Dunham, DPT and Sally Woller, MSPT.

Brian Jacob, MHA, President, feels that this location will be ideal to meet the increased needs of the local community due to the expected completion of the expansion and renovation of Butler Memorial Hospital. He noted that this new center is less then one mile from the hospital



ALLE-KISKI MEDICAL CENTER BEGINS SECOND PHASE OF EMERGENCY DEPARTMENT CONSTRUCTION & RENOVATION

Alle-Kiski Medical Center (AKMC) officials recently announced that part two of the Emergency Department Expansion and Renovation project has begun at the main hospital campus in Natrona Heights. The first part of the construction project was completed earlier this year with the relocation and renovation of the Endoscopy Short Term Procedure Unit which moved to the first floor of the hospital.

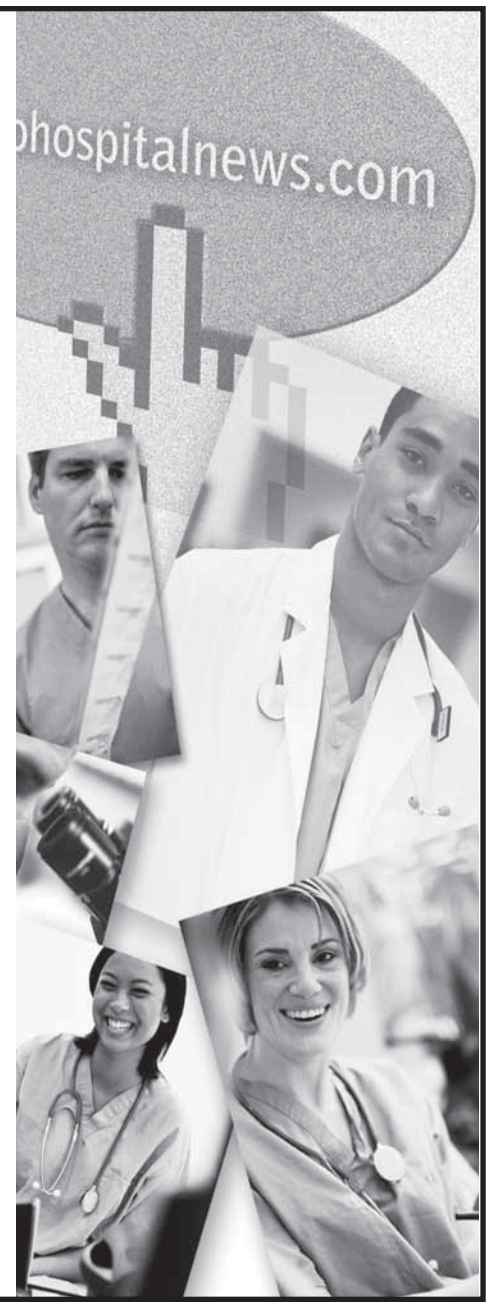
The $11.6 million project is expected to take approximately a year and a half to complete. The construction will be coordinated and completed in seven phases designed to minimize disruption to patient care.

The much awaited expansion project will increase the capacity of the Emergency Department and double the number of patient exam and treatment rooms from 12 to 24. The plan involves expansion of the current department into existing hospital space, renovation of the existing Emergency Department and external construction. A new electronic tracking and documentation system will also be initiated to facilitate patient flow.

VA FINALIZES DESIGN OF NEW COMMUNITY LIVING CENTER

VA Butler Healthcare finalized the design of a new Community Living Center to be constructed on the VA's 88 acre campus. The modern residential design concept of the facility was developed by the architectural engineering firm Radelet McCarthy Incorporated. The construction contract has been awarded to Jack Gibson Construction of Warren, Ohio. Construction is now underway, with an anticipated completion date of 2011.

The Community Living Center (CLC) will be constructed beside (east of) building two, the Rehabilitation Therapy Center. The CLC will be a single level residential community consisting of 60 private bedrooms with the nursing station and other amenities centrally located. The facility will be connected to building two so that residents can easily access other areas of the healthcare facility.



10 Ways That Health Care Insurance is Improving

BY SUE SCHICK

As the Obama administration, policy makers and industry leaders continue to debate the future of health care reform, negative news of the health care insurance industry remains at the center of attention. Everyday, reports of higher premiums, alarming numbers of uninsured and skyrocketing costs of medical care dominate media coverage, supporting a widely held belief that health care insurance is on a long and continuous downward spiral.

Meanwhile, what most people don't see is that quietly over the last 5 or so years, most health insurance plans have added features and programs that improve health, make it easier to deal with our convoluted health care system or cut overall health care costs. These new features don't solve all our health care woes, but they have made inroads into addressing some of our most complex challenges.

Here's a list of the Top Ten improvements and innovations the health care insurance industry has instated over the last few years:

10. The medical swipe card. Patients swipe the medical swipe card through a device similar to a credit card swipe to give caregivers access to all appropriate patient eligibility information and to the patient's health records. With the card, the physician is able to submit claim forms online and receive approvals from the insurance company in a matter of seconds.

9. Health care coupons. Some health care plans have begun offering discount programs that enable covered employees to get discounts of up to 50 percent on health care products and services, including lasik surgery, smoking-cessation programs, gym memberships and even fitness apparel.

8. Medical data synchronization. New data processing software such as the eSync platform collects and synchronizes medical data from a variety of sources, analyzes it and converts it into individual health care recommendations for specific patients.

7. Tele-medicine and advice over the phone. A number of insurance plans now offer health care advice over the phone. In the typical service such as NurseLine a nurse with experience can help the consumer find a doctor or hospital, understand treatment options and get medical questions answered.

6. Generic drugs in formularies. Health insurance plans now routinely include generic drugs in their drug formularies resulting in a lower copay for consumers who use gererics in place of higher-priced brand names that do the same thing.

5. Health savings accounts. A health savings account (HSA) enables employees to pay for their share of health care with pre-tax dollars and is offered in conjunction with a low premium, high deductible healthcare insurance policy. Employees can save money in the HSA tax-free and draw out funds anytime they want to pay for the premium, deductibles, co-pays or other medial costs.

4. Personal health records. A personal health record (PHR) provides a complete and accurate summary of the health and medical history of an individual using data gathered from many sources. The PHR is accessible online to the individual and anyone who has the necessary electronic credentials to view the information.

3. Real-time claims adjudication. Doctor's offices can now submit their claims online and know within 10 seconds if a procedure is covered by the patient's health plan, instead of having to wait days or weeks.

2. Online Resources. Many health care insurance plans now provide online resources for medical information and health care management. Innovative web tools provide instant access to disease management information, in-network physician directories, wellness programs, health coaching and a variety of other resources that streamline the process of health care decision-making.

1. Wellness programs. From smoke cessation to exercise, from weight loss to managing diabetes, consumers now have a wealth of wellness programs available through their health care insurance plan and/or their employer.

Regardless of what happens in health care reform, one can be sure that health care insurance will continue to make progress and improve the broken system. With an ongoing commitment to research and development, new innovations in service and technology will bring us closer to a better health care system, one step at a time.

Sue Schick, CEO, United Healthcare of Pennsylvania, can be reached at sue_schick@uhc.com.

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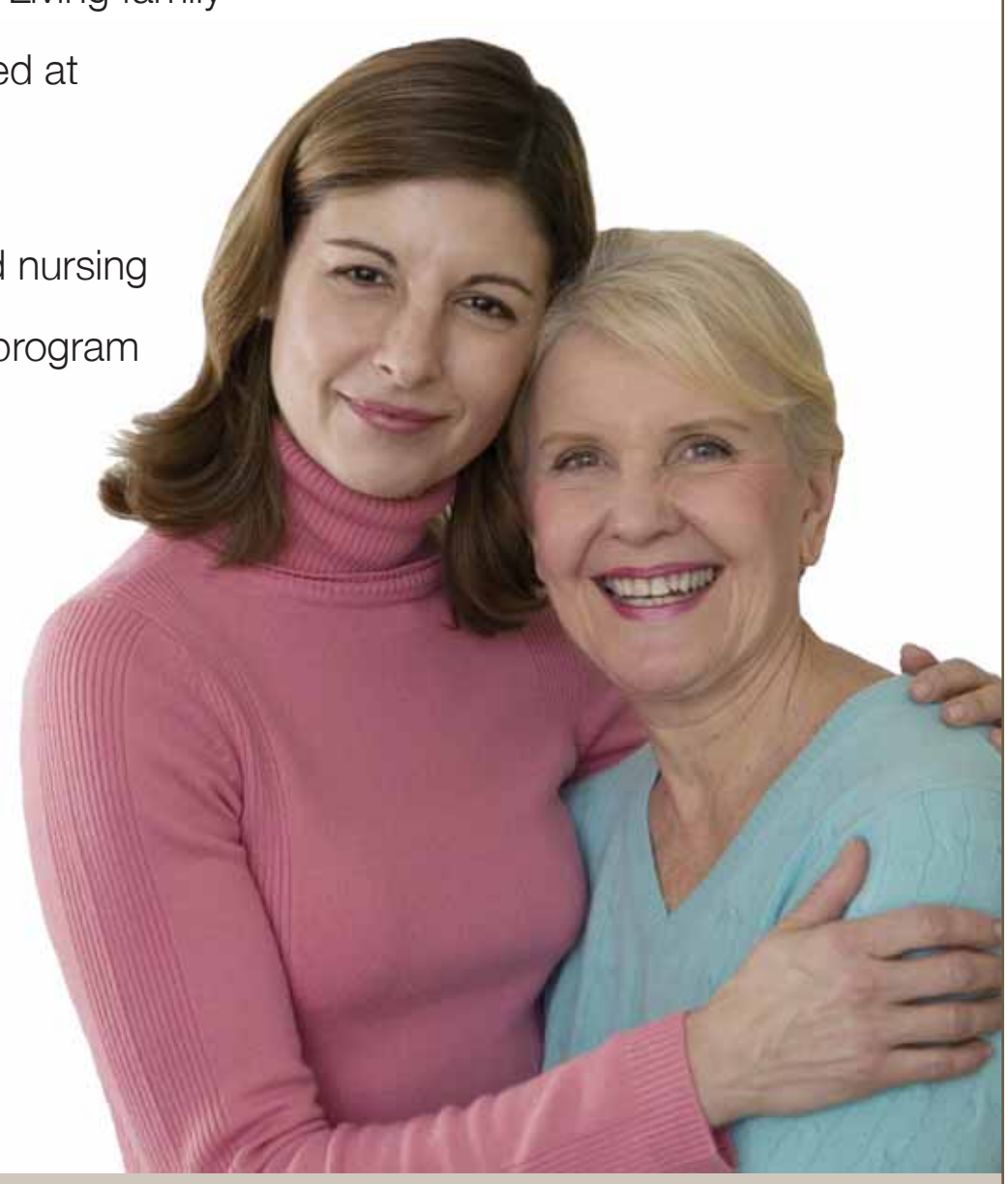

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St. Barnabas Health System is comprised of a 172-bed skilled nursing facility in Gibsonia, a 47-bed skilled nursing facility and a 182-bed assisted living facility in Valencia, an outpatient Medical Center and three retirement communities. RN and LPN positions available at the two nursing facilities. Home Care Companion positions are available to assist our Retirement Village and community clients with daily living and personal care needs. Earn great pay and benefits now. Fantastic country setting, convenient drive from Pa. Turnpike, Rts. 8 & 19, Interstates 79 & 279.

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For more information, please contact Joan Mitchell, for Independent Living; Michele Bruschi for Nursing Admissions; or Lisa Powell for Assisted Living at 412-341-1030. Visit our website at www.asbury-heights.org.

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For almost 100 years, Baptist Homes Society has served older adults of all faiths throughout the South Hills. As a continuing care retirement community, we provide a full continuum including independent living, short-term rehabilitation, personal care and assisted living, memory support, skilled nursing programs and hospice care. Between our two campuses, we offer one-stop shopping for senior living services. Baptist Homes, our Mt. Lebanon campus, serves nearly 300 older adults. Providence Point, our new campus in Scott Township, has the capacity to serve over 500 older adults. Our mission is to offer a full continuum of enriched living, compassionate care, and benevolence to a broad spectrum of individuals. Baptist Homes Society is both Medicare and Medicaid certified. For more information visit our websites (www.baptisthomes.org or www.providencepoint.org) or arrange for a personal tour at either campus by calling Karen Sarkis, Community Outreach Liaison, at 412-572-8308. Baptist Homes is located at 489 Castle Shannon Boulevard, Mt. Lebanon, and Providence Point is located at 500 Providence Point Boulevard, Scott Township.

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412-828-5600
Presbyterian SeniorCare - Washington
825 South Main Street, Washington, PA 15301
724-222-4300

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- St. Barnabas Nursing Home
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- Valencia Woods at St. Barnabas/The Arbors at St. Barnabas
  85 Charity Place, Valencia, PA 16059, (724) 625-4000 Ext. 258
- St. Barnabas Communities
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For more information write to Private Duty Services, 400 Penn Center Blvd., Suite 100, Pittsburgh, PA 15235, visit our website www.likenservices.com, e-mail info@likenservices.com or call (412) 816-0113 – 7 days a week, 24 hours per day.

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28-bed, licensed pediatric specialty hospital serving infants and children up to age 21. Helps infants, children and their families transition from a referring hospital to the next step in their care; does not lengthen hospital stay. Teaches parents to provide complicated treatment regimens. Hospice care also provided. A state-of-the-art facility with the comforts of home. Family living area for overnight stays: private bedrooms, kitchen and living/dining rooms, and Austin's Playroom for siblings. Staff includes pediatricians, neonatologists, a variety of physician consultants/specialists, and R.N./C.R.N.P staff with NICU and PICU experience. To refer call: Monday to Friday daytime: 412-617-2928. Afterhours/weekends: 412-596-2568. For more information, contact: Kim Reblock, RN, BSN, Director, Pediatric Specialty Hospital, The Children's Home of Pittsburgh & Lemieux Family Center. 5324 Penn Avenue, Pittsburgh, PA 15224. (412) 441-4884 x3042.

PUBLIC HEALTH SERVICES

ALLEGHENY COUNTY HEALTH DEPARTMENT

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

333 Forbes Avenue, Pittsburgh, PA 15213
Phone 412-687-ACHD • Fax 412-578-8325 • www.achd.net

THE CENTER FOR ORGAN RECOVERY & EDUCATION

The Center for Organ Recovery & Education (CORE) is a nonprofit organization designated by the federal government to provide individuals an opportunity to donate life through organ, tissue and corneal donation. CORE devotes a large portion of its resources to developing innovative educational programs and engineering research that will maximize the availability of organs, tissue and corneas. Lastly, CORE strives to bring quality, dignity, integrity, respect and honesty to the donation process for the families, hospitals and communities it serves.

For more information, please contact CORE at 1-800-366-6777 or www.core.org

PROFESSIONAL DEVELOPMENT

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In the new consumer-based healthcare environment, the marketing, communications, and strategic planning of hospitals and healthcare systems has never been more important. Professionals in these fields are often given high expectations from senior management and a shoestring budget for implementation. Through membership in the Society for Healthcare Strategy and Market Development of the American Hospital Association, you will have access to the resources and education you need to increase the productivity of your department and your professional growth. For more information, call (312) 422-3888 or e-mail shsmd@aha.org.

REHABILITATION

THE CHILDREN'S INSTITUTE

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

For more information, please call 412-420-2400.
The Children's Institute
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Greensburg - 724-838-7111

LIGHT READING

Light Reading is a series of communications from MASSolutions that sheds light on common business challenges and provides solutions to strengthen your bottom line.

The 'Not My Problem" Problem

BY DAVID M. MASTOVICH, MBA

When a new process is implemented, there are inevitable bumps in the road. Instead of taking a proactive approach to the challenge, many employees and middle managers ignore or avoid problems they perceive to be outside of their area.

If a customer isn't completely satisfied, the front line response is often an excuse that shifts the responsibility elsewhere.

After hearing a new idea, many people only point out potential negatives or say nothing.

These and other examples make the "Not My Problem" Problem one of the biggest roadblocks to positive change.

When you are acting as the change agent, remember it's human nature to:

- Seek the path of least resistance
- Avoid incurring blame
- Fear a loss of control or an increased workload resulting from a new process.

Also, keep in mind many key departments are responsible for keeping work flow moving, paying attention to details and avoiding mistakes. While this is essential to day to day operations, it creates a mindset of getting things done the same old way rather than focusing on new, creative ideas.

So when you are leading a change initiative what can you do to increase your chances for success?

First, find a leadership champion who has the formal or informal authority to gain broad support throughout the organization. Ideally, you would have a senior level sponsor of the new process or idea.

Next, communicate clearly and often. Create a sense of urgency among the troops by pointing out both what they stand to lose by standing pat and what will be gained by moving forward. Think beyond your immediate area to how other departments will be impacted. Acknowledge there could be some challenges for others during the transition.

Listen to constructive feedback but be firm with naysayers selfishly focusing only on the negatives. If you don't hear from some people, a common mistake is to misperceive their silence as support of your idea. You need to probe to find out what they really think and flesh out potential roadblocks.

The ultimate goal is to achieve some level of buy-in throughout the organization and to have a comprehensive change management plan.

Hey, no problem ...

David M. Mastovich, is the president of MASSolutions, a Pittsburgh based Strategic Marketing firm. David can be contacted at (412) 201-2401 or info@massolutions.biz. You can view the Light Reading Archives online at www.davidmmastovich.com/reading.html.

Financial Advice for Young Doctors

BY JOE JOSEPH

Investors' Lab

Young doctors early in their working careers should think about saving for their retirement. Even though the 40+ years you will be working may seem like an eternity, saving early is the best and easiest way to make your money - and the time you are employed - work for you. Just putting a small percentage of your salary away now can produce big results through the compounding of the gains you make from interest, dividends and asset appreciation.

Here are six of the smartest moves physicians in their 20s and early 30s can make today to start towards a great financial future:

1. Contribute the maximum towards an individual retirement account (IRA) and invest the contributions in a balanced mix of stocks, bonds, mutual funds and other assets. Depending on your tax bracket and the type of IRA you choose to open, these contributions could be deducted from current income taxes or future distributions could be taken tax-free. The current maximum contribution for 2009 is 100% of earned income, or $5,000, whichever is less, although tax laws may change that amount in the future.

2. Either begin a 401(k) plan for your private practice, or if employed by a hospital or physician practice group, contribute to your employer's 401(k). You can invest 401(k) funds among the various investment options the employer has selected. Many hospitals and physician practice groups match the employees' contributions up to a certain amount. If your employer match were 5%, you would be wise to try to contribute at least 5% of your earnings, which would double the annual contributions. If you leave the employer, you can keep your 401(k) assets in your current account or roll them either into your new employer's plan or into your IRA.

3. Pay off your credit card each month. Using a credit card can help you mange cash flow and track expenses, but it's always best to pay the card off before interest charges and penalties accrue, so that you have free use of the credit card company's money for a short period of time instead of paying steep rates. If you have decided that a credit expenditure that you cannot pay off right away is necessary, make every effort to pay it off as soon as possible and make sure you pay the minimum each month to avoid ruining your credit history. As credit options tighten around the country, many banks offering credit have increased percentage rates while lowering limits. Getting caught up in a web of interest from a small charge that takes a long time to repay will leave you with less money to save or spend on other things, so if there is a chance you may not be able to make the minimum monthly payment, the purchase may not be worth it.

4. Automatically invest into a mutual fund on a regular basis. Because mutual funds pool moneys from many investors to buy stocks, bonds, real estate and other securities, it enables investors to create a much more diversified portfolio much more affordably than they could if they were to buy all of the individual securities themselves. Most investment accounts will allow you automatically to invest in mutual funds on a monthly basis, which will mitigate most price fluctuations by dollar-cost averaging. When dollar-cost averaging., or investing a specific amount on a regular basis, you will tend to purchase more mutual fund shares when prices are low and fewer when prices are high. There is no "timing" of market ups and downs.

5. Start a savings account. The general rule of thumb to save 10% - 20% of your income for future goals such as a college fund or retirement. One early goal of savings should be to create a savings account with a value equal to at least 6 months of your current expenditures. A car breakdown or a health emergency can quickly drain your checking account, so saving - before you need it - is the best rule of thumb.

6. Select a financial advisor who can provide advice and counsel. Pick one who is concerned with your current and future plans, and who wants to develop a long-term relationship with you.

While physicians tend to earn high incomes, a beginning doctor may face many immediate expenses, such as paying off school loans or paying for equipment for a private practice, in addition to the normal costs of living and raising a family. Despite these financial burdens, a doctor must take a disciplined approach to building a solid financial foundation by saving and investing right now.

Joe Joseph, Senior Vice President, BPU Investment Management, Inc., can be reached at jjoseph@bpuinvestments.com.

A Healthy Bottom Line

In Stitches:

Ron Cichowicz is an award-winning, Pittsburgh-based author and lecturer, whose presentation topics include the benefits of humor (for individuals and organizations), motivation and leadership, and public relations and fund raising for nonprofits. Ron can be reached via email at roncichowicz27@comcast.net.

BY RON CICHOWICZ

Hard as it is to believe, I think our elected officials in Washington are going about the whole "reform our national healthcare system" bass ackwards as my old man used to say.

Instead of taking the time to actually read the 1000 page proposal circulated last month through the halls of Congress, it seems everyone would rather rant and rave about the problem of paying for a healthcare overhaul, regardless what is contained in the final bill.

Ladies and gentlemen, relax. Paying for the new healthcare system is the easy part, if you'll only think outside the proverbial box, look beyond the Beltway, and let some good old fashioned American capitalism lend you a hand.

The answer my friends, is as close as the nearest television set, or as convenient as a drive through the neighborhood.

My first bit of inspiration came while watching "Deal or No Deal." Why not, I thought, instead of putting dollar amounts in those briefcases, fill them with various surgical procedures, medical tests, and prescriptions? Contestants could be chosen based on who needs some treatment, from minor procedures to life-saving operations.

Once the banker offers a contestant something they need—say, a liver transplant—they can take the deal or opt for something really cool, like liposuction.

They could call it "Spleen … or No Spleen"—much more upbeat than "Live…or Don't Live." And nobody goes home empty handed; everyone leaves with at least a coupon for a free colonoscopy.

Or why not have television shows with medical themes—Nip/Tuck, House, Scrubs—use real sick people, who otherwise could not afford operations, as patients? Sure, it might be a bit risky to have Hugh Laurie, Zack Braff, or Julian McMahon actually perform real surgery on you, but given the alternative of no surgery at all, it might be worth the risk.

Besides, you get to meet real honest-to-gosh TV stars, something sure to be mentioned in your eulogy.

Given the contribution that fast food restaurants allegedly make toward our deteriorating health, no doubt these corporations would appreciate the opportunity to improve their image by helping to underwrite the cost of healthcare reform. Imagine pulling up to the takeout window and, along with your double bacon cheeseburger, large fries and soft drink, you receive a scratch off card that could reward you with anything from a free breakfast sandwich to quadruple bypass surgery.

Before you know it, healthcare providers will adopt these successful marketing techniques. We already have drive-through pharmacies. Why not "Botox in a Box," where you merely pull up to the window, stick out your face, and some high school kid making minimum wage help eliminate those crow's feet and worry lines.

How long will it take before super market chains who offer discounted gas figure out that even more customers will shop at a place that allows you to earn points for healthcare needs for every dollar spent?

"Tell Uncle Fred to hold on, honey. Just two more trips to the super market for a big order and we can get him that brain operation. That's unless we decide to fill up our gas tank before our vacation to the shore."

Finally, with all the casinos springing up around the country—if you can't beat 'em, join 'em. Replace the cherries and other fruits on the slot machines with various body parts—three "eyes" in a row and you can have your LASIK surgery. Or win on red at the roulette wheel and that blood transfusion is yours. I'm telling ya, just with the huge numbers of senior citizens filling the casinos and spending their social security checks, the market is HUGE.

Now, about this U.S. auto industry mess …

DATEBOOK:

Cancer Caring Center Programs

The Cancer Caring Center is pleased to announce two new ongoing programs at two locations.

"What's On Your Plate?" will be led by Leslie Bonci, MPH, RD, CSSD, LDN, on the second Tuesday of each month, from 7:00 – 8:30 p.m. beginning September 8, at the Cancer Caring Center Headquarters in Bloomfield, 4117 Liberty Avenue. Leslie will "set the table" by discussing the timing of eating, food amounts and choices and invite guests to ask questions.

"Laughter Club Yoga," led by Dave Russell, M.Ed., will be held at the First Unitarian Church of Pittsburgh in Shadyside on the 1st and 3rd Thursday of every month from 7:00 to 8:00 p.m. During this interactive process, Dave discusses laughter and how the art of laughing can help reduce stress and increase deeper breathing.

To register, call (412) 622-1212 or visit www.cancercaring.org.

October 6-7
Corazon Annual Fall Conference

Join Corazon, October 6 and 7, as they host their Annual Fall Conference, "Raising the Stakes: Playing a Winning Hand in Heart, Vascular, and Stroke" taking place in Pittsburgh, PA, at the Doubletree Hotel Pittsburgh Airport. For more information, call (412) 364-8200 or visit www.corazoninc.com.

October 10
Chamber Classic

Northern Allegheny County Chamber of Commerce presents The Chamber Classic 1/2 Marathon & 5K Run on October 10 at North Park Boathouse. Proceeds benefit The Advisory Board on Autism and Related Disorders and NACCC Educational Foundation. To register, call (724) 934-9700.

October 13
Spiritual Care Event

On October 13, Family Hospice and Palliative Care will host a unique day-long event sponsored by the Institute to Enhance Palliative Care with spirituality as its focus. The event features a keynote address by The Reverend Dr. Tom Long of the Candler School of Theology as well as a live performance of Vesta, the nationally renowned drama of aging, love and loss performed by the Open Stage Theatre. For more information, call (412) 572-8747 or visit www.familyhospice.com.

October 24
Masquerade Ball

The Fourth Annual Masquerade Ball will be Saturday, October 24 from 6:00 p.m. through the Bewitching Hour at Gateway Hall, Monroeville Fire Co. #4 4370 Northern Pike Monroeville. Buffet dinner, open bar, raffles, silent auction, music and dancing. For more information, call Bill Schneck at (412) 373-3900 ext. 172. All proceeds benefit Cedars Community Hospice.

October 28
Without a Job, Who Am I?

All are welcome to meet Gateway Rehab's founder and medical director emeritus, Dr. Abraham J. Twerski, as he introduces his new book *Without a Job, Who Am I?* from 7 to 9 p.m. on Wednesday, October 28, at the Sheraton Station Square Hotel, Pittsburgh.To register, call 412-766-8700, ext. 1234 or e-mail cindy.vongray@gatewayrehab.org.

November 2-3
HIMSS Chapters Midwest Fall Technology Conference

The HIMSS Chapters Midwest Fall Technology Conference will be held November 2-3 at The Amway Grand Plaza Hotel, Grand Rapids, MI. The theme of this year's conference is "Enabling Healthcare Reform: The Role of HIT and the 2009 Stimulus Provisions." For more information, visit the website www.falltechnology-conference.com.

November 2 - 5
PPC University

The Perfecting Patient Care℠ (PPC) University, developed by The Pittsburgh Regional Health Initiative, is a powerful, proven healthcare education and training program, based upon Lean concepts and principles of The Toyota Production System. The University will be held at the Marriot Courtyard, Monroeville. Mandatory registration can be completed online using the form available at www.prhi.org/ppc_reg_list.php. For more information, contact Barbara Jennion at bjennion@prhi.org or (412) 586-6711.

November 4
Healthcare Trade Faire & Regional Conference

The 3rd Annual Northeast US Healthcare Trade Faire & Regional Conference, sponsored by WPHIMSS, will be held on Wednesday, November 4th at Four Points by Sheraton Pittsburgh North. For more information, visit the website http://healthcaretradefaire.com/Pittsburgh/09/.

November 3-4
HIMSS Virtual Conference & Expo

This is a fully interactive event that includes online learning, live chat, active movement in and out of exhibit booths and sessions, vendor presentations, contests and more. It truly is an event so amazing, you don't have to be there … to be there. You can log on from anywhere, which makes it perfect for someone with a busy schedule. For more information or to register, visit www.himssvirtual.org.

November 20
Western PA Autism Fitness Initiative

ABOARD presents Western PA Autism Fitness Initiative on Friday, November 20 from 8:30 a.m. to 4 p.m. at the Regional Learning Alliance at Cranberry Woods. The seminar will involve both lecture and hands-on instruction. For more information, visit www.aboard.org.

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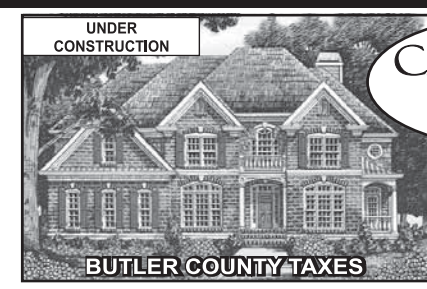

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For more information, tour or brochure… Call Today or Visit Our Website at www.gloriacarrollteam.com for a visual tour.
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Tuesday 4-7pm
Saturday & ***Sunday 12-5pm***

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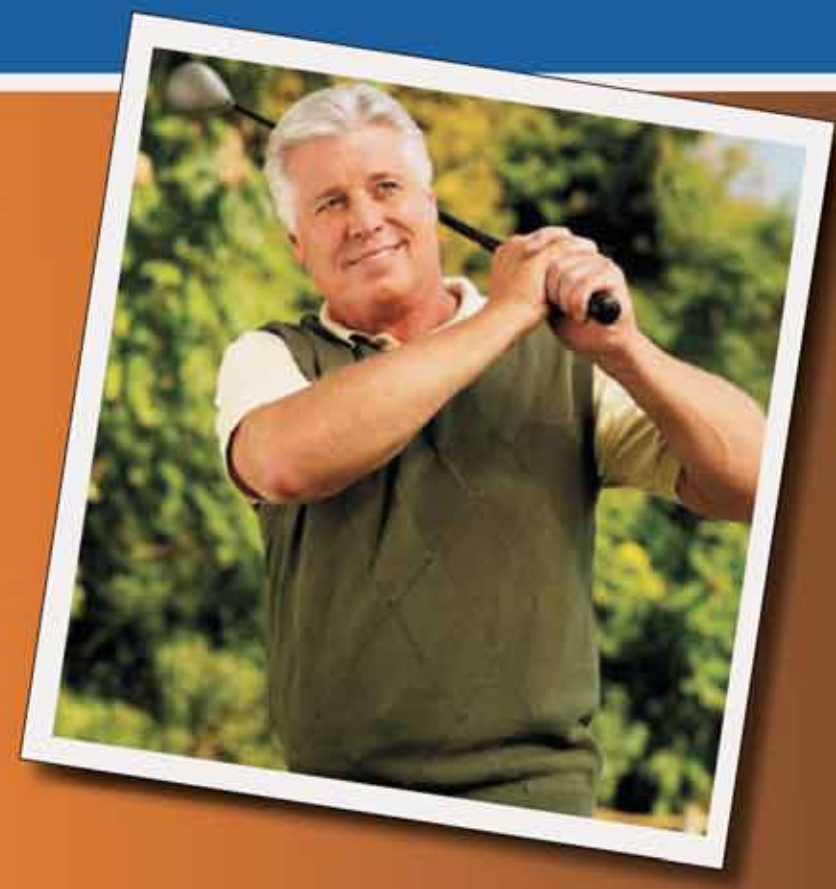
A PROVEN LEADER



Roger had a knee replacement. After the surgery, he needed physical rehabilitation before returning home. ManorCare helped him regain strength and endurance. Roger is home and golfing with his friends and family.

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