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A.E.D.s Still Not Everywhere They Should Be

By Kevin O'Neill

Any idea what the leading cause of death is in the United States? No, it isn't Cancer. Try Heart Disease, specifically *Sudden Cardiac Arrest (SCA)*. Over 1000 people per day fall victim to SCA. It doesn't play favorites either. SCA can strike any age, any time.

So, it makes sense that an A.E.D. (automated external defibrillator) should be visible just about everywhere, right? Unfortunately, that's not the case. A.E.D.s are simple to use, provide voice prompts and give the victim of SCA a better chance of survival. So, why don't we see more of them besides the mall and the airport? Education. Simply put, there is a fear of responsibility and knowledge of how simple an A.E.D. is to operate. Today's A.E.D. is designed with the layperson or infrequent responder in mind. Although a CPR class, (an important component of SCA survival) will teach you how to use an A.E.D., there is also peace of mind that anyone can turn on an A.E.D. and follow the simple voice prompts guiding you through the whole process.

The "fear-factor" also plays a role. Most responsible companies that sell A.E.D.s provide the training and knowledge of how to use an A.E.D. Once individuals see the simplicity of how they operate, have the opportunity to role play, and have their questions and concerns answered, they embrace the idea of placing an A.E.D. in their organization. In fact, there is a growth of A.E.D.s finally being placed in churches, schools, manufacturing and anywhere people gather. But there is still more work to do. Helping people understand the importance and simplicity of A.E.D.s is paramount.

The other factor that limits mass placements of A.E.D.s is the unfounded notion that SCA victims should rely on our 911 system and the paramedics that serve us. While they are by far our first choice, they can't always be there in the critical

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Inside ...

Mario Lemieux Center for Blood Cancers Helps Ease Stress for Patients and Families

By Kathleen Ganster

Undergoing treatment for cancer is undoubtedly a difficult period in anyone's life, but the new Mario Lemieux Center for Blood Cancers at UPMC CancerCenter at Hillman Cancer Center makes this stressful time a bit easier for patients and families.

The project is funded in part by The Mario Lemieux Foundation. The Foundation was created by Penguin great and cancer survivor, Mario Lemieux and his wife, Natalie.

Skylar Van Soest, project manager from Landau Building Company said, "We asked ourselves as a team. 'How can we remove reality while reality is staring them in the face?"

The result is 25,000 square-foot premier treatment facility with a "spa-like" atmosphere to promote healing and comfort for the patients. Making the Center even more noteworthy is a 4,000 square-foot outdoor terrace complete with a putting green.

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Pictured from left to right: John Innocenti; Nancy Davidson, MD; Tom Grealish; Mario Lemieux; Stanley Marks, MD; Nathalie Lemieux

How Our Universal Exercise Unit Helps Individualize Therapies

The old saying "one size fits all" is almost never true—in hospital gowns or anything else.

But for today's physical and occupational therapists, one type of equipment is so versatile that it can be useful with virtually every patient who has neurological issues—for example, cerebral palsy, brain injury or stroke.

It's the Universal Exercise Unit (UEU), a gridded white steel structure about six-and-a-half feet on each side—a cube with no front or bottom. Accessories including bungees, straps, pulleys, weights and slings can be attached to the UEU anywhere on the top, sides or back, depending on the goal of the therapy and the size of the patient.

The UEU was developed in Europe—and The Children's Institute of Pittsburgh was the first organization in this region to put it to use benefiting patients.

"The UEU is extremely flexible," says Children's Institute occupational therapist Terri Wonsettler, OTR/L, ATP. "Depending on how we set it up, we can easily isolate the specific muscle or muscles we're targeting, and help our patients build strength, increase range of motion and improve balance."

Taylor Levin, 11, achieved all those goals. A beautiful child with a delightful giggle, Taylor has gross motor skill delays resulting from premature birth. Her parents brought her to The Children's Institute, where therapists said Taylor would benefit from the Intensity Program.

The program turbocharges progress in a three-week regimen that runs two-and-a-half hours daily: 30 minutes of stretching and heat, then an hour each of physical and occupational therapies on the UEU.

It's challenging, but Taylor is a determined young person—she pushed on through and made huge gains. Then she moved from the UEU to traditional therapies, applying those gains in functional activities.

"Think of a golfer practicing on the driving range and improving significantly," says Lorelli Moser, OTR/L, Children's Institute Director of Occupational Therapy. "Then it's time to apply those improvements in a functional situation—on the golf course. That's basically the relationship between the UEU and traditional therapies."

Today, fifth-grader Taylor is doing "better than we ever expected she could do," smiles her mom, Karin Levin. "She gets around independently, often without even a brace or cane—and we'd been told she'd never walk."

Another young patient, three-year-old Amiyr Mack, is a lively little guy who was born with cerebral palsy. Most of his therapies are traditional, but sometimes his therapists use the UEU. When that happens, Amiyr shouts "Yay!"

One session has Amiyr on a table inside the UEU, using his legs to lift weights attached by pulleys to the UEU. Physical therapist Jen Venet, DPT, says, "We can increase or decrease the workload by attaching the pulleys in different places on the UEU—higher or lower, or laterally nearer or farther."

After working—although he thinks it's playing—in the UEU, Amiyr uses his increased strength and flexibility in a functional situation, practicing stair-climbing.

Then, for occupational therapy, it's back to the UEU in the "spider" configuration—Amiyr's feet are on the floor, but much of his weight is borne by a sling suspended from the UEU by multiple bungees. As Amiyr moves from side to side and front to back reaching for puzzle pieces, he is strengthening the core muscles that provide a stable foundation for fine motor movements—and he's learning balance. "The setup gives him confidence to move, and the constant sensory input helps improve his quality of movement," says Terri Wonsettler.

The Children's Institute of Pittsburgh has 4 UEUs—one at the main campus in Squirrel Hill, and one at each of the three satellite locations: Wexford, Bridgeville and Norwin Hills.

Director of Physical Therapy Brooke Racicot says, "We like to use every good tool that's available—and the UEU is a terrific one. It's not easy to find equipment appropriate for our kids' range of ages and sizes, but the UEU works beautifully with patients from 2 to 21."

And that's as close as it can get to "one size fits all."

5 Elements of a Successful Blog Post

By Daniel Casciato

If you maintain a blog or thinking of starting one for your organization, there are five main characteristics that each of your blog posts should contain if you want to get your point across and generate some attention. We'll explore each of these elements below.

Get attention

If your posts do not draw the eye of your readers, they will most likely ignore it and your message could be lost forever. The online space is crowded—your audience is inundated with hundreds of emails clogging their inbox; their RSS feeds could run the entire length of their laptop screen; and they may have dozens of web browser tabs open.

One way to get attention with your blog posts are generating attention-grabbing headlines (which we discussed in Issue 2 of *Western Pennsylvania Healthcare News*). A good headline will stop readers in their tracks and compel them to read further.

Another way to capture your readers' attention is with great visuals. An appealing image can get your blog post noticed. But be sure the image applies to the content of your blog post. Remember, you can't just grab images using Google. Many images you find have copyright protection. Instead, use a service like istockphoto.com where you can purchase images or better yet, take the time to take some original photos on your own.

Focus on your audience

Keep the readers in mind as you write your blog posts. Always write from their point of view. Put yourself in their shoes and try to understand their problems. For instance, if you're writing blog posts for benefits managers at small companies, you may want to learn which trade magazines or website they read or even attend some of the same seminars or webinars they do.

The more you understand them and their problems, the more you can write effective posts that address their concerns.

And always write in the second person. Pretend it's a one-on-one conversation with you and one customer or client.

Include examples to illustrate your point

While you may offer great theories and have a tremendous amount of knowledge to convey in your blog posts, you still need to write your posts in way that your readers can easily understand and apply in their own workplace.

The best way to do that is to offer mini case studies or brief examples so they can better grasp what you're trying to say. Concrete examples can help your readers better relate to your blog posts. These examples can be real-life situations; however hypothetical scenarios work just as well.

Add a call-to-action after each post

After each post, you want to direct your readers to take some call-to-action to keep them further engaged. These call-to-actions can include: following you on Twitter, subscribing to your blog, leaving a comment, joining your mailing list, or even buying a product or service.

If you neglect to include a call-to-action and your post just ends abruptly, you could potentially miss out on a good prospect. Some bloggers will include their call-to-action in the middle of a blog post; but we find it more effective at the end of each post.

Make your blog post easy to read

As we mentioned earlier, your audience is crunched for time these days. They're not going to have the time or the patience to sit through a three-page blog post. Keep it short and to the point.

Use subheadings (as I did in this piece), bold or italicize your text, and insert bullet points to break up copy. Using these formats will make your post easier for your audience to scan and read.

What tips have you found to be effective when writing your own blog posts? Email me at writer@danielcasciato.com and we'll share them with our readers in the next issue.

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

5 Considerations When Migrating to an EHR

By Brian O'Neill

Having the right electronic health records system in place benefits healthcare providers as well as their patients. That's why the United States government has encouraged a movement toward EHRs as a way to foster improvements in healthcare quality, safety, efficiency and access.

While the reasons to migrate to an EHR system are undeniable, some healthcare professionals find the task to be daunting. It needn't be, particularly if you keep five things in mind:

Know what you need. All EHR systems are not alike and systems for various medical sub-specialties have distinctive features specifically designed for their unique needs. For example, a software system designed for a mental health professional would have a completely different set of templates and guidelines than would a cardiologist. A psychologist would never have a need for electronic prescribing. Whereas the cardiologist would use automated coding to ensure highest possible E/M codes, and medication and prescription management tools. A cardiologist would also use electronic lab requests as well as electronic radiology orders. Get a system that's right for you.

Choose Meaningful Use. The economic stimulus package passed by Congress in 2009 promises maximum incentive payments for Medicaid and Medicare providers who adopt and use EHR technology in a "meaningful-use" designation. This is categorized as technology that improves care coordination, reduces healthcare disparities, engages patients and their families, improves population and public health, and ensures adequate privacy and security. Make sure you choose an EHR partner that has been certified for meaningful use.

Consider your patients' needs. Some EHR systems will allow patients access to a secure website to view test results and other important information from their medical records. This helps patients better understand their healthcare choices – and the more informed the patient, the greater the likelihood that he/she will be able to make intelligent, proactive decisions about their own health and healthcare options.

Consider cost. EHR systems are available today for as little as $29.95 a month with minimal start-up costs. Some of these systems work with your practice's existing computer system – whether it is Windows- or Mac-based – thus minimizing the cost even further. In short, cost should not be a barrier to adapting EHR for your practice.

Have patience. Even good change comes with an inherent set of frustrations, challenges and hiccups. Be patient as you work through this process and make sure that you have a EHR partner that will help you through the process – one who has deep experience and a track record of success. With the right partner, your chances of success increase dramatically and the frustrations will be short-lived.

Medical records have always been an essential part of the relationship between patients and their doctors. By tapping into today's technology and embracing electronic health records, providers and patients can avail themselves of the best that modern technology has to offer.

Brian O'Neill is president and CEO of Office Allyn the only organization in the country offering healthcare providers a full complement of revenue-cycle management services including a patient portal, electronic health records, a practice management system, a clearinghouse and a billing service all under one company. The company currently works with more than 290,000 providers and 5,600 insurance carriers in all 50 states. Further information may be obtained at www.officeally.com.

HIT or Miss: The Necessity of Health Information Technology

By Leslie Doyle

The face of healthcare is changing through the use of outcome based medicine, but the bigger news is the acceleration in health information technology, particularly in the fields of informatics and personalized medicine. This was the theme of the Second Annual Innovation in Health Care Technology Conference, held at Carnegie Mellon University, on Friday, April 5.

This conference is organized by the graduate students of Tepper School of Business and Heinz College, however, the audience was composed primarily of students, business leaders and medical professionals. The keynote speakers were Dr. Raymond Urbanski, Chief Medical Officer Of Mylan Pharmaceuticals; Dr. Pat Basu, former White House Fellow, and current Chief Medical Officer Of Virtual Radiologic; and Larry Miller, Executive in Residence at Innovation Works, a Pittsburgh technological start up incubator.

Calling for "a new type of doctor –patient relationship" in his talk named "Math and Physics: A New Paradigm for Health Care Innovation", Dr. Urbanski called for a "more targeted approach" to healthcare. He stated that there is an "information economy where information is the new currency." Data analysis is key where the "knowledge broker is the intangible asset." In his speech, Dr. Urbanski discussed the possibility of biological systems being governed by the law of physics, and if the universe is made up of the same components, physical laws should apply, postulating the use of quantum mechanics for nanomedicine.

As an expert in finance and an MBA, Dr Basu discussed the economics of health care policy. There is the question of what we are actually getting for our money. He estimated that health care for a family of four could cost $22,000 per year. Due to the cuts that need to be made in our nation's budget, he called the economic compromise, "The Grand Bargain" indicating that all parties could be satisfied with the outcome.

In the final keynote address, Larry Miller emphasized the importance of a potential technological entrepreneur knowing the government agencies, reimbursements, market share of their innovation, and having the business framework established as he or she approaches a start up incubator for funding. He said that Pittsburgh has numerous opportunities for entrepreneurs, including ten incubators, five accelerators, venture capitalists, strategic venture capitalists and investment "Angels". He gave the following equation to illustrate the importance of doing the work to assure your product's viability : (2 x effectiveness) + (Price/2) = success potential. Innovation Works has put in $60 million towards start-ups and made $287 million, for their investment.

There were concurrent morning panel discussions on Healthcare Policy and Biopharma. The policy session featured discussion on healthcare delivery, reform, e-visits, bundled payments, effective patient care, and most prominently, the implementation of the local Health Information Exchange (HIE). The panelists agreed that it was important to increase patient empowerment, and thus, patient care. It was also vital that reform move more quickly, to improve the quality of health care, as there is an "enormous health care deficit."

The Biopharma session discussed the changes and challenges the industry is undergoing in the areas of generics, biotechnology and pharmaceuticals , due to technology and the evolution of medicine. Innovation in business models and big data are creating new opportunities.

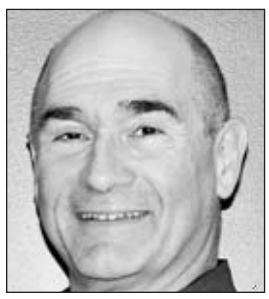
The concurrent afternoon panel sessions discussed Health Care IT and Entrepreneurship. Information Technology is prevalent in all areas of health care, but there continue to be issues of coordination of care, patient outcomes and cost reductions. In the field of data analysis, it was stressed that although ninety per cent of captured data is noise, it can be used to improve efficiency in health care delivery and disease prevention. The panelists also discussed the barriers and benefits to improving technology.

The Entrepreneurship panel discussed analysis of the medical market, and the forces that drive the decision making for future innovation. Insight was given by panelists on identifying solutions for the market and subsequent implementation.

The day concluded with a networking reception in the Great Hall in the College of Fine Arts. The sponsors for the event were Mylan, Boehringer Ingelheim, Merck, Amgen, the Jewish Healthcare Foundation and the Graduate Business Association of Carnegie Mellon University.

Leslie Doyle recently received a Certificate in Health Information Technology from the Community College of Allegheny County after 17 years in health care. She has also contributed to several national and regional publications. For more information, Leslie may be contacted at lfowlerdoyle@gmail.com or follow her on Twitter @lafdoyle.

The Future of Healthcare Patient Data



By Simon Wieczner

Recent advances in medical technology have completely revolutionized the way in which we administer and facilitate healthcare. The days of relying solely on paper charts to track patients' medical histories or even specialized diagnostic data systems are gone, replaced by sophisticated, relatively general purpose solutions that handle all documents digitally, thereby improving care, reducing administrative burdens, improving efficiency and saving money.

While these are certainly key benefits, the reality is that electronic health care records (EHRs) pose numerous integration challenges as patient documents are often created in disparate systems and departments. Additionally, individual medical departments may have their own information system organized around a particular function, rather than sorted by patient, which further complicates the issue. In order for healthcare providers to easily locate and review patient information across these fragmented databases, they need the industrial strength document management and viewing technologies first adopted by the world's largest financial institutions.

These solutions can retrieve virtually all patient records—be they text (i.e., prescription information, physician orders, specialist diagnoses) or images (i.e., X-rays, MRIs)—and provide easy access across a variety of repositories or platforms. The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was signed into law by President Obama in 2009, requires universal EHR adoption by 2015, which means that document management will become an increasingly important tool in healthcare providers' arsenal.

HITECH

The buzz and excitement relating to HITECH was palpable at HIMSS 2013, the annual healthcare conference that took place in New Orleans last month. The opportunity around HITECH is probably the most important investment growth opportunity of the decade, and everyone wants in. Even companies not in the healthcare space are buying their way in by purchasing companies already in the space or developing products for the space. Rubbermaid, for example, entered the arena with workstation cabinets and mobile carts. Dell, HP, Lenovo, Lockheed Martin, Microsoft and many more were also showing off their relevance to this field and how their products can help healthcare providers achieve HITECH compliance.

With the landscape changing so rapidly, companies already serving the healthcare industry must adopt new technology to allow them to expand their markets—or at least stay abreast of the new entrants—and healthcare providers need to take inventory and figure out the best way forward in their quest for compliance.

With that in mind, let's consider the myriad benefits that effective document management tools provide in the healthcare space and their current and continuing roles in helping providers achieve HITECH compliance in the coming years.

Security and Safety

First and foremost, advanced document management tools help ensure the safety of patients in hospitals and healthcare facilities, which is always the top priority for healthcare providers across the board. With patient records shared across departments, systems and sometimes facilities, ensuring that all critical patient records and information is integrated and easily accessible in one place is essential to help healthcare providers prevent dangerous treatment errors.

This also helps hospitals avoid doubling up on costly tests, which can easily run up bills for both the hospitals themselves and the individual patients. In addition to basic safety, effective document management tools also help protect patients' personal information by ensuring that only authorized parties can access certain files and the information they contain. This type of security guarantees that critical personal information stays safe, protecting patients' identities and hospitals' reputations.

Usability and Efficiency

In addition to the core functions of security and safety, the use of document management tools in the healthcare space also delivers top-level usability and facilitates greater efficiency. High performance document management systems seamlessly integrate numerous different file types into one easy-to-read, digestible document. This means that with only one system, users can access records generated in any department using any file type, which greatly speeds access and response time and means no time is lost in file conversions. This feature also helps users overcome the data retrieval difficulty often associated with siloed information systems. All of these features help reduce time lost and improve overall efficiency in document sharing and access within and across departments.

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Timely Data: A Must for Effective Stroke Program Management

By Scott Bachik and Jan Yanko

In these tough economic times, it's more important than ever to ensure our healthcare system is organized with exceptional leadership that understands how to run the business side of a service line, while keeping the clinical patient care perspective top of mind. But, too often, we come across homegrown managers with excellent clinical skills who lack any formal management and/or business training. Although some succeed, far more fail due to a gap in understanding that the programs they manage must be managed *as a business*.

Whether working to manage patient care, aspects of a clinical program, or a hospital's operations, program leadership must have access to key data points that aid decision-making *in real-time*. In the absence of timely data, how are we to make informed decisions? The phrase "you can't manage what you can't measure" has relevance… Although there is truth in thinking that some important aspects of "the business of healthcare" cannot be measured, it remains important to effectively measure what can be quantified in order to ensure efficient operations and appropriate allocation of resources.

How can a manager be expected to effectively improve practice, or a clinician be asked to enhance the care of a patient in the absence of good data? For instance, consider how the lack of timely data impacts the management and care in a stroke program.

In many instances, the data available to those tasked to manage a stroke program is derived from processes that still utilize paper charts or notes written on pieces of paper towel or even scrubs. Further, this data typically lands in systems that are homegrown, retrospective, or functioning in a stand-alone environment. In the less likely instance that the systems are integrated with others in an acute care setting, they're often the result of an attempt to fit metrics specific to stroke patient care into a larger system—not specifically designed for the effective management of the stroke patient and program. These efforts to address the gaps in good and timely data availability are admirable, but do not suffice for the complex needs of the patients, nor the diverse needs of the program leadership.

Improving the quality of patient care should no doubt be a primary goal of every stroke program in the country. Unfortunately, many of the processes that impact efforts in quality improvement are hampered by data collection processes conducted retrospectively or processes that rely on caregiver's memories. A look-back approach does not allow providers to actually use the data to make decisions about patient care, which could positively affect the course of future care and outcomes. By the time aggregate data is collected, analyzed, and reported, weeks or months may have passed. All the while, factors causing poor performance and outcomes may go unnoticed. In addition, the ability to draw upon memory to determine the root cause of decision-making becomes nearly impossible when working retrospectively.

Real-time data collection and availability, as found in Cerebros, Corazon's Stroke Patient Management Solution, can eliminate these obstacles, making the data collection processes more relevant to the staff, while allowing providers to make better informed decisions that affect care delivery for these acute patients. The result: great potential for increased patient satisfaction, improved outcomes, and decreases in length of stay and cost. With current healthcare technologies constantly improving and new technologies continually in development, concurrent data collection is not only possible, but realistically achievable…and perhaps should be obligatory.

As we continue to feel the economic pressures within the business of healthcare, we cannot lose sight that quality must come first. While hospitals are continually being asked to do more with less, leveraging the latest technologies to provide the needed data on a real-time basis will no doubt assist in the care delivery process. It is time to change the majority of our focus and effort from collecting and reporting historical data, to using real-time data in the delivery of 'best practice.' So as the saying goes, *"those with the data win!"*...but in Healthcare, when hospitals collect and measure the right data in real-time, the patient wins as well!

Scott Bachik is a Senior Vice President and Jan Yanko is a Consultant at Corazon, Inc., a national leader in strategic program development for the heart, vascular, neuro, and orthopedics specialties, offering consulting, recruitment, interim management, and physician practice & alignment services to healthcare organizations across the country and in Canada. To learn more, visit www.corazoninc.com or call 412-364-8200. To reach the authors, email sbachik@corazoninc.com or jyanko@corazoninc.com.

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Mobility

To say mobility is a hot trend these days is an understatement. It is infiltrating every industry and all areas of business; everyone wants to go mobile, and the healthcare industry is no exception. With the advent and rapid adoption of mobile technologies in different areas of the healthcare world, effective document management solutions must provide access for all the latest devices—tablets, smartphones and laptops, in addition to the more traditional desktops. From some of the discussions at HIMSS, it's evident that the younger generation of doctors and other healthcare professionals are rapidly becoming reliant on tablets—and to a lesser extent smartphones—for all their medical record reviews and note-taking. Their compact size, ease of use and flexibility are providing immense utility to the healthcare industry.

As the above underscores, while document retrieval and viewing technologies are key for achieving HITECH compliance, there are numerous benefits for internal processes, as well. Just as the ability to quickly access a patient's entire medical history will revolutionize healthcare delivery, so too will document management revolutionize the way in which health care records are processed and accessed. Healthcare practitioners use and will continue to use a wide variety of methods to record patient data, and they are often slow to change. That said, companies who look to adopt cutting edge technology now, like high performing document management solutions, will reap the benefits and achieve HITECH compliance via a quicker, smoother process.

Simon Wieczner is the CEO of Snowbound Software. For more information, visit www.snowbound.com.

Hepatitis C Awareness and Screening Recommendations

By Amy N. Puntureri R.Ph

May is Hepatitis Awareness Month and Giant Eagle is partnering with the American Liver Foundation to offer a series of FREE Hepatitis C screenings at several Pittsburgh-area Giant Eagle Pharmacies. Please see page 9 for details on the screenings.

Hepatitis C is a viral infection that causes damage to the liver. It is a contagious disease that can present as a mild illness that lasts for several weeks, or as a serious, lifelong illness that can cause scarring of the liver, liver failure, liver cancer or death. According to the Centers for Disease Control and Prevention (CDC), approximately 15,000 people die every year from complications of Hepatitis C liver disease. There is currently no vaccine available for the Hepatitis C virus, furthering the importance of screenings and early detection.

Hepatitis C is usually spread through exposure to blood from an infected individual. The most common means of exposure are by sharing needles during IV drug use, accidental needlesticks in the healthcare field, children born to an infected mother, and receiving a blood transfusion or organ transplant prior to 1992, when the widespread blood-supply screenings began.

It is estimated that over 3 million people in the U.S. have a chronic Hepatitis C infection, and the majority are not aware that they have the disease because they can live for decades without feeling sick. While more than 70% of individuals infected with the virus do not experience any symptoms, possible symptoms can be mild to severe and include:

- Fever
- Fatigue
- Loss of appetite
- Nausea/vomiting
- Stomach pain
- Dark urine/clay colored stool
- Joint pain
- Yellowing of the skin or eyes

According to the CDC, "Early diagnosis and treatment can help prevent liver damage, cirrhosis, and even liver cancer. It is estimated that one-time testing of everyone born during 1945 through 1965 will prevent more than 120,000 deaths." The CDC recommends that the following populations be tested for Hepatitis C:

- Anyone born between ***1945 and 1965***
- Current or former IV drug users
- Anyone who received a blood transfusion or organ transplant before 1992
- Long term hemodialysis patients
- Patients with liver disease or abnormal liver tests
- Healthcare workers exposed to blood through a needlestick or injury
- Anyone treated for a blood clotting problem prior to 1987
- Anyone infected with HIV

For more information on Hepatitis C, please visit www.liverfoundation.org/ or www.cdc.gov/hepatitis/c/

To learn more about Giant Eagle Specialty Pharmacy, please visit www.gianteagle.com/specialty-rx

Amy N. Puntureri R.Ph is a 1994 graduate of the University of Pittsburgh School of Pharmacy. She has been a retail pharmacist for 18 years, 13 of which at Giant Eagle Pharmacy, and most recently was the Pharmacy Team Leader at the Village at Pine Market District in Wexford, PA. For the last year and a half she has been the Retail Pharmacy Operations Liaison for Giant Eagle's Specialty Pharmacy program.

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In the spirit of continued excellence in patient care, Giant Eagle Specialty Pharmacy is honored to partner with the American Liver Foundation to offer

AMERICAN LIVER FOUNDATION
Your Liver. Your Life.

FREE HEPATITIS C SCREENINGS

May is Hepatitis Awareness Month

The Centers for Disease Control and Prevention (CDC) recommends Hepatitis C testing for anyone born between 1945 and 1965.

SATURDAYS, April 27 & May 4, 11 & 18

10 a.m. - 2 p.m. No appointment necessary

Monroeville Giant Eagle
4010 Monroeville Blvd.
Monroeville, PA 15146

South Hills Market District
7000 Oxford Dr.
Bethel Park, PA 15102

Robinson Market District
100 Settlers Ridge Center Dr.
Pittsburgh, PA 15205

Twp. of Pine Market District
155 Towne Centre Dr.
Wexford, PA 15090

Free Hepatitis C screenings valid at select locations during listed dates and times only. Screenings available to those 18 years and older only and while supplies last. See Pharmacy for complete details.

IN YOUR NEIGHBORHOOD. IN YOUR CORNER.

Vision Impaired Persons Have More Opportunities to Join the Workforce

By Tara Zimmerman

Gone are the days when persons with disabilities are expected to remain at home with no hope of earning a paycheck and becoming independent. Much of that is due to a more enlightened society and to the tireless work of nonprofit agencies at the local, state and national levels.

In Pittsburgh, one of those agencies providing employment to the disabled is PBA Industries, the manufacturing and assembly division of nonprofit Blind & Vision Rehabilitation Services (BVRS) of Pittsburgh. More than 75 percent of PBA Industries workers are blind or vision impaired craftsmen who create some unique products for both the public and private sectors. One product line includes custom, peat-filled socks, pillows or pads that absorb spilled oils and fuels. PBA workers also make construction safety products, portable highway signs, signage, and textiles.

Evelyn Nickel, who is both vision and hearing impaired, has been employed at PBA Industries for 27 years.

PBA Industries works closely with the Pennsylvania Industries for the Blind and Handicapped (PIBH) and the National Industries for the Blind (NIB) to provide products and services to federal and state governments. BVRS is one of 91 nonprofit agencies throughout the country associated with NIB, the nation's largest employment resource for people who are blind.

BVRS was honored in 2012 by NIB for its efforts to increase employment retention, growth, and upward mobility for people who are blind with the Employment Growth Award. Award recipients receive cash payments from a fund created to recognize and encourage NIB associated nonprofit agencies that grow or sustain employment for people who are blind. Emphasis is also placed on efforts to increase upward mobility in the workplace and job placements.

"It is an honor for me to recognize Blind and Vision Rehabilitation Services of Pittsburgh with a 2012 Employment Growth Award," said Kevin Lynch, president and CEO of NIB. "BVRS continues to do an outstanding job in creating employment and high-growth career opportunities for people who are blind."

Tara Zimmerman is director of PBA Industries, the manufacturing and assembly division of Blind & Vision Rehabilitation Services of Pittsburgh (BVRS).

A 103-year-old private nonprofit, BVRS has been a leader in programs and services for people of all ages who are blind, vision impaired or have other disabilities. We believe in independence through rehabilitation. Our mission is to change the lives of persons with vision loss and other disabilities by fostering independence and individual choice.

We offer comprehensive and personalized computer instruction, employment and vocational services, personal adjustment to blindness and deaf blindness training, independence skill building, in-home instruction, low vision services, preschool vision screening, prevention of blindness services, and an industrial employment program. BVRS is a United Way Impact Fund Award for Excellence Agency and is accredited by the National Accreditation Council for Blind and Low Vision Services (NAC).

For more information, visit www.BlindVR.org.

Department of Labor Issues New FMLA Interpretations in 2013

By Elaina Smiley

The Department of Labor (DOL) is putting a lot of focus on the Family and Medical Leave Act (FMLA) this year. The FMLA allows employees to take unpaid, job-protected leave for covered family and medical reasons.

In January, the DOL released a new interpretation of the FMLA that now makes it easier for a parent to care for an adult child with a disability. Previously, there had been controversy as to whether the FMLA applied when an adult child is diagnosed with a disability after the age of 18. The new DOL interpretation specifically states that the onset of the child's disability can come at any age, and that employees may take FMLA leave to care for an adult child who is incapable of self-care because of a serious health condition.

The DOL also released the long-awaited Final Rule in February, which addresses many of the issues surrounding FMLA leave for former and current military members and their families. Significant changes detailed in the Final Rule include:

- Defining covered veterans as those who had been discharged within the past five years for any reason other than dishonorable discharge.
- Expanding the definition of covered illnesses and injuries of veterans, including those that existed before active duty and were aggravated by service.
- Allowing certification of a service member's serious illness or injury to come from any healthcare provider covered in the FMLA regulations, not just those in the military healthcare system that are affiliated with the Department of Defense, Veterans Affairs, or TRICARE networks.
- Expanding qualifying exigency leave, which previously included only the National Guard and Reserves, to include the Regular Armed Forces deployed to a foreign county. Exigency leave includes arranging for care for a parent or child, financial and legal arrangements and other activities.
- Expanding qualifying exigency to allow employees to take care of the urgent needs of a service member's parent who cannot take care of his- or herself while the service member has been called to active duty. Previously, leave was granted only for care for a military member's spouse or child.
- Expanding the amount of time from 5 to 15 days that an employee can spend with a military member on rest and recuperation leave.

The new FMLA interpretations also clarify the minimum increments that can be taken for intermittent FMLA leave.

Earlier regulations state that employers should count intermittent leave by the smallest increments by which they measure other forms of leave, but those increments cannot be larger than one hour. The new interpretation clarifies that employers cannot require employees to take more time than the employee requests to address the circumstances that require the leave.

The changes to the FMLA are accompanied by a new poster requirement of employee FMLA rights and new forms. Employers should revise their current FMLA polices and carefully consider employee requests that may be covered under these expansions to FMLA.

Elaina Smiley is a partner at Pittsburgh law firm Meyer, Unkovic & Scott and is co-chair of the firm's Employment Law Group. She can be reached at es@muslaw.com.

Lead and Grow Your Medical Practice through the Power of a Peer Group

By Bill Reed

The merits of peer-to-peer collaboration have long been heralded, with global groups promoting a formula for leadership success and life enrichment for nearly six decades.

At the core of the peer group leadership experience is personal growth, shared learning and accountability, access to new perspectives and the opportunity to receive wise counsel from leaders in a variety of professions and industries with a wide range of life experiences.

While the peer advisory group model is conventionally associated with chief executives and owners of technological, industrial, manufacturing and hospitality companies, doctors and those who head healthcare facilities can also reap the rewards of this winning paradigm. Ultimately, all business owners and chief executives share the desire to become better leaders, grow their company's revenue and profitability, enhance their decision making skills and achieve better results. And as human beings they all share the desire to enhance their lives.

A Long Island based gastroenterologist with a multi-million dollar practice and a staff of 25 faces many – if not most – of the same business issues as the CEO of a billion dollar software company employing hundreds.

So how does this proven model work? Groups of 12 to 18 leaders – the "ultimate decision makers" in their respective organizations commit to meet regularly in an environment of total safety and trust, where there can be no conflicts or hidden agendas, to discuss their business and life opportunities and challenges. By giving voice to and sharing these hopes, dreams and hurdles with their peers, they gain access to fresh viewpoints, new ideas, and the ability to test assumptions. They are cheered on while sharing their success stories…and they reap the benefits of their peer counterparts' experiences when addressing the challenges that keep them awake at night.

In the end, they engage in a process of "care-frontation" to hold each other accountable for confronting their own business and life truths and for making progress towards creating the business and life of their own design.

You won't find it in the dictionary, but "care-frontation" is one of the hallmark tenets of the powerful peer-to-peer leadership group experience. The peer group dynamic fosters self-accountability for achievement of results by requiring members to share their plans and hopes for the future with fellow members. Here is where the concept of "care-frontation" unfolds and blossoms as fellow members provide the persistent, yet nurturing peer pressure to hold each other accountable for following through on initiatives to realize their respective strategies and dreams.

Specific issues relating to the overall economy and commerce, growth, and best business practices are addressed within the chief executive peer group model. But at the heart of meetings is conversation about becoming a better leader and enhancing one's life. This safe and non-judgmental environment allows participants the freedom to reveal to others their life dreams and challenges, and in the process reveal to themselves obstacles in the way of, and opportunities open to them for achieving their goals.

The popularity of this shift toward learning from one's leadership peers with whom one has no functional or other conflicts has been evidenced over the last decade by the growth in memberships in these groups.

Leaders of enterprises who would prefer to turn to their peers for guidance rather than pay high-priced consultants or invest in expensive, more abstract leadership training programs.

There can be an overwhelming sense of isolation in heading a medical practice or being CEO of a healthcare organization. Moreover, the financial and economic crisis that has defined the past several years has created additional uncertainties for company leaders. There exists a growing sense of "we're all in this together" fueling the trend toward peer-to-peer leadership groups where sharing, caring and personal accountability for achieving one's business and life dreams are the elemental instruments of success.

Bill Reed is Chair of a Vistage chief executive peer advisory group comprised of members from the eastern RI, MA- South Coast, and Greater Boston region. Vistage (www.vistage.com) is the oldest and most experienced peer-to-peer chief executive membership organization dating back to 1957 and has 16,000 members in 15 countries. For more information, please contact bill.reed@vistage.com or (508) 243-6578.

Celtic Healthcare Helps Fulfill Patient's One Final Wish

By Kathleen Ganster

There weren't any one-of-a-kind white dresses, sharp tuxedos, fancy decorations or hundreds of guests. There weren't lovely gifts, a large band or numerous photos.

But for everyone there, it was one of the most beautiful weddings they had ever attended.

"There wasn't a dry eye in the room," said Penny Haas, Hospice R.N with Celtic Healthcare.

Haas and other Celtic healthcare team members helped Mark Adams and Amy Matthews* get married when Mark was in the final stage of his life. While he had recently transitioned into hospice with Celtic, it wasn't an easy path for him or his beloved partner of 15 years, Amy.

According to Matthew Bupp, Hospice Chaplain, Mark was in his early 60s and suffering from a heart condition that would be fatal without a heart transplant.

"He was holding out hope that he would receive a heart and Mark and Amy just clung to any good news," Bupp said.

When Mark learned from his doctor that he had reached a stage where he was to ill for transplant consideration, it was hard news for the couple.

"He didn't want to leave her and was very worried about her. He wasn't at peace with dying," said Bupp.

Bupp started ministering to the couple before Mark's transition to hospice because they were in such great turmoil.

"I sat with both of them and Mark's heart started to open up. Even though his physical heart was dying, his spiritual heart was growing," Bupp said.

When Mark finally made the difficult decision to move into hospice care and turn off his defibrillator, he and Amy decided they wanted to get married.

"It is part of our job to make sure our patients have their affairs in order. Mark wanted to do is make sure that Amy was taken care of after he was gone,' said Haas. And that meant marrying her.

Erica Sickafuse, Mr. Adams' home health nurse said, "He wanted to do right in the eyes of God and marry her."

When the subject came up, Haas said Amy was "delighted."

"She had thought the time had run out for that dream of hers," she said.

Haas, Sickafuse and Bupp were all at the couple's home when the difibulator was turned off. When they expressed a desire to get married, everyone jumped into action. Haas and Sickafuse went outside and quickly gathered flowers from the yard and nearby woods. Bupp prepared a ceremony.

In a matter of minutes, the ceremony was started.

"They were both still in their pajamas, but it was beautiful," said Haas.

Mark's health was so tenuous, that at one point during the service, Haas and Sickafuse thought he might have passed.

"Amy was saying, 'Not yet, not yet,' and it really seemed like he was gone, but then he came too again," said Haas.

Sickafuse said, "Even though he was so ill, he was so mentally sharp. It was really amazing."

After the service, Bupp worked with county officials to get the marriage license processed as quickly as possible.

"They even had someone drive the marriage license out to me to get everything signed," he said.

Sickafuse took the photos on her cell phone.

"It was an old flip phone, but we didn't have any other camera and we needed photos," she laughed.

Within 24 hours of being removed from his difibulator and getting married, Mark was gone.

"He was so happy that night. He couldn't stop smiling and he kept calling her 'Mrs. Adams," said Bupp.

While gathering bridal flowers, snapping wedding photos on a phone and serving as witnesses for a wedding may not be in their job descriptions, it is something Haas and Sickafuse didn't think twice about.

"It is important to realize providing hospice care extends beyond medical care to the spiritual, mental and emotional healthcare of patients as well," said Haas.

"We are a team; it isn't just those of us in the field, but people behind the scenes as well. We do what we need to do to take care of our patients," she said, "We even took another patient fishing. His last wish was to fish, and through a network of community and Celtic team members, we were able to fulfill his wish to fish one final time."

And all three members of the healthcare team remember the wedding with great fondness.

Sickafuse said, "It was so very sad, but so very beautiful at the same time. He had a beautiful death."

Bupp said, "I had never seen him so happy and at peace."

And that was just one day in the life of a Celtic hospice team – a true dream team – fulfilling wishes during their patients' final journeys at end of life.

For more information, visit www.celtichealthcare.com.

The real names have not been used to protect the privacy of the patient and his family.

PR vs. Communication — What This Can Mean to the Medical Professional

By Teresita K. Kolenchak

For many years, public relations specialists have been seen as "spin doctors," people who come in to clean up messes or make the public think one way when the facts of the matter may lead them to a completely different conclusion. Working in education in the past 10 years, there has been a distinct change in the role of the public relations specialist. These individuals have gone from "spinners" to communicators. The goal of most public relations specialists in this day of instantaneous information access is communication—making the facts accessible, accurate, and immediate.

When you look at practices which are affiliated with major hospitals, you will find websites that give educational backgrounds or bios for the doctors. For smaller practices, you may find a basic website that provides general information but whose functionality (i.e., email) may be hit or miss. It is rare these days to visit a doctor who is the sole practitioner in his or her office. Now, there is a multitude of doctors and support staff, to the point where it can be dizzying to keep a simple office visit.

More and more, the average person with no medical background is being put in the position of serving as doctor or nurse, either for himself/herself or as a caregiver for a family member. This can take that dizzying office visit to new heights of confusion. Seeing a specialist for a chronic condition can mean seeing five professionals during that office visit, each asking questions and providing important information. By the end of the visit, the person or caregiver leaves with a handful of papers containing all manner of instructions, prescriptions, and information. Sometimes, it is not until the person has returned home and had a cup of coffee before the questions that should have been asked in the office come to mind. The person is left either calling the office staff repeatedly for clarification or feeling the pressure of making medical decisions on his or her own.

This is where communication comes in but in ways that can only now be utilized in this technological age. Patients need access to information at all times of the day or night, every day of the week. They need more than an answering machine, which some offices do not even have. The patient may hesitate to page the doctor for a question, feeling like they are bothering him or her over what may be a minor matter. They are simply not sure what to do. This leads to incredible frustration, stress, and possibly bad choices on the part of the patient or caregiver. What is the solution, then, to this situation?

Patients and caregivers need to know that there is somewhere they can turn for information or help. With the increasing staff that is now part of almost every doctor's office, it is time for resources to be allocated to patient informational assistance. Patients and their caregivers can be kept in the loop about their condition, treatment options, signs to watch out for, when to call the doctor, helpful tips, relevant links, etc. It is in the best interests of the doctor to provide patients and caregivers with as much information as possible in the most accessible way possible. Even letting patients know who staff members are, what is new in the office—these can make patients feel part of the practice.

This is the role that PR plays—as a function of communication. Keeping the lines of communication open with patients, making sure they have the information they need to make informed choices . . . these are in the best interests of both the doctor and patient. Whether that means a comprehensive website, weekly or monthly electronic newsletter, or email address that actually works and is monitored for reasonable turnaround time—these are all options to consider in this digital age. In a small practice with limited staff, the service can be contracted out.

Communication—clear, accessible communication—is a must as people live longer and more active lives with serious, chronic medical conditions. And, in taking PR to new levels of communication, it is time for the real doctors to put their "spin" on things.

Owner of Pen to Paper – The Write Stuff, Ms. Kolenchak has been working in the area of information dissemination, writing, and public relations for over 25 years. For more information, visit www.pentopaper-tws.com.

But What If It Doesn't Work?

By David M. Mastovich

When we have an idea, one of the first things we ask ourselves is "But what if it doesn't work?"

How many times does this prevent us from trying something new? How often do we accept the status quo even though we think there has to be a better way?

It's OK to consider what might happen if an idea doesn't work as long as we ask two other important questions:

"What if it does work?"

"What do we stand to lose by sticking with the current way of doing things?"

We subconsciously fight change. Our self-doubt and negative inner thoughts prevent us from proposing or implementing new ideas. We avoid or ignore problems and make irrational rationalizations like "That's not my responsibility."

Whether you are a team member, middle manager or senior leader, you owe it to yourself and your health care organization to focus on creative solutions that improve your customer experience, operational processes and overall bottom line.

You have to do your part to foster an environment of creativity and innovation. Challenge assumptions. Offer solutions rather than just pointing out problems. Ask questions of peers, bosses, subordinates and customers. Actively listen and think about what you hear.

Try following the 5 W's Technique used by journalists, police officers and market researchers. Ask and answer: Who? What? Where? When? Why?

- Who do you want to reach and influence? Clearly define your target markets. Learn how they think. What makes them tick? Why do they say both "yes" and "no?"
- What are you selling? Not just the mission statement or website copy points. What are you really selling?
- Where do we have a competitive advantage? What makes us different? Why do they want and need us?
- When can we maximize our opportunities? When do they (your target audiences) want and need the solution?
- Why aren't we making it happen?

Instead of convincing yourself a new idea might not work, ask the 5 W's. The answers will lead to creative solutions that enhance your customer experience.

David M. Mastovich is president of MASSolutions Inc., which focuses on improving the bottom line for clients through creative selling, messaging and PR solutions. In his recent book, "Get Where You Want To Go: How to Achieve Personal and Professional Growth Through Marketing, Selling and Story Telling," Mastovich offers strategies to improve sales and generate new customers; management and leadership approaches; and creative marketing, PR and communications ideas. For more information, go to www.massolutions.biz.

Relationship Coaching: A Game Plan for Gaining More Happiness and Fulfillment

By Laura Roman, LCSW, BCD

Like all good "teams," our personal relationships can benefit from qualified, caring and committed coaching. At least that is my belief and it is why, after 25 years as a practicing psychotherapist, I decided to add Relationship Coaching to what I could offer my clients.

A number of reasons prompted my decision. To begin with, I noticed over time a need for couples to have an option other than couples counseling, which can be too limiting for many people. Being a Relationship Coach enables me to take a more "hands on" approach, which in turn allows clients greater access and flexibility to either come to my office, talk on the phone, or even Skype. One of the beauties of coaching is that it is more informal, it has no insurance limitations and you can do it at times that are most convenient for the client.

Research shows that people do better when they have access to the therapist/coach between sessions. Coaching also allows clients unlimited email access. This means that the problems can be worked on between sessions—and they don't have to wait another week for some issues to be resolved!

But Relationship Coaching is not just about overcoming time or money constraints. It also allows the coach to work with one person in the relationship when necessary or helpful. As one of my clients so succinctly put it: "I just don't know how to be in a relationship."

I believe this is true for so many people who live in unnecessary pain and sadness—unnecessary because they can learn to make the changes needed. I can teach them. The truth is, our relationship skills are week and yet, as humans we are meant to be in relationships. Sometimes it starts with the simple, yet lost, art of communication. How often have you been in a restaurant and watched a table of people reading email or texting while ignoring those in their company?

Yet people can learn the skills necessary to have more rewarding relationships at home and even at work, skills that can be transferred to many situations. Don't we owe this to ourselves? That is why I am on a quest as a Relationship Coach to help people develop more satisfying relationships. *After all, shouldn't that be the most important aspect of life?*

In many cases, one partner is more invested in improving the relationship than the other. Working with the more-committed partner follows the Systems Theory, which works from a theoretical frame that once you change a part of the system, you can change the entire system.

Coaching is also more forward looking in that it does not focus on the past history of clients, but rather on today and the issues being faced NOW. Together, we work to develop skills and strategies to meet current challenges. This gives hope to people who may be struggling in a relationship but their partners are not interested in seeking professional help. Even by participating without a partner, an individual can develop the tools and skills necessary to make improvements in a relationship.

Relationship Coaching is not based on hope, but science. Specifically, the field of neuroscience teaches us that we can change our brain and, therefore, change the way we think and behave. For years, I was taught that individuals are stuck thinking and acting in the same destructive patterns. But more recent research is showing that our brains have *neuroplasticity*, which enables us to change or eliminate toxic thoughts that lead to self-sabotaging behaviors.

Through Relationship Coaching, individuals learn to work with this new information in dynamic, innovative ways. I don't just work with married people. I often work with individuals who need to build a better relationship with themselves. Together, we identify their core values, core beliefs and strengths. I teach them skills to identify and eliminate self-sabotaging behavior. I also work with them to develop the skills of authentic happiness. And to any naysayers out there, let me say that this can be done and scientific research supports this.

I also have seen this work to improve workplaces. Managers I have coached have learned better leadership and relationship skills. Work teams, too, have learned to develop necessary relationship skills to become more effective and productive together.

Happiness and living life with a positive attitude were mostly "pie-in-the-sky" concepts just two decades ago. But now I am convinced these are attributes that can be gained through skill-development and that, once learned, they can lead to more fulfilling and enriching lives both at home and at work.

Laura Roman, LCSW, BCD, is a relationship coach and psychotherapist based in Wexford, PA. This May she is offering a group coaching class, "Strengthening Your Emotional Core: Moving from Fearful to Fabulous." To learn more about how you can have a more fulfilling life, visit www.lauraroman.com or call 412-247-1955.

Occupational Therapy — a Valuable and Misunderstood Service

April was Occupational Therapy (OT) Month and Mission Home Health took that opportunity to dispel the many misconceptions about OT, which is a misunderstood and underutilized service among the public and even other healthcare professionals.

National figures show substantially less utilization of OT services by comparison to other services with Medicare statistics commonly showing equivalent referrals or reimbursements at less than one-quarter of Physical Therapy (PT). The name itself can be misleading. "Occupational" was intended to represent the more global definition of "anything that one does to occupy oneself" rather than the more common employment definition.

OTs deal specifically with barriers to function that inhibit participation in meaningful and safe activity. OTs in the home environment help restore functional life behavior through a variety of interventions such as physical rehab, sensory retraining, education and modification of a patient's home environment.

"The perception is that OTs help people bathe and dress. While these are functional areas we certainly address, we're not in the business of bathing people—we're in the business of restoring maximum functional independence," said Jon Mancil, lead OT at Mission Home Health. "My goal is to broaden the understanding and enhance the perception held by healthcare providers and the community about the key role OTs play in developing independent function and creating sustainable solutions to keep people in their homes."

OTs work with patients and caregivers who are having difficulty maintaining a safe and sufficient quality of life in their home. Common conditions include falls or fall risk, dementia or early memory loss, debilitating injuries and chronic conditions such as arthritis, surgical aftercare and/or any other condition that reduces the capacity to function normally. When individuals are having trouble performing routine skills it can be extremely disruptive to health and wellness, often leading to depression. OTs are invaluable in helping individuals restore their activity routine—and their life.

"One of our more significant responsibilities is working closely with the caregiver," said Mancil. "It is commonplace to find people performing below their optimal level because a caregiver progressively takes over every element of a task for the sake of compassion and efficiency. The result is that the client declines in health and ability. For obvious reasons, this will lead to increased risk of injury and hospitalization. There is also strong correlation between loss of self-driven function and depression."

The role of the OT is to create a plan to optimize the caregiver-client dynamic by slowly reintroducing client participation in routine activities as their skill and safety permit. Educating both the client and caregiver about the life-long benefits of this method is essential for long-term compliance.

Another major responsibility is working with the physical environment. OTs go into the home and assist with the safety of the environment to make sure it is conducive to independent function.

"If a patient has a high risk of falling then not only should a physical therapist assess and treat the patient, but an OT should be ordered to assess the safety and balance while performing their essential activities and daily living functions in the home," said Mission's Director of Rehabilitation Services, Warren Smith.

Lastly, OTs may work with any number of specialized interventions such as neuromuscular therapies and sensory retraining. If a patient is unable to brush his or her teeth because of weakness and loss of sensation in their dominant hand after a stroke, an OT may work on interventions to drive the return of strength and sensation while also seeking ways to adapt the hand and/or the toothbrush. For example, using a larger or softer handle for easier hold, a cuff to secure it to the hand or grip tape so that it sticks to the hand for a more secure grasp.

"In healthcare in general, one of our larger issues is compliance. Compliance is, at least in part, a direct reflection of education and understanding," said Mancil. "It's crucial that our clients are educated and work to apply and reinforce that education repetitiously until they reach the point of consistent performance. The healthcare system is under tremendous stress—we have to be out there doing everything we can to reduce costly and unnecessary injuries and hospitalizations."

Mission Healthcare is a clinically owned and operated organization whose services include Mission Home Health, Mission Hospice, and Mission Home Care. By providing a continuum and continuity of care, Mission Healthcare strives to have a positive impact on the lives of patients, their families, and their healthcare partners no matter what their needs may be. Mission Healthcare utilizes all available resources to provide the highest level of care possible to their patients, all while in the optimal healing environment, the home. www.homewithmission.com.

Well on Your Way — Introducing Vincentian Home's Short-Term Rehabilitation Center

By Michele Dolby

Today's active adults enjoy varied lifestyles but have one thing in common – they want to keep moving! This philosophy is behind the development of the new Short-Tern Rehabilitation Center opened recently at Vincentian Home, McKnight and Perrymont roads in the North Hills.

"For basic hip or knee replacement, complex stroke or neurological rehabilitation, Vincentian Home's new Short -Term Rehabilitation Center offers a refreshing approach to rehabilitation," says Linda Parkinson, OTR/L, director, Vincentian Rehabilitation Services.

A spacious occupational therapy center is a short trip from the private rooms and relaxing lounges of the short-term rehabilitation wing. Each room has a private bath, flat screen TV, phone and Wi-Fi access.

Residents adjust to a home environment in the full-size, complete kitchen, dining area, full bathroom with in-home adaptive devices, washer and dryer, and large work table for a wide array of flexibility and dexterity exercises. They can actually cook a meal, load the dishwasher, or fold laundry. Residents also can practice on adaptive equipment, maneuvering around the kitchen or bathroom safely, developing the confidence to live comfortably at home again.

Vincentian Short-Term Rehabilitation Center Features

- 120 private rooms, each with a private bath
- 24-hour country kitchens, cozy living rooms and comfortable common spaces
- Abundant natural light through large windows
- Balconies and courtyards, outdoor spaces, green space and gardens
- A chapel, beauty salon and mini-aviary

The large physical therapy area is flooded with natural light and fully equipped for hip or knee replacement, complex stoke or neurological rehabilitation. Private offices minimize distractions and support concentration for speech therapy, including cognition, memory, orientation, swallowing, use of language and vital stimulation — a state-of-the-art therapy to improve facial and swallowing muscles.

Donna Muders, a recent resident, comments, "My daughter and I are nurses so we know what to look for in quality care. While I was hospitalized for a broken ankle, my husband took our checklist and visited several rehabilitation centers. Vincentian stood out. The customization of care is truly remarkable. My therapist asked my husband to measure our steps at home so I could practice on comparable ones here. He even got some tips on how to install handrails for me! I felt really prepared to go home."

Vincentian encourages planning the rehabilitation stay before hospitalization or discharge. Admissions are accepted 24 hours a day, seven days a week. Visit www.vcs.org/rehabilitation or call Julie Schell, admissions coordinator, or call 412-348-2346.

Michele Dolby is a Community Liaison for Vincentian. The Vincentian ministry in western Pennsylvania stretches back over 100 years. The Vincentian Sisters of Charity were the religious sponsors of Vincentian Collaborative System (VCS) and its member ministries. VCS grew from a single nursing home to an organization managing four nursing homes offering a continuum of senior living services, a rehabilitation company and child care businesses. In 2008, the Vincentian Sisters of Charity merged with The Sisters of Charity of Nazareth, based in Nazareth, Kentucky, who now sponsor Vincentian Collaborative System.

Coordination of Care Leads to Quality Outcomes for Patients With Cancer

By Mary Gullatte, PhD, RN, ANP, BC, AOCN®, FAAN; and Paula Rieger, MSN, RN, CAE, FAAN

From the moment of diagnosis, patients with cancer face a frightening and unfamiliar journey. They often feel helpless and alone. The special needs of patients with cancer are as varied as the patients themselves. Oncology nurses help patients through this difficult and frightening time.

Coordination of care by a nurse is a key theme in healthcare reform and is essential to the Oncology Nursing Society's (ONS) mission of providing excellence in oncology nursing and quality cancer care.

The American Nurses Association (ANA) defines care coordination as (a) a function that helps ensure that the patient's needs and preferences are met over time with respect to health services and information sharing across people, functions, and sites; and (b) the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.

Oncology nurses, through interaction with other disciplines, coordinate care in the oncology population by encouraging cancer screening and helping patients through diagnosis, treatment, follow up care, and survivorship. Nurses prepare patients and their families and caregivers with strategies to manage the symptoms related to their disease and treatment. They develop and provide an effective plan of care as well as associated patient education and instructions specific to their disease and treatment.

It has been shown that this type of focused patient education at the outset of cancer treatment affects self-care, adherence to treatment, and ultimately patient outcomes.

Delivering Quality & Innovation in patient care

Oncology nurses also coordinate appointments between different oncology specialties, lead the transition to survivorship care at the completion of treatment, and prepare patients to move into the primary care setting once active therapy is completed. Coordination of psychosocial support and psychosocial distress screening for the patient, family, and caregivers is also a critical component of the nurse's role in providing the best possible care.

Patients with cancer spend more time with their oncology nurses than any other healthcare professional throughout the continuum of their care. Nurses take the time to listen and answer their patients' questions, interpret complicated information, and help them navigate the healthcare system. Once active treatment is complete, patients return for follow-up care and for the information they need to transition to life as a survivor. This is especially important, as many cancer survivors cope with late effects of treatment, as well as psychological concerns such as fear of recurrence. Survivors and their families and caregivers must be able to rely on their cancer care team to provide them with the information and support they need to make decisions that affect their quality of life.

ONS is dedicated to being the leading resource for best practices in oncology nursing because we are committed to patients with cancer and the oncology nurses who guide them along the cancer journey and into survivorship.

Year after year, nurses are recognized in Gallup surveys as some of the most-trusted professionals. Their dedication to caring for their patients is second to none.

In honor of Oncology Nursing Month and National Nurses Week, ONS salutes these dedicated, compassionate, and caring professionals for the work they do every day.

Mary Gullatte is President of Oncology Nursing Society and Paula Rieger is Chief Executive Officer of Oncology Nursing Society. For more information, visit www.ons.org.

The Education of the Nurse Has Never Been More Important

By Jacqueline Dunbar-Jacob, PhD, FAAN

When the Patient Protection and Affordable Care Act is fully implemented in 2014, 33 million more Americans will become eligible to get affordable health care coverage. But access to coverage will not necessarily translate into care. Experts doubt there will be enough doctors to meet needs. There are not enough now.

The Association of American Medical Colleges estimates that in 2015, the country will have 63,000 fewer doctors than needed, and that number will more than double by 2025 as the expansion of insurance coverage and the aging of baby boomers drive up demand for care. It typically takes a decade to train a doctor, so there is little the government or the medical profession can do to close the gap before the law takes full effect in 2014.

Advanced practice nurses are helping to fill the gap. Hundreds of walk-in clinics run by nurses are already operating across the country. While they most commonly treat routine ailments, the nurses in these clinics are increasingly helping people suffering from chronic illnesses. Nurse-managed clinics offer checkups and help patients to manage their high blood pressure, heart disease, and diabetes. Studies by the RAND Corporation found that these clinics provide care at costs that are 30–40 percent less than similar care provided at a physician's office and that the care for routine illnesses was of similar quality.

For many people, nurse practitioners are now the main source of primary care—the experts who diagnose those aches and pains and then write the prescriptions that relieve them. But as medicine has grown more complex and sophisticated, so have the skills needed to practice it. Given the ballooning of their clinical duties, it's no surprise that the education required of many health professionals is expanding as well.

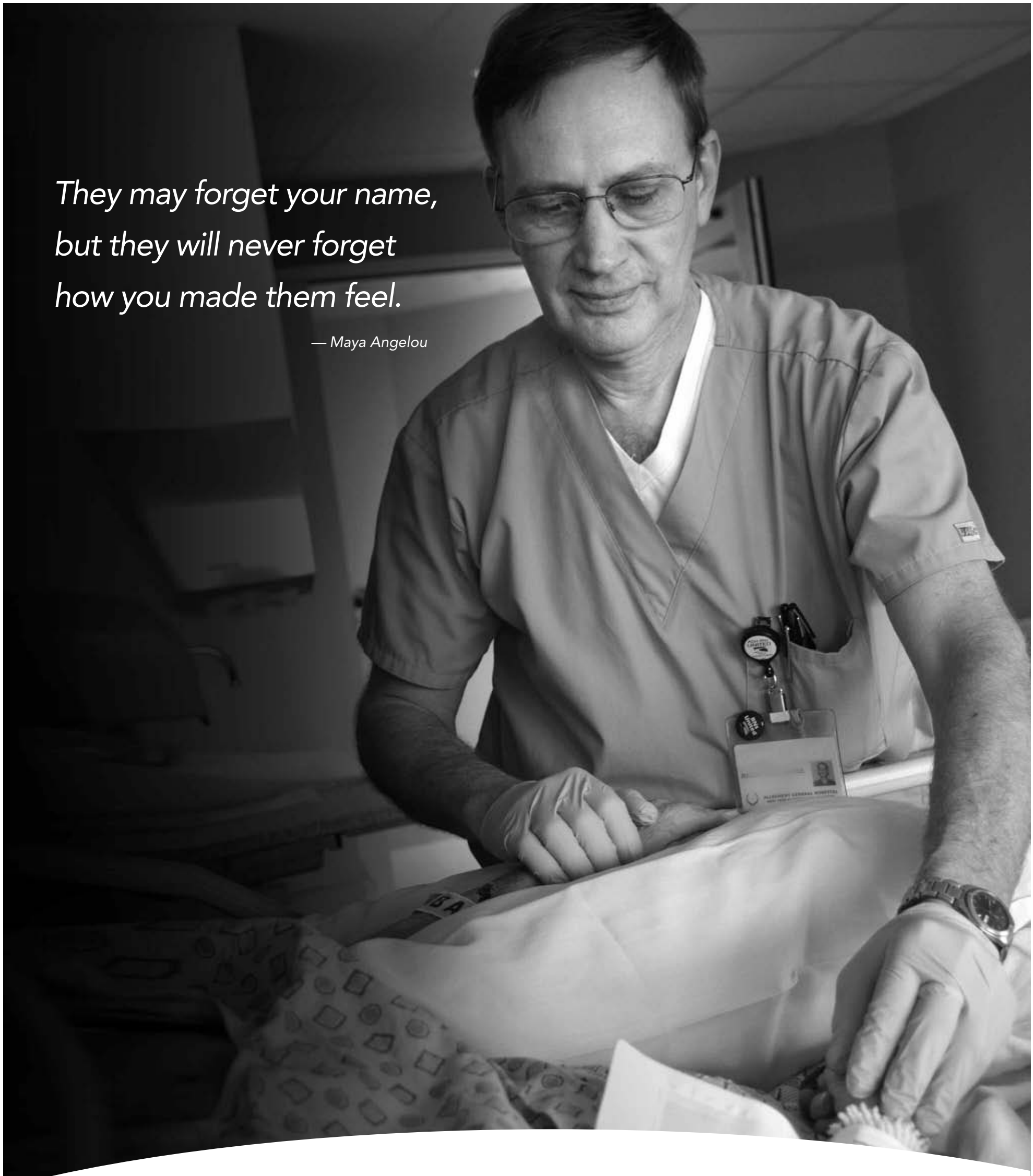
Recognizing that the changing demands of this nation's complex health care environment require the highest level of scientific knowledge and practice expertise to ensure quality patient outcomes, the American Association of Colleges of Nursing (AACN) advocates the baccalaureate "as the minimum educational requirement for professional nursing practice." The Robert Wood Johnson Foundation and Institute of Medicine's report "The Future of Nursing: Leading Change, Advancing Health" support this initiative, calling for 80% of nurses to hold baccalaureate degrees by 2020. In addition, the AACN voted in 2004 to move the current level of preparation necessary for advanced nursing practice from the master's degree to the doctoral level by the year 2015. This decision followed almost three years of research and consensus building with a variety of stakeholder groups.

According to AACN, some of the factors building momentum for change in nursing education at the graduate level include the rapid expansion of knowledge underlying practice; increased complexity of patient care; national concerns about the quality of care and patient safety; the shortage of nursing personnel, which demands a higher level of preparation for leaders who can design and assess care; shortages of doctorally prepared nursing faculty; and increasing educational expectations for the preparation of other members of the health care team.

Transitioning advanced practice nurses to the Doctor of Nursing Practice (DNP) degree reflects the complex clinical skills and sophisticated knowledge of the evidence base necessary for advanced practice nurses practicing in today's health care environment. Unlike Doctor of Philosophy (PhD) programs that emphasize academic research, the clinical Doctor of Nursing Practice (DNP) program emphasizes the skills and knowledge students will need to practice their profession at its highest level.

The DNP moves nursing in the direction of other health professions that offer practice/clinical doctorates, such as: medicine (MD), dentistry (DDS), pharmacy (PharmD), psychology (PsyD), physical therapy (DPT), and audiology (AudD). DNP graduates are prepared to affect the health care delivery system not only by delivering primary care and serving as hospitalists but also by evaluating the evidence base for nursing practice, becoming leaders in clinical arenas, establishing standards and policies, and partnering with other members of the health care team to meet the needs of today's diverse health care systems.

Jacqueline Dunbar-Jacob is dean of the University of Pittsburgh School of Nursing. The National Institutes of Health (NIH) places the school third in the total dollars received – the sixth consecutive year it has ranked in the NIH's top five list and the fourteenth consecutive year in the top ten. In addition, U.S. News & World Reports ranks the school 9th overall in their 2013 edition of Best Online Programs and seventh overall in the 2011 America's Best Graduate Schools, the most recent issue ranking schools of nursing. For more information about the University of Pittsburgh School of Nursing, visit www.nursing.pitt.edu or call 412-624-4586 or toll free 888-747-0794.



Pittsburgh Technical Institute Approved to Offer Associate in Science in Nursing (ASN) Degree

Pittsburgh Technical Institute (PTI) recently announced approval from the Pennsylvania State Board of Nursing and the Middle States Commission on Higher Education (MSCHE) to offer an Associate in Science in Nursing program beginning in July 2013.

The seven-quarter program is designed to enroll students into a cohort model, an advantage of PTI's program, which streamlines course availability and guarantees that ASN students will take nursing courses from the first day of class. "We assure our students that if they work hard to progress, they will be able to complete the program in less than two years," said Lynette Jack, Academic Chair, PTI School of Nursing.

PTI's 21-month ASN program curriculum was developed to meet competencies established by the National League of Nursing and prepares students to sit for the NCLEX-RN exam upon graduation for licensure as a Registered Nurse.

"Job expectations for the RN include additional responsibility for leadership and management of complex patient care," said Jack. Career opportunities include positions in hospitals, pediatric settings, hospice care, critical care and private physician offices.

Distinguishing features of PTI's new ASN program include extensive simulation technology and hands-on skills labs. Each student will use a personal iPad mini and Nursing Central software to access online nursing resources through subscription. "We don't want students to rely on textbooks that can become out of date," said Jack. "With these resources, students will become accustomed to working with the same types of information sources used in modern healthcare practice."

The ASN degree consists of 76% nursing courses and 24% general education courses. Students are required to spend 55% of their nursing course time in clinical rotations or labs including primary care and wellness, acute care, chronic illness, OB-GYN, pediatrics, psychology, and an area of the student's interest.

"Nursing is both an art and a science," said Jack. "It's imperative that students use their ability to care about people, along with reasoning, judgment and knowledge and learn to see themselves as decision makers." According to Jack, the program maintains a strong emphasis on courses in science and critical thinking in addition to nursing courses that develop clinical reasoning and hands-on skills.

A sample of nursing degree program courses required of PTI's ASN students are Anatomy & Physiology, Microbiology, Nutrition, Primary Care & Wellness, Pharmacology, Acute Care of the Adult, Care of the Adult with Chronic Illness, and Professional Transition to Practice.

The ASN degree is PTI's second program offering within its School of Nursing. PTI began offering a Practical Nursing (PN) program in July 2010 which prepares nursing students to become Licensed Practical Nurses.

PTI PN graduates consistently pass the state NCLEX-PN licensure exam with a 94% first attempt pass rate.

PTI's PN credits are fully transferable into its ASN program; PTI PN degree graduates can complete the ASN program in just nine months. Additionally graduates of other practical nursing programs can take advantage of opportunities for advanced standing.

"Abundant evidence suggests that advanced education in nursing significantly reduces clinical risks and increases the quality of patient care," said Jack. "We planned our curriculum to make it possible for students to smoothly transition when they choose more education."

In addition, PTI ASN courses are designed to meet some curriculum requirements of an RN to BSN program, so graduates will have an incentive to continue their education in nursing at the next level. PTI has an established articulation agreement with the School of Nursing at Robert Morris University and is exploring several others.

Lynette Jack was appointed to the position of Department Chair in January 2012 and earned a Bachelor of Science in Nursing at the State University of New York Buffalo, and both a Master's in Nursing and a Ph.D. in Higher Education at the University of Pittsburgh.

For more information, visit www.pti.edu/school_nursing_practical.php.

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Workforce Development Programs Must Put Focus on People

By John G. Lovelace

Training programs that are designed to help persons find meaningful employment who are from low-income families or who have disabilities need to do more than just connect people to work opportunities.

When workforce initiatives put more focus on the program than the person they are working with they are unlikely to produce positive results. There needs to be an enhanced paradigm of workforce development, one that recognizes that understanding is the basis for successful employment.

In the working world, there's landing a job and there's keeping a job. The latter is sometimes more difficult than the former. When employers have plenty of job applicants, they have little patience for underperformers.

Those who come from disadvantaged, low-income backgrounds often have difficulty realizing the need for employment as well as knowing how to find and keep a job. For these people, barriers such as child care and transportation can be daunting and workplace expectations can be overwhelming.

At UPMC a couple of innovative workforce development programs have shown that those barriers can be overcome through education and training.

UPMC noticed among its own workforce that the turnover rate for service level positions had become high and needed to do something about it. It created an innovative program called the Partnership on Workforce Readiness and Retention, or POWRR.

POWRR – a collaboration with UPMC and several community partners – is designed to help people choose career paths within the health care industry. POWRR helps prepare them for jobs and develop the skills needed to keep those jobs. UPMC reaches out to populations with significant barriers to employment including persons with disabilities, those in welfare-to-work programs, people with limited work experience and/or education, those for whom English is a second language, and people with criminal backgrounds.

The POWRR curriculum includes workshops in understanding the job, preparing for the job and learning how to get the job. After successfully completing the three workshops, job seekers become POWRR certified and are guaranteed contact with UPMC, usually in the form of a phone interview.

Since the program launched in 2010, UPMC hired more than 250 participants via the POWRR program. Moreover, as of December 31, 2012 the retention rate for POWRR program participants was 66.3 percent higher than for employees hired through traditional recruitment methods.

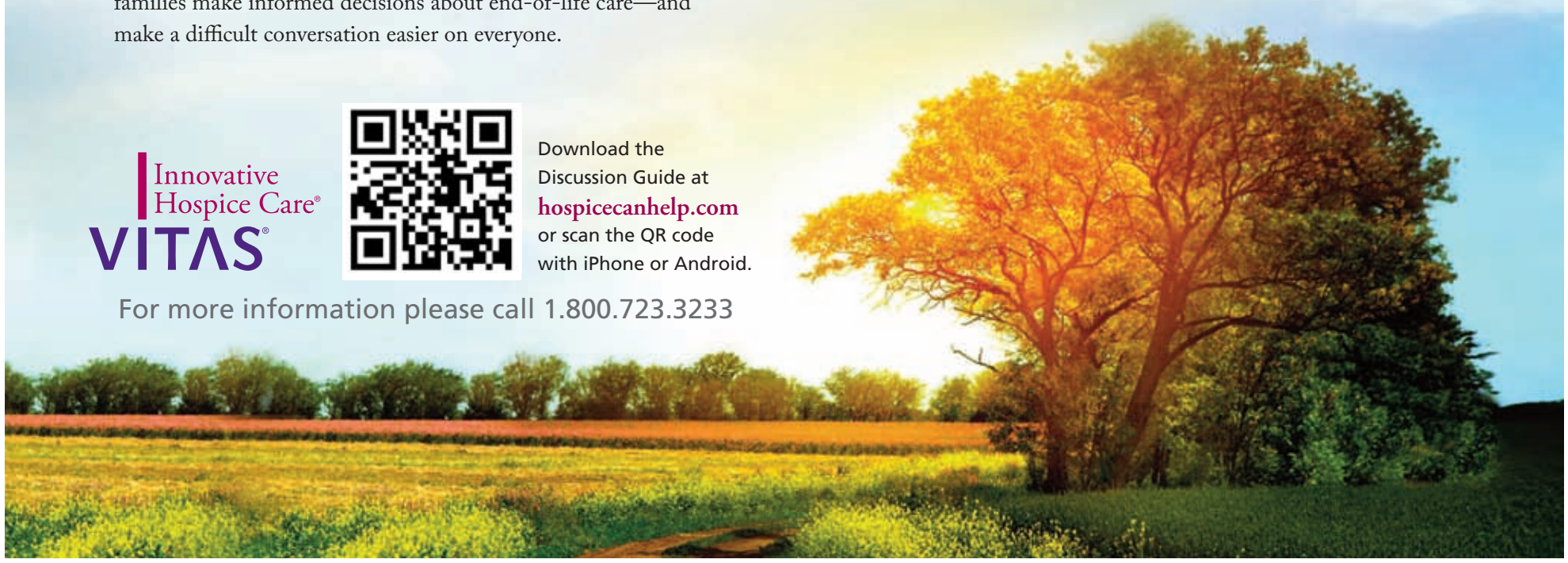
Discipline is a vital skill that is taught in another UPMC offering, the UPMC Health Plan Pathways to Work program. This program, which began in 2007, has become the first step in a successful career for many participants.

The program starts with UPMC Health Plan hiring someone to work in an administrative position as a temporary employee. Employees are chosen among those receiving cash assistance from the state's Temporary Assistance to Needy Families (TANF) program. HR staff works with the employee to help him or her to develop the job skills and discipline necessary to be an effective worker. HR staff also looks for UPMC system-wide positions that appear to be a good match for the employee.

The Pathways to Work program has proven to be a "launching pad" for many UPMC employees who find jobs that match their abilities and who know how to hold onto the position once they get it.

UPMC's workforce programs have yielded success and improved lives because of the focus those programs put on the individual job seekers. As a result, success has been tangible for the participants – they have had success in preparing for a job, success in finding a job, and success in taking the first steps on a true career path.

John Lovelace is president of UPMC for You, a managed care organization that serves Medical Assistance and Medicare Advantage Special Needs Plan recipients in 40 counties in Pennsylvania. He holds graduate degrees in rehabilitation counseling from the State University of New York at Buffalo, as well as in information services from the University of Pittsburgh. For more information, visit www.upmc.edu.



Five Secrets to a Successful Acquisition in Healthcare

by David Braun

With so many new laws and regulations raising the pressure on hospitals and healthcare institutions, more consolidation in the industry can be expected. Every merger or acquisition brings challenges of integration. As you start putting the two entities together, it's essential to look out for the teams of people responsible for operations and patient care. So what does it take to meld two companies into a single thriving entity that improves relationships and builds confidence?

Bridging two workforces requires identifying and integrating their approaches to short and long-term operations and, just as important, their day-to-day working styles. The fact that both companies are in the healthcare industry isn't enough to guarantee an easy fit. Needless to say, there are as many cultures and business strategies in this industry as there are companies. Common ground has to be discovered, explored, built and tested. Even with the best-matched companies, integration can still be tricky. below are 5 tips to ease your path:

1. Move quickly: Have a 100-Day Plan Ready to Go

Once a merger is announced, employees from both the buyer and the seller naturally expect changes to occur. Moving quickly over the first 100 days will give you the smoothest path to implementing changes. If you procrastinate, you are likely to meet more resistance as employees go back to business as usual. You need a written 100-Day Plan for your entire integration team to work from. The Plan should be built around two basic questions: Where do we begin? And what do we want the new company to look like after the first 100 days?

2. Quality not quantity when it comes to communication

Communication is key to successful integration; however communication shouldn't be measured by how much is shared but rather how well it is shared. Your employees do not need dozens of meetings or bulletins. They want honesty and credibility. If you plan to change something sensitive, like vacation policy, it is important to explain openly to employees why, when and how you will make changes — whether online, in print or through in-person announcements. While you won't eliminate uncertainty or doubt, being direct and honest with your employees will ease concerns and lessen the spread of rumors.

3. Listen to your employees

This is a time when the healthcare industry is in huge upheaval, and employees are generally anxious about the future. Add the stresses and unknowns of a merger, and there could be a crisis of morale looming. The best strategy is to listen to your employees. You might set up a toll-free hotline or in-house online forum for them to anonymously vent their frustrations and ask about rumors. Not only does the staff need to know what you are thinking — just as important is knowing what they are thinking. Creating easy-to-use "listening posts" will allow management to understand what employees are concerned about and respond quickly.

4. Speed up integration through Secondment

Secondment involves taking a few people out of the company you have acquired and placing them in equivalent roles in the your own organization and vice versa. These embedded representatives serve as interpreters. They learn about the culture of the new partner, and take their insights back to the home team. The move need not be permanent, but should last for at least six months – enough time to get everyone up to speed and make the adjustments that will realize the maximum synergies. Secondment will allow you to get a sense of what matters most to the employees on both sides of the deal. You'll also discover hidden strengths and weaknesses in both cultures that help you make the best of your new acquisition.

5. Reverse Integration

Integration needn't be a one-way street, with only the buyers bringing their systems or culture to the newly acquired company. The healthcare industry is unusually dynamic, with new management strategies and technologies constantly appearing on the scene. Your acquisition should help both companies grow and move forward, embracing the strengths of each. Does one have a unique sales team structure that increased the bottom line? Does one have higher employee retention based on a strong rewards program? You want to discover and incorporate the winning elements from both entities.

David Braun is the Founder & CEO of Capstone Strategic, www.CapstoneStrategic.com, a management consulting firm specializing in corporate growth strategies, and author of the new book, Successful Acquisitions: A Proven Plan for Stategic Growth. David has over 20 years' experience formulating growth strategies in a wide range of manufacturing and service industries and has completed more than US $1 billion in transactions with his firm Capstone. He can be reached at dbraun@capstonestrategic.com

It's What You're Eating

By Nick Jacobs

One of the things that I get to do while consulting all over the country is to periodically attend lectures about health. Because of my interests in non-traditional, ancient medicine practices that often work better than some new medical treatments, I get to attend some pretty interesting presentations, the type that you're not likely to see on the Discovery Channel anytime in the near future. One of the last talks that I heard in the interesting category was about primitive food.

The presenter, a Harvard M.D., used the descriptive word primitive in only the best possible context. It was about the kind of food that people ate before big business, bad science and deceptive marketing got involved. It was about pure food, nature's food, unadulterated food. It was about natural foods: meat and milk from cows that graze in fields, chickens that don't live in cages; he discussed real butter and milk that is not pasteurized, insects, fish and other sea creatures, whole grains, and pure water.

This cardiologist started out with a series of photographs of what people's faces looked like in the 30's. I'll admit they were not all models, but there was a certain beauty, a quality that is not seen much anymore.

These were the faces of people who were not consuming modern chemically treated foods that encourage shelf-life, kill predator insects or thrive during a drought: no hydrogenated fats or MSG, no genetically altered corn, and no high fructose corn syrup.

After each picture of the faces of those eating natural foods, he showed us pictures of people who grew up eating the altered, chemically produced food. To the majority of us in attendance, those pictures were very surprising.

The crux of his presentation was that back in the 30's a very curious dentist noticed something about people and the impact of what they ate on the formation of their facial bone structure. The bone formation in their faces had changed dramatically. This doctor then traveled the world in order to substantiate his findings. The first place that he visited was Switzerland: not developed, modernized Switzerland, but some tiny little village tucked in a mountain pass that was only accessible by foot and couldn't be reached at all in the winter. When he got there he found the people were living on only locally and naturally produced food—dairy products, grains and meat.

This is where things gets interesting. Their faces were full, and their teeth were perfect. They were happy, healthy and fertile. In other parts of the country where sweets and processed foods were more prevalent, the people had thinner jaws and plenty of cavities. The bone structure of the faces had actually changed over a few generations, and there was not enough room for all of their teeth. So, he decided to keep traveling and went to Africa, the South Pacific, Alaska and several other remote locations where he discovered exactly the same thing, Natural foods—fuller faces; processed foods—thinner faces, tooth decay, infertility and not enough room for their teeth, hence the need for braces.

By the end of this lecture, our presenting cardiologist had me convinced that I should consider switching to eating seal stomachs, grub worms, pig tails or even fish heads as long as the food was not adulterated, not injected with preservatives, chemicals, artificial colors, sugar, corn syrup and antibiotics. The people who ate primitive foods were happier and healthier, sexier and had prettier smiles; their faces were full and their teeth fit in their mouth.

As I sit here and contemplate our various food groups: artificially flavored chips, injected beef, chemical-laden white bread, sodas containing a chemical used as a fire retardant, make-believe spray cheese, factory-produced chicken eggs, and enough corn syrup to float the Titanic, I now understand why my dentist had to pull my wisdom teeth.

Bottom line? Eat natural stuff. You'll be sexier!

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

Five TIPS for Effectively Using Benchmarks to Achieve Goals

By Stacey Lang

Enhanced access to data can be of tremendous value to hospital leaders in navigating the rapidly changing landscape of U.S. healthcare. But, ready access comes with challenges. We are all familiar with "the paralysis of analysis," a common pitfall for organizations that may be data rich but lack the necessary infrastructure to effectively use the data to develop meaningful benchmarks for effecting change.

The following tips are recommended for hospitals working to use available internal data, as well as all available benchmarking information, to drive organizational change.

1. Ensure the integrity of source data and the validity of resulting benchmarks in advance of integration into process improvement.

If questions exist around data integrity, doubts relative to the goals for improvement or growth based on "flawed data" will likely arise, hampering efforts to secure buy-in for process change.

Understanding the origin of data to be utilized and vetting with involved administrative, physician, and clinical leaders in advance of any public dissemination is essential. Further, assigning the task of gathering the necessary data from disparate systems and the creation of reports to one person will help to ensure accuracy and validity.

2. Evaluate available data and benchmarking resources for synergies with organizational strategic vision and financial performance goals.

After validation of the identified data and benchmarking resources, we recommend distilling the information and identifying the key points that serve to support overall organizational goals as well as those of specific service lines. These are the metrics that should be continually monitored and tracked due to their impact on the organization overall, and should assist in the creation of realistic goals based on the data.

3. Identify, develop, and prioritize goals as well as the source of supporting data to compliment strategic and operational targets.

The number of goals developed should be limited to four or five. The risk of dilution of effort or failure due to inadequate resources increases significantly once this number is exceeded. These goals must then be prioritized with clearly defined expectations for achievement, along with objective data targets. Identifying timeframes for completion as well as assigning responsibility for discrete tasks will help

to ensure accountability of all involved.

4. Develop necessary dashboards and reporting forums to facilitate the rapid dissemination of information.

Measuring progress and success in goal achievement is essential to maintaining momentum and commitment of those involved. Time should be dedicated to developing meaningful dashboards that are routinely produced and shared in a public forum. Report review in a group setting fosters an environment of teamwork, along with shared ownership and accountability, which can aid in the achievement of identified goals.

This collaborative setting can also facilitate idea sharing for process improvement.

5. Establish a process for ongoing oversight, modification of goals, and data collection and dissemination methods.

Implementation of a formal process improvement method requires significant effort at start-up, and significantly more effort on an ongoing basis! Goals must constantly be re-evaluated and assessed to ensure that they continue to be relevant to the overall organizational (and/or programmatic) direction.

The program leader who invests the time and effort necessary to develop a benchmark-driven approach to process change and program improvement or expansion, will no doubt realize the value of these endeavors. Most importantly though, the effort must be focused and ongoing in order to be worthwhile. The use of benchmarks should be flexible and continually reassessed in order to maintain effectiveness in the achievement of goals and the accountability of those involved.

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

Longwood at Oakmont Senior Living Community Gives the Gift of Art to Its Residents

by Christopher Cussat

Longwood at Oakmont is a beautiful, not-for-profit, retirement community located near Verona, Pennsylvania, where approximately 25 artists also explore various art techniques in its art studio and showcase their work throughout this senior living community. Workshops consist of a mix of beginners to professional artists including: Gloria Goldsmith Hersch, whose paintings can be found locally in the H.J. Heinz World Headquarters; Carol Swift, who was honored by the LeadingAge-Pennsylvania (PANPHA) senior artist program; and Louise Menges, a former art teacher.

Unlike other retirement communities, Longwood at Oakmont gives its residents the autonomy to form activity groups that they are interested in doing. The art group began a little over five years ago by residents, Louis Menges and Martha Browne.

It actually began as a few people getting together in the old arts and crafts room to learn about various art techniques. During the once-a-week meeting, residents who were more accomplished in art would give instruction about the various art techniques and help beginners with their artwork.

Resident, Edith McElfish, says that when Longwood at Oakmont's Grandview structure was built, a creative arts studio along with a gallery was included in the design—and as a result, more people began coming and joining the group. "We now have two designated meeting times: on Wednesdays, that time is designated to learning a new technique (collage, watercolor, acrylics, etc.) and Fridays are an open studio time." The group is currently learning about how to make medallions and incorporating their initials.

"At Longwood at Oakmont, we actively encourage our residents to join our various resident-run groups and Wellness Center activities in order to stay active," says wellness coordinator, Jason Klein. "In regards to the art group, art stimulates your mind and according to recent Alzheimer's research, mental stimulation is an excellent preventative measure."

He adds that the mental stimulation comes from not only painting or making the

piece of artwork, but in observing it as well. "For example, our art gallery has a sitting area where other residents can enjoy the paintings and they often leave remarks in the comment book like, 'Great job.'; 'I didn't know this kind of talent was living at Longwood.'; and 'What great artists we have here!'"

Klein was most likely referring to the work and studies done by art therapist, Ruth Abraham. According to this author of *When Words Have Lost Their Meaning: Alzheimer's Patients Communicate Through Art,* "Art therapy has been shown to be a powerful tool for people with Alzheimer's because it helps them express their feelings, feel less isolated and lonely, and calm their restlessness."

Art has also been proven to be a stress reliever, which can be the root of several diseases including high blood pressure, obesity, sleep disorders, fibromyalgia, and cancer. "One example of how it helps one's well-being is through intergenerational programming," notes resident, Mary Groggel. "Every summer the group works with kids on different areas of art—and being able to work with children is very rewarding."

Art classes have also been found to positively impact the brain and overall health of senior citizens, especially those dealing with brain diseases like Alzheimer's. "The art group at Longwood truly is a mixture of experience. Some in the group haven't picked up a paint brush since they were a child and others haven't had any previous experience at all," explains Shirley Elinsky, a Longwood at Oakmont Art Committee co-chair. "We love the opportunity to socialize with others who share the same interest and continue to express our love of art."

Groggel says it is easy to lose yourself in art, but that is one thing she enjoys about it. "You run with your imagination and forget about reality," she adds. McElfish believes that participating in art helps one to remain more independent.

"As you get older, you want to stay active and independent—to achieve that, it is important to try something new and be involved in activities to keep you busy. This is something that I never thought I would do—and I'm having a ball with it!"

Every month the resident artists have an opportunity to showcase their new artwork in Longwood at Oakmont's Art Gallery, which is located in the lobby of the Wellness Center.

During the month of February, it featured artwork by Shirley Elinsky. Recently, the gallery had a display where 26 residents contributed to the exhibit. Additionally, select group members participate in area gallery shows, submit their artwork for competitions, and attend local art classes.

For more information on Longwood at Oakmont and its Art Gallery, please call: (877) 214-8410 or visit: www.longwoodatoakmont.com. Outside donations are welcome.

(Pictured right to left): Louise Menges, Christina Uber, Garnet Clark, Edith McElfish, Robert Schultz, Mary Groggel, and Margaret Groninger

Stantec It's a Matter of Perspective.

My Classmate Vince Was The Exception; The Design Process Is The Rule

By John Reddick AIA

We all knew a similar classmate in High School. In my class it was Vince. Vince and I attended the same junior-year first-period English Composition Class. When the class was assigned yet another five paragraph essay Vince would blow off the topic brainstorming session. He would also skip the research, the outline, and the rough drafts. Vince would pen the first draft – which was also his final product on the bus ride to school the morning the assignment was due. A few days later, after the teacher had evaluated the work, Vince received a better mark than most of the class even though we had spent many evenings working diligently through the process. Vince was representative of the truly gifted among us - the exception not the rule. To the less gifted – our only option is to respect the process. Then work smart, and work hard, to make a positive difference in the world. An effective process combined with time, diligence, and perseverance is the key to success.

As a healthcare architect my experience has shown that the design process, much like the process to create a five paragraph essay, requires time, diligence, and perseverance. Shortcuts often result in added time, money or an inferior product. Here is a brief description of the design process used for most healthcare construction projects.

The Master Plan

First and foremost the hospital leadership must establish the direction – Where does the institution want to be in five years? A well-considered Master Plan can have a synergistic effect on the overall campus, hold design costs in-check, and provide built-in operational efficiencies. The hospital leadership should establish an effective Master Plan and then work diligently not to take shortcuts during implementation.

Once the Master Plan is established, and if renovation or building is part of the solution, the owner must assemble a design team *(see Healthcare News, Issue 11 / 2012, p. 21)* and choose a delivery method *(see Healthcare News, Issue 2 / 2013, p. 20)*. The architect typically is assigned the lead role. The owner's project manager facilitates the process.

Schematic Phase

An effective programming effort establishes an architectural layout that is sized correctly and flows efficiently. The initial Schematic Plan is the first visual image of the user's ideas. It is not too early to consult the engineers and other stakeholders (i.e. security, and equipment vendors). This phase sets the location, budget and schedule for the entire project. This is the time to think big and measure the user's wish list. Changes are expected. At the conclusion of the Schematic Phase the deliverables include a Schematic Floor Plan, a Preliminary Schedule, and Budget. Only after owner sign-off should the process move forward.

Design Development Phase

With location, budget, and schedule established; the design team begins to add detail and depth to the Schematic Plan. Aesthetics and materials are considered, building sections are created that coordinate disciplines (electrical, mechanical, and plumbing). Potential show stoppers are identified and addressed. Equipment selections are made. An outline specification is completed. The Preliminary Budget and Schedule are fine-tuned. Design Development Documents continue to use a language understood by the users and provide the client with a visual expectation of the completed project.

Construction Document Phase

In theory all the user meetings have been completed and key decisions made before entering the Construction Document Phase. In this phase the drafters assume the lead role as they define the quantity and location of the construction (with drawings) and the quality (with specifications). The information is translated into the contractor's language. During this phase the design team will resist changes to previous decisions. Additional fees may result if changes cause rework or more time than was initially budgeted. The deliverables include a set of Construction Documents that clearly define the design intent. The documents are used to bid the construction and to review with the regulatory agencies.

Bidding

By addendum the design team may be asked to clarify items or issue missing information. Qualified bidders review the Bidding Documents and submit a cost to complete the work. A Scoping Meeting with the apparent low bidder is critical to ensure the scope of work is understood. At the conclusion of the bidding phase the successful bidder signs a contract with the owner to complete the construction.

Construction Administration

During the Construction Administration Phase the design team may be contracted to oversee the construction by visiting the site and attending weekly or bi-weekly Construction Meetings to ensure the work adheres to the drawings and specifications. Review of shop drawings, material samples, and manufacturer information may also be a part of the construction administration services. Changes resulting from unforeseen conditions, errors and omissions, or change in scope are processed. In the end -inspections are completed, occupancy permits issued, ribbons cut, and the users take ownership of their new space.

My senior year I tried to imitate my gifted classmate Vince. I wrote an essay, not on the bus the morning the piece was due, but the evening before. I tried to squeeze the process into a few hours. Needless to say I did not sleep well that evening and the essay was nothing short of disaster. And so it goes with the design process. An effective process combined with time, diligence, and perseverance is the key to success. Anything less, like my classmate Vince, is the exception not the rule.

John Reddick is a Registered Architect and Associate at Stantec Architecture and Engineering LLC. John works in the Stantec Butler, Pennsylvania Office and can be reached at john.reddick@stantec.com.

Moving Medical Ethics Beyond Discussion

By Kathy Gennuso

Dr. Edmund Pellegrino, one of the godfathers of medical ethics, wrote many years ago that he hoped the future patient would experience an environment in which most physicians and medical students would understand that ethics is an inherent and inseparable aspect of quality clinical medicine. Perhaps his statement was based on the belief that somehow today's physicians would gain the moral knowledge and ability to effectively work with patients; however, this is not the case. Can we expect this to happen without a formalized and disciplined approach to effectively educating our medical students and future physicians?

New reports suggest that medical school faculty mentors are not providing their residents with sufficient training in ethics; therefore they are not adequately prepared to face the day-to-day ethics dilemmas they will experience in their profession. Almost two-thirds of medical students and residents feel that there is a need for more ethics training to be included in their curricula and training programs. They cited a lack of teaching about common ethical concerns, which are complicated by situations that involve values, obligations, and principles, such as respect for persons and confidentiality, as well as conflicts between these principles. A study by Johns Hopkins Medicine in Baltimore found that training occurred in only 12% of resident-preceptor interactions. Less than half of respondents felt that medical school training was adequate.

Often, ethics curricula focus on what one author has called the "neon issues" in healthcare such as abortion, euthanasia, and global healthcare resource allocation rather than the day-to-day moral struggles faced by early-career physicians. Similarly, ethics curricula have often been "top down," i.e., structured in relation to abstract bioethical principles, rather than based upon trainee experiences and self-identified educational needs, which represent a more "bottom-up" approach.

Medical educators are confronted with the decision on what to teach (content) as well as with how to teach (process) ethics to the physicians of tomorrow. Becoming a good physician requires both the mastery of knowledge and the experience acquired in improving one's technical ability. These are also the principal goals of formal medical training, but it is clear that these achievements, while necessary, are not sufficient. Medical practice also demands the ability to make sound decisions and act upon them with professionalism. The result is a need for greater specialization in ethics, particularly for residents and those in highly patient-centered disciplines. Different content and formats of delivery are necessary to reach the needed state for preclinical and clinical students and future ethics programs.

A variety of teaching and evaluation methods have traditionally been utilized in ethics education such as lectures, written examinations, debates, role-playing (simulation), small group discussion, and case study analysis. The most prevalent approach involves ethical analysis of case studies, wherein the student is asked to read a case or discuss a case with others, identify the ethical issues orally or in writing, propose different resolutions supported by principles and theory, and select the best course of action. Yet, analysis of a case is unlikely to develop skills in coping with the uncertainty and emotional nature of ethical issues commonly encountered in a physician's day-to-day environment. This type of training does not provide an accurate indication of what students would really do when they encounter an actual ethical problem.

There is clearly a difference between reading a text or listening to a description of a particularly difficult case involving ethical issues and interacting with a real patient or another health professional. The truth is that medical educators need both robust content related to ethics, as well as the flexibility to conduct the teaching process in a variety of different methods in order to accomplish the transfer of knowledge to their students.

Newly released software, developed in the Pittsburgh area by a team of bioethics experts, provides an ideal mechanism through which the longstanding deficit in ethics education for medical students can be remedied. EthAssist™ features a comprehensive, well-organized, searchable bioethics knowledge repository; video library; ethics process and procedural guidelines; and other educational tools and resources that are available to students and clinicians 24/7. Developed by the Institute of Consultative Bioethics (ICB), EthAssist™ stands to revolutionize the manner in which physicians are educated, thereby fulfilling Dr. Pellegrino's hopes for quality clinical medicine that delivers best-in-practice care to patients.

Kathy Gennuso is the CEO of the Institute of Consultative Bioethics, based in Pittsburgh, Pennsylvania. Kathy is currently pursuing her doctorate degree in Healthcare Ethics at Duquesne University and holds a Master Degree in Business Ethics and a Bachelor of Science in Information Technology. For more information, visit www.icbioethics.com.

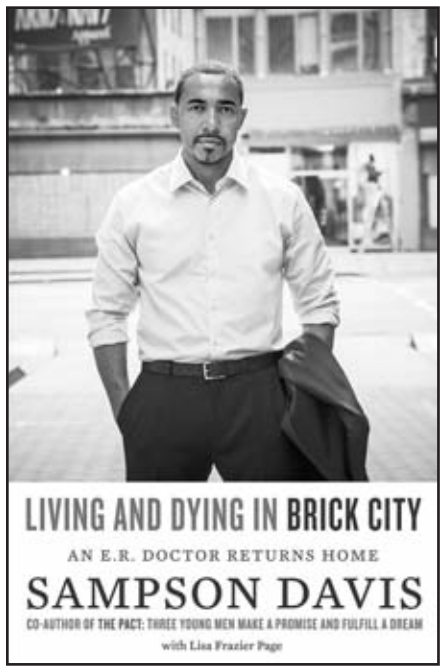
Living and Dying in Brick City by Sampson Davis (with Lisa Frazier Page)

Book Information: c.2013, Spiegel & Grau

$25.00 / $29.95 Canada 245 pages

Throughout your life, you've dodged a lot of bullets.

By accident or design, you were in the wrong place at the wrong time but somehow remained unscathed: the almost-hazard while driving, the near-miss at work, the moment you caught yourself just in time from falling.



Things could've been worse – *much* worse - but you dodged a bullet. So did it make your heart pound, or did it change your life? For author Sampson Davis, it was the latter because, as you'll see in his new memoir "Living and Dying in Brick City" (with Lisa Frazier Page), the bullets were sometimes real.

Sampson Davis hid his intelligence from his friends.

He was an A-student and had, in fact, landed a college scholarship and was on his way to becoming a doctor. But since it wasn't cool to be intelligent, he hid his smarts until he did something dumb: at age seventeen-and-a-half, he gave in to the streets, participated in a robbery, and was caught.

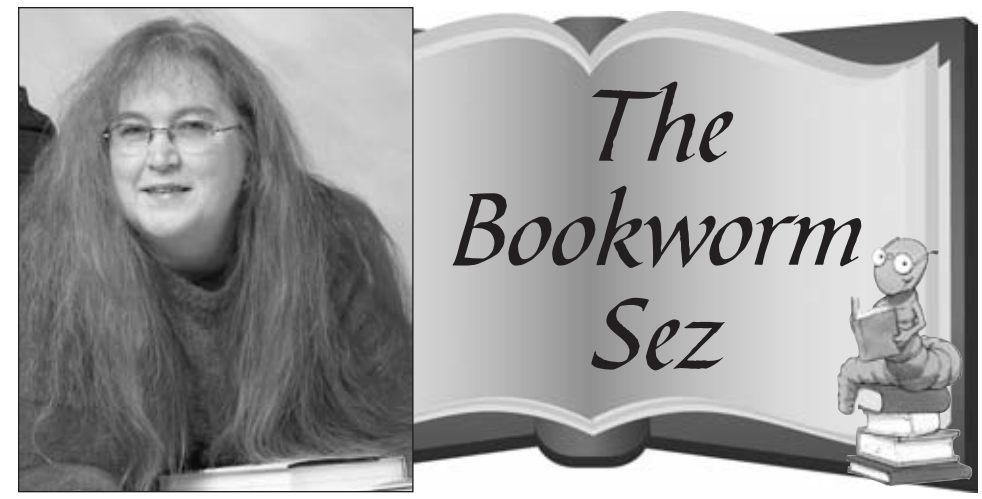
Because he was a juvenile with no prior record, he got off easy with scholarship intact but it was a sobering wake-up call. Grateful for a second chance, Davis buckled down and went to med school.

When given the chance to intern in the emergency department at Newark's Beth Israel Hospital, Davis seized it. He wanted to do something good for his community and working at the hospital where he drew his first breath seemed extraordinarily right. He felt that he could empathize with the patients who were brought to "Beth," and he was correct.

Too correct, as it turns out.

Time and again, Davis discovered to his dismay that he knew the people who lay on the tables in front of him; gunshot victims, domestic violence survivors, addicts, smokers, the sexually active, and the mentally ill.

He knew them – or he knew he might've been one of them, if not for a youthful near-miss and a bullet dodged.



No doubt about it, "Living and Dying in Brick City" is one of those books you want to read slowly, not because it's difficult to understand but because it's difficult to accept that it will end.

But long before that happens, readers are treated to a heart-racing memoir filled with guns, blood, violence, and life's unfairness. Rising above all that, though, is author Sampson Davis' amazingly powerful sense of gratitude: he fully realized that he could very well have been a man on a gurney, rather than the man caring for the man on the gurney.

But that's not all.

At the end of many chapters, Davis offers brief, helpful information and stats on STDs, heart attacks, AIDS, domestic violence and other issues of particular interest to African Americans and inner-city residents. This information and the accompanying stories pretty much glued me to my chair.

As memoirs go, this one's a stunner and if you're a medical professional, fan of medi-dramas, or if you just want a fast-paced book to read, don't miss it. Grab "Living and Dying in Brick City"… and fire away.

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

Neutralizing the Threat of Technology on the Patient and Caregiver Experience

A Triangle of Care approach addresses the evolving point of patient care needs and EMR requirements

By Steve Reinecke, MT (CLS), CPHIMS

Is technology becoming a threat to patient centric care?

In a 2011 New York Times commentary, Dr. Abraham Verghese surmised that hospital staffs are in danger of focusing too much on the technology and less on the patient. His realization came after an experience as an emergency room patient.

"My nurse would come in periodically to visit the computer work station in my cubicle, her back to me while she clicked away. Over her shoulder she said, "On a scale of one to five how is your ...?" wrote Verghese.

As described by Verghese, many caregivers may spend their time focused on a computer screen rather that their patient depending on their digital workflow in the patient room and throughout the floor.

In theory, with the introduction of technological advancements into the healthcare facility, both the patient and caregiver should experience significant gains in overall experience like treatment facilitation, improved safety, and reduced medical errors. And while providing the caregiver with exponentially more information and easier access to such information, the intimate presence of technology in the patient centric experience is a hindrance at times. The problem is not with the EMR requirements but rather the implementation of the technology used to access it.

Effectively integrating technology into all aspects of the healthcare environment without compromising the patient experience requires a new way of positioning all the players—the patient, the caregiver and the technology, into a more favorable alignment, a Triangle of Care, or something Ergotron calls Patientricity™.

Creating a patient-centered environment inclusive of technology, must be done with sensitivity to the needs of the patient and medical staff alike, whether documenting at the bedside or reviewing radiology reports in the lab. Done right, it promotes increased interaction, satisfaction, safety and efficiency into the patient-caregiver exchange. The patient receives the benefit of the face-to-face connection with the caregiver, while the technology becomes a partner to the exchange.

Achieving this balance involves a combination of computer technology and display mounting and mobility solutions properly placed at the point of care. These factors should be explored:

- Avoiding inappropriate or cumbersome placement of technology that impedes the efficiency of care.
- Considering adjustable options that allow caregivers to sit or stand while accessing or inputting data to offer a new level of work flexibility.
- Not skimping on key ergonomic considerations in terms of helping users achieve proper computing postures, and adjustability when manipulating the equipment in and out or up and down.

Evaluating and understanding the human interaction that needs to take place within the digital workflow should remain a primary concern.

Other areas of evaluation include understanding space constraints to determine whether fixed, permanent and dedicated equipment is required, or whether a mobile solution best serves the care-giving requirements of that space. As well, understanding the types of rooms, and levels of care given in each room — critical care, pre-op, post-op, emergency, long-term, children's ward, maternity, etc. — since all require different styles of patient caregiver interaction and duties.

Good news to the administrators, IT directors, physicians, nurses, and support staff facing these challenges, the flexibility to arrange unique display, notebook, and tablet mounting patient-centric configurations is available today — wherever

the patient is — throughout the entire facility and throughout the length of their care.

The Triangle of Care benefit does extend beyond the welfare of the patient to that of medical stakeholders. Since stakeholders come in all shapes, sizes and temperaments; the equipment chosen must accommodate the broadest group of users. The goal is to encourage optimum performance of both machine and person, while fostering meaningful interaction with the patient while gathering critical information. The same factors that influence creating a patient-centric environment apply, like good ergonomics, access to sit-stand adjustability, range of motion, user force, and product safety certifications. Allowing the caregiver to naturally and spontaneously adjust their postural rotations as their body's demand, while staying in the Triangle of Care, opens the door to a more comfortable, stable, focused and energized experience for the caregiver too.

The Triangle of Care, when carefully planned for, offers everyone a new view on care. Dr. Verghese's reminder is a good one. No matter what form the care can take, human interaction is still a key component to cherish and support.

Steve Reinecke, MT (CLS), CPHIMS is Senior Director for the Canada and Eastern US division, for Ergotron, Inc. For more information, visit www.ergotron.com.

Western Pennsylvania Healthcare News wants to hear from you!

How are you using social media to increase awareness?

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

What They Give

By Franco Insana

We make a living by what we get, but we make a life by what we give.

~Winston Churchill

It was one of those many cold mornings we had in March. By all accounts, it was a typical day at The Center for Compassionate Care/Canterbury, Family Hospice and Palliative Care's inpatient center in Lawrenceville, on the campus of UPMC's Canterbury Place.

Despite the chill in the air, though, a certain warmth filled our inpatient unit. It came in the form of a woman bearing a broad smile who had much to give.

Celeste is a retired RN. Despite the fact that she needs the support of a walker to get around, she visits patients at The Center for Compassionate Care/Canterbury a couple of days every week, spending four hours at a time. A Family Hospice volunteer since the summer of 2012, Celeste brings music to play for some patients – and is known as a wonderful presence, providing companionship for patients and realizing their needs even when no words are spoken.

Celeste is one of more than 500 dedicated volunteers that share their time, talents and energy with Family Hospice. And whether these volunteers provide clerical support, patient companionship or staffing at one of our special events, what they give makes a difference in lives each and every day.

Who doesn't like pie? In Hermitage, a volunteer named Virginia is known to visit our Family Hospice office in Mercer County, delivering homemade pies to our staff – a gesture of appreciation for the care we provided to her husband. But beyond that, Virginia's most unique contribution as a volunteer has brought a whole new dimension to Camp Healing Hearts, Family Hospice's annual camp for grieving children and their caregivers. Over the years, Virginia has fashioned by hand a small "village" of puppets, some life-size, and has used them to entertain at events throughout her community. This past year, Virginia created puppets "Hope" and "Sunny" specifically for Camp.

The simple message and story was met with delight by the children, who were then invited to take the stage and manipulate the puppets themselves.

At our Center for Compassionate Care in Mt. Lebanon, Annabelle, Wilma, Ann, Marlin, Jane, Barbara, Francine and Mary are among the volunteers who make it possible for our lunchtime café to serve families and staff alike. These folks greet the lunchtime crowd with a smile and friendly conversation as they run our check-out register and can usually provide a first-hand review on the special of the day.

Family Hospice works closely with many area long-term care facilities. Through our Candlelight Companion program, it is our goal that no patient dies alone. Tracy is a volunteer who ensures that our patients have companionship by sitting vigil with them. Although she works full-time, Tracy makes time for weekly visits, seeing two or three patients during her stops at local nursing facilities, sometimes staying until 11 p.m. or later.

Then there's Kim, a volunteer who helps our North Side office and is famous for never saying no. She provides patient companionship so caregivers may get rest, she volunteers as a Candlelight Companion, *and* spends time helping in our office.

And finally, Mary, a volunteer who literally travels far and wide. Mary visits patients for Family Hospice wherever asked: from White Oak to the North Hills, to Oakmont.

These are just some examples of those we are blessed to call our volunteers. There are so many more and each one plays a vital role. Each one makes a difference by what they give.

Making the Most of Life

Annabelle and Barbara are two of many who give their time and talents as Family Hospice volunteers.

Please join me in thanking the volunteers that make a difference in your corner of the world.

Franco Insana is the Interim CEO and full-time Chief Financial Officer of Family Hospice and Palliative Care. He has more than 25 years experience in business and accounting, particularly in the health care and non-profit environments. He may be reached at finsana@familyhospice.com or (412) 572-8800. Family Hospice and Palliative Care serves nine counties in Western Pennsylvania. More information at www.FamilyHospice.com and www.facebook.com/FamilyHospicePA.

Doctor, Why Are You Hurting Me?

Dr. Steven G. Goldberg, DDS, FADFE

The very thought of going to the dentist sends chills up the spine for many people.

According to worldental.org upwards of 40 million Americans avoid dental care as a direct result of anxiety and the fear of pain.

These statistics are compelling when you consider the consequences of pervasive dental neglect. Maintaining optimal oral health is essential to good overall health. Unfortunately, too many people fail to realize that their teeth and gums share tissue, nerves, and blood with other parts of the body.

Overcoming the fear of going to the dentist:

Communication with the dental professional is the key to overcoming the fear of going to the dentist.

But what if you weren't able to effectively communicate? What if you didn't even understand why you were sitting in the dental chair in the first place? And worst of all, the dentist gives you a painful injection in your mouth, and all you can think of is "doctor, why are you hurting me?"

This is a dilemma facing millions of dental patients who require special attention from dental professionals, more specifically, special needs patients. These patients need dental care and depending on their condition, may or may not be tending to their teeth, or may lack the physical ability, mental capacity, or emotional wherewithal to do so.

Left untreated, these patients are susceptible to tooth decay, gingivitis, periodontitis, and the myriad of complications that can eventually result from inadequate oral hygiene, including potential fatality.

Dentists are more prepared to treat patients with special needs:

As this special segment of our population increases, dental professionals are receiving a much greater, more in-depth education on methods, modalities and compassionate ways to treat patients with special needs.

In 2004, the Commission on Dental Accreditation (CODA) adopted a new standard that directs dental and dental hygiene programs to prepare dental professionals for the care of persons with special health care needs.

According to CODA, "Graduates must be competent in assessing the treatment needs of patients with special needs."

Family members can help:

- Family members of those with special needs can be effective in preparing special-needs patients for a dental appointment. These individuals can assist in care for the disabled by supervising daily toothbrushing, flossing and the use of an antimicrobial mouth rinse.
- Because dental treatment of those with special needs may require additional time, staff attendance and office preparation, family members must see to it that dental appointments are made regularly and as far in advance as possible.
- The caregiver should remain in the operatory during treatment. This can have a calming effect on the patient, as well as support the dental team when needed.
- Bring patients who require special attention on a non-treatment trip to the dentist. Make it a fun visit. Meet the doctor and the staff, and don't forget to make a stop at the treasure chest. The next treatment visit will be that much easier.

New Scientific Technology reduces anxiety and pain:

Special needs patients already deal with an inordinate level of stress and anxiety due to their underlying condition and the sheer number of medical appointments that they must attend. Providing these patients with the most comforting experience possible will substantially reduce their anxiety.

The dental injection is by far the most painful part of any dental procedure. After all, once you're anesthetized, the dental procedure is relatively painless. DentalVibe® Injection Comfort System is a new scientific device that dentists use to block the pain of dental injections.

When using the DentalVibe on a patient with Autism, Dr. Victor Avis, DDS of Staten Island, NY said "it was amazing, Justin sat comfortably and acted as if I had done nothing at all!"

Dr. John C. Comisi, DDS, MAGD of Ithaca, NY said, "Andrew holds out two fingers, resembling the vibrating prongs of the vibe, before I begin a procedure, I won't ever treat him without it!"

There are certainly challenges inherent in the dental treatment of patients with special needs, but they are far from insurmountable.

With recent advancements in dental technology and education, these challenges will be overcome.

LEMIEUX From **Page 1**

Landau Building Company worked closely with David Wells, principal architect with Radelet McCarthy Polletta Incorporated Architects and Interior Designers, UMPC, and other members of the construction team to renovate the 4th floor of the UPMC Hillman Cancer Center.

David Wells said, "It was nice for UPMC to allow us to join with Landau as the project manager early in the process. We started working together when we were about 50 percent through the documentation process and they could share their expertise which helped us work more effectively."

Wells said that working together with Landau, they were able to keep the project costs well within budget and use products that were most effective both in usage and costs. They also worked with Landau's subcontractors, again saving costs and time on the project.

The new center was also created with the Hillman staff in mind. Van Soest said that the goal was to create an area that was patient and family friendly, but also making it easy for staff to do their jobs – all within the constraints of a budget.

"The entire team went to great length to interview patients elsewhere in the facility to see what they wanted and what they didn't enjoy about the treatment process," he explained, "They wanted an area that was calming and made them feel like home, not an institution."

The design and construction team also had roundtable discussions with staff to see what their needs were.

"We talked with not only the doctors and nurses, but also the staff that was in charge of replenishing stock. We wanted to keep supplies accessible, but not visible," he said.

The "spa-like" reference was one that kept coming up, said Van Soest. Keeping that in mind, when the area was created, it became a setting that didn't look like a typical treatment center, rather one where patients could relax, even while receiving treatment.

"We wanted them to relax, a feeling that is usually counter what someone is normally feeling when they are undergoing cancer treatment," he said.

Landau Building Company was responsible for constructing the area that had to workaround several banks of electrical and teledata conduits that had to remain in place. Additionally, 50 percent of the area to be renovated was occupied for the first six weeks of construction.

A special feature of the new Center is the outdoor terrace, said Van Soest.

"In most treatment facilities, patients are sitting in a back corner, under a florescent light, with only a magazine or TV to help pass the time. That's not really the most healing of settings – the terrace is a totally different setting," he said.

The area has shaded areas, open areas and a small putting green for patients and their families. Even the smallest of details were taken into account. The terrace surface is level, created without gaps in the pavers or a pitch in the surface for ease in walking with an IV pole or other medical considerations.

Van Soest said the construction phase of the project began in May 2012 with an expected completion date of February of this year, but during construction, Landau indentified and captured of several cost-savings measure that created a budget surplus and allowed them to complete the project early. UPMC and The Mario Lemieux Foundation hosted the dedication in December of 2012 – two months early. Mario and Nathalie Lemieux attended the ceremony.

The Mario Lemieux Center for Blood Cancers project was one that Van Soest said was a "dream project."

"I am most proud of the collaboration of the entire team. We wanted it to be the première Cancer Center and to give the UPMC staff and patients everything we wanted within the constraints of the budget," he said, "And we achieved that."

For more information, visit www.mariolemieux.org.

A.E.D.S From **Page 1**

moments necessary for SCA revival. They can be stuck in traffic, out on another call, across town, or any one of many variables. When SCA strikes, you have a 10-15 minute window of saving that victim. Which minute did you find the person? Are you willing to take a chance and wait, or begin the life-saving technique of CPR combined with the availability of an A.E.D.? For every minute that goes by, an SCA victim's chance of survival goes down 10%.

Still another reason for the A.E.D. void is the fear of liability. Can I get sued? Should I get involved? What if I hurt the victim? All are good questions but all with easy answers. The Good Samaritan Act protects you. The same law that protects you from pulling someone out of a burning car. An A.E.D. will not let you shock someone if they are not in true cardiac arrest. Therefore if the victim is unconscious for another reason, low blood sugar, fainting, or any other reason, the A.E.D. will not let you shock the victim. You simply cannot hurt, but only can help matters. The only time liability comes into play is when an A.E.D. is not properly maintained. Today's devices have long battery and pad life, however, they must be paid attention to. Nothing could be worse than to implement an A.E.D. program and have the device not work when you need it most, just because no one kept it updated.

The excuses are gone, the reasons removed. A.E.D.s have a place in all public domains. If you know of a company, golf course, health club, school or church that doesn't have an A.E.D., find out why. Talk to those who have them and hear their stories of success and implementation. You might even owe it to yourself. It could be a matter of life and breath.

Kevin O'Neill is President of Square One Medical, distributor of the Zoll A.E.D. Plus, wound care products, nutritional supplements and more since 1996. Follow Square One on Twitter @MedSupplyGuy, FACEBOOK, and www.sq1med.com or can be reached at 724-779-2278

Submissions? Story Ideas? Suggestions?
Contact Daniel Casciato at
writer@danielcasciato.com

HONOR ROLL

Kim Tillotson Fleming, CFA, Honored for Supporting Health Care in Pittsburgh Region


Kim Tillotson Fleming

The Allegheny County Medical Society (ACMS) presented **Kim Tillotson Fleming, CFA**, with the Benjamin Rush Individual Award during the ACMS Foundation Gala, Pittsburgh Proud, its annual community awards and fundraising gala at the Omni William Penn Hotel on April 6.

Established in 1947, the Benjamin Rush Individual Award recognizes an individual who is not a practicing healthcare professional, who devotes time, skills or resources to assisting others and contributes to the advancement of healthcare.

In 2010 Fleming was elected chairman and chief executive officer of Hefren-Tillotson, Inc. a privately held Pittsburgh-based firm offering comprehensive financial planning and investment advisory services for individuals, foundations, trusts and qualified retirement plans. She had served as president of Hefren-Tillotson since 1996.

Fleming is a graduate of Northwestern University with a degree in Economics and holds several professional designations. A member of numerous financial associations and societies, Fleming also serves on the boards of Allegheny College, Allegheny Conference on Community Development (Treasurer), The Buhl Foundation, Pittsburgh Civic Light Opera Dollar Bank, Imani Christian Academy and The Pittsburgh Foundation.

She was recognized for the countless hours she has dedicated to many of the health institutions in the Pittsburgh region, including serving on the board of UPMC Health Plan. In addition, she has served on the capital campaign committees for the Children's Institute of Pittsburgh, the University of Pittsburgh Cancer Institute, and Children's Hospital. She is also a deacon and youth leader at Hiland Presbyterian Church.

Fleming co-chaired the United Way Women's Leadership Council in 2007 and 2008. She was twice named an Athena Award finalist and in 2005 received YWCA's "A Tribute to Women Leadership" award for business.

In April 2012, Carlow University awarded her with the Women of Spirit Award for Values, which recognizes a woman who leads her company to higher realms of excellence and service by personal example and commitment to others. Also in 2012, Geneva College honored Fleming with their Serving Leaders Award. This service award is presented annually to a person of faith who implements servant-leadership qualities in their life and work.

Fleming has also been actively involved with local, national, and international project-related mission trips, including annual youth group work camps.

ALPHA Pittsburgh, Inc. and former Allegheny County Health Department Director Honored with *Pittsburgh Proud* Award


Bruce W. Dixon

The Allegheny County Medical Society (ACMS) presented ALPHA Pittsburgh, Inc. (AIDS Leadership for Prevention and Health Awareness) with a Pittsburgh Proud Award during the ACMS Foundation Gala, *Pittsburgh Proud,* its annual community awards and fundraising gala at the Omni William Penn Hotel on April 6.

The Pittsburgh Proud Award recognizes individuals or groups who have made a significant contribution to improve health in the community that makes us 'Pittsburgh Proud.'

ALPHA Pittsburgh, Inc. is a group of HIV+ men and their allies who are dedicated to increasing HIV/AIDS awareness in Southwestern Pennsylvania. ALPHA seeks to reduce the stigma surrounding HIV/AIDS and empower the community to reduce homophobia and promote wellness within their community. ALPHA is the only advocacy group established by consumers with a mission to address HIV/AIDS issues in the region.

The vision of ALPHA is to reduce and end stigma in the gay community; advocate for LGBT health including gay men's health education; educate people at risk for HIV; and develop leadership among HIV positive gay men and their allies.

Recent accomplishments include building a presence within the HIV/AIDS communities and ensuring that funding for prevention is distributed according to the priorities that helped to define this region. ALPHA endorses a methodical approach to prioritizing prevention efforts in the region that is supported by appropriate data. They endorse evidence-based prevention interventions specifically targeted at the priority groups based on the most recent data. They continue to participate and speak out on behalf of the HIV/AIDS community.

ACMS also presented **Bruce W. Dixon, MD,** (posthumously) with the Pittsburgh Proud Award. Dr. Dixon worked to improve the health and safety of the state of Pennsylvania as a physician, professor, and leader in public health since the 1960s. Dr. Dixon received a bachelor of science degree in chemistry from the University of Pittsburgh School of Medicine in 1961 and a doctor of medicine degree from the University of Pittsburgh School of Medicine in 1965. He completed his residency at Duke University and then served on the university's faculty before returning to the University of Pittsburgh in 1975.

Physician Honored for Exemplary Service to Organized Medicine


Ralph Schmeltz

The Allegheny County Medical Society (ACMS) presented ***Ralph Schmeltz, MD, FACP, FACE,*** with the Frederick M. Jacob Service Award during the ACMS Foundation Gala, *Pittsburgh Proud*, its annual community awards and fundraising gala at Omni William Penn Hotel on April 6.

The Frederick M. Jacob Service Award, established in 1966, honors a physician who has performed outstanding service to ACMS through demonstrated leadership in the improvement of healthcare in the community.

A member of ACMS since 1973, Dr. Schmeltz has dedicated his time and efforts to physicians through organized medicine for more than 20 years.

He has served on several committees including Member Benefits Committee, Bio-ethics Advisory Committee, Peer Review Board, Medical-Legal Committee, Third Party Liaison Committee, Managed Care Committee, Board of Directors, and the Primary Care Coalition.

Dr. Schmeltz, who specializes in internal medicine and endocrinology, has fulfilled other leadership roles including president of the Pennsylvania Endocrine Society; president of the Pennsylvania Society of Internal Medicine; Governor of the PA Chapter of the American College of Physicians, and chair of the Health and Public Policy Committee of the Pennsylvania Chapter of the American College of Physicians.

In addition, he serves on the Legislative and Regulatory Committee, Socioeconomics and Advocacy Committee, and the Task Force on the Future of Medicine of the American Association of Clinical Endocrinologists.

Dr. Schmeltz also serves on the board of the Pittsburgh Regional Health Initiative.

Dr. Schmeltz recently received the Laureate Award from the Pennsylvania Chapter of the American College of Physicians.

The award honors ACP Fellows and Masters who have demonstrated a commitment to excellence in medical care, education, research and service to their community, their region and the college.

At the state level Dr. Schmeltz was a founding member of the Subspecialty Leadership Cabinet; internal medicine (primary care) trustee and Patient Safety Committee member. He served on the Task Force on Board Leadership & Membership Roles/Accountability and chaired the Task Force on the State of Medicine.

In 2010 he served as president of the Pennsylvania Medical Society. Governor Ed Rendell also appointed Dr. Schmeltz to the Pennsylvania Commission on Chronic Care Management, Reimbursement and Cost Reduction from 2007 to 2010.

Dr. Schmeltz earned his medical degree from the State University of New York College of Medicine Downstate Medical Center.

He served his internship, residency and training in endocrinology and metabolic disease at the University of Pittsburgh School of Medicine.

Dr. Schmeltz practiced medicine at UPMC from 1974 to 2004; he served as associate chief of medicine at Magee Hospital where he directed a rotation for senior medical residents in Medical Complications of Pregnancy.

He also served as chief of endocrinology at St. Clair Hospital before moving to the Washington Hospital in 2004 where he was director of the Diabetes Education and Management Program.

In addition, Dr. Schmeltz currently serves as clinical professor of medicine at the University of Pittsburgh School of Medicine.

He served his country as a flight surgeon in the United States Air Force, achieving the rank of major.

He flew combat missions in Vietnam and was chief of aerospace medicine at the USAF Regional Hospital, Westover Air Force Base, Massachusetts.

Dr. Schmeltz and his wife Sheila reside in Pittsburgh and have four grown children and twelve grandchildren.

HONOR ROLL

Physician Honored as Outstanding Humanitarian


Dayle B. Griffin

The Allegheny County Medical Society (ACMS) presented **Dayle B. Griffin, MD** with the Physician Volunteer Award during the ACMS Foundation Gala, *Pittsburgh Proud*, its annual community awards and fundraising gala at the Omni William Penn Hotel on April 6.

The Physician Volunteer Award recognizes a physician for the donation of their time or talents for charitable, clinical, educational or community service activities, domestically or internationally.

Dayle B. Griffin, MD, a board-certified pediatrician and medical director of St. Clair Hospital's Pediatric and Newborn Services, has been making medical mission trips since her residency years. During residency, she traveled to Nicoresti, Romania, just after the fall of the dictator Nicolae Ceausescu, to spend a month caring for and evaluating the abandoned children in that country's notorious orphanages. While still in residency, to help address the need of local underserved children, Dr. Griffin founded a free pediatric clinic at Jubilee Kitchen in the Uptown section of Pittsburgh. In 1999 she began making trips to La Croix, Haiti, with Daniel Lattanzi, MD, sometimes making multiple trips in one year.

In January 2010, Dr. Griffin was collecting donations and making plans for her annual trip to the village of La Croix when an earthquake struck the impoverished nation. The earthquake left a path of death and devastation in its wake, particularly in the capital city of Port-au-Prince, the epicenter of the quake. Located about 90 miles north of Port-au-Prince, La Croix was spared during the unprecedented natural disaster; however, the people, its medical center, maternity center and school were still in desperate need following two hurricanes that tore through the village in 2008. In addition, many refugees, injured, homeless, hungry and desperate for help, had fled there after the quake.

Although her scheduled commercial flight to Haiti was cancelled due to the earthquake, Dr. Griffin managed to fly into Port-au-Prince, one week after the earthquake on a medical relief flight organized by a Pittsburgh area businessman. Dr. Griffin journeyed to La Croix and nearby communities where she worked steadily for a week. When she returned to Port-au-Prince for transportation back to the United States, she received word that pediatricians were urgently needed at St. Damien's Hospital, a children's hospital. Dr. Griffin stayed, working virtually non-stop for another week in Port-au-Prince.

During her multiple trips to La Croix, Dr. Griffin has worked with remarkable physicians to provide much needed medical attention to patients of all ages suffering from a host of ailments, such as severe malnutrition, HIV, syphilis, malaria and typhoid. The Haitian mothers and mothers-to-be also covet Dr. Griffin's skills as a pediatrician. During other trips to La Croix, she has spent time with the midwives helping to train them to provide quality health care for newborns and their mothers.

She earned her doctor of medicine from Howard University and completed her pediatric residency at Mercy Hospital of Pittsburgh. Dr. Griffin received St. Clair Hospital's 2011 Physician Recognition Award, which is given to only one outstanding physician annually.

Physician Honored with Humanity in Medicine Award


Daniel H. Brooks

The Allegheny County Medical Society (ACMS) presented **Daniel H. Brooks, MD** with the Richard E. Deitrick Humanity in Medicine Award during the ACMS Foundation Gala, *Pittsburgh Proud*, its annual community awards and fundraising gala at the Omni William Penn Hotel on April 6.

The Richard E. Deitrick Humanity in Medicine Award honors a physician who has improved the lives of patients by caring for them with integrity, honesty, and respect of their human dignity, and serves as a role model for other physicians.

A graduate of the University of Pittsburgh School of Medicine, Dr. Brooks began his career with the University of Pittsburgh School of Medicine before becoming the head of the Division of General Surgery at Allegheny General Hospital from 1976 to1978. Following this appointment, Dr. Brooks joined Surgical Associates of Sewickley where he remained until 2000 when he joined Heritage Valley Health System as vice president and chief medical officer, and later as chief operating officer of Heritage Valley Sewickley. Since 2008, Dr. Brooks has held the position of vice president, Community Health Services, where he directly and indirectly touches the lives of thousands of patients through his leadership of Heritage Valley's prevention and wellness programs, behavioral health services, outpatient diagnostic centers and other community-focused services.

Through Dr. Brooks' leadership, Heritage Valley has initiated programs that address pediatric obesity, pediatric asthma, low birth weight babies and prevention and management of diabetes, resulting in successful health-related outcomes and improved quality of life for more than 23,000 individuals and their families within the communities served by Heritage Valley.

Also under his leadership, Heritage Valley has remained committed to the delivery of behavioral health services in the community. Heritage Valley's Staunton Clinic, a mental health and mental retardation treatment and resource coordination center, has expanded to six locations in the communities served by Heritage Valley.

Dr. Brooks also oversees the services of Heritage Valley's nine diagnostic centers. Most recently, Dr. Brooks has been instrumental in the integration of new strategic mobile MRI services that provide patients with the convenience of accessing primary care, as well as ambulatory and diagnostic services in one easy community location.

He has served and continues to serve on a number of boards and committees including, the Hospital and Health System Association of Pennsylvania (HAP), Health Policy Institute, Valley Care Associates and the Pittsburgh Fellows. He received the ACMS Frederick M. Jacob Award in 1986 for his outstanding service to the medical society and leadership and advocacy for patients and physicians.

Dr. Brooks and his wife Loretta reside in Sewickley.

For more information, visit www.acms.org.

Primary Care Physician Recognized for Outstanding Dedication to Patients


Gregory L. Molter, DO

The Allegheny County Medical Society (ACMS) honored **Gregory L. Molter, DO,** with the Nathaniel Bedford Primary Care Physician Award during the ACMS Foundation Gala, *Pittsburgh Proud,* its annual community awards and fundraising gala at the Omni William Penn Hotel on April 6.

The Nathaniel Bedford Primary Care Physician Award, presented by the ACMS since 1975, recognizes a primary care physician for exemplary, compassionate, comprehensive and dedicated care of their patients.

Dr. Molter graduated from West Virginia School of Osteopathic Medicine in 1986 and completed his internal medicine residency at Allegheny General Hospital (AGH), where he served as chief resident in 1991. Board certified in internal medicine, Dr. Molter is a practicing internist with North Hills Internal Medicine.

In addition to demonstrating the exceptional qualities of an attentive and caring physician, Dr. Molter is also dedicated to mentoring students and serves as assistant professor of medicine, Drexel University College of Medicine. He has served on the AGH Curriculum Committee since 1991 and the Pastoral Care Committee since 1993. Dr. Molter is also serving as president-elect of the AGH medical staff through the year 2014.

For more information, visit www.acms.org.

HONOR ROLL

World-Renowned Physician Honored for Outstanding Care of Cancer Patients in Pittsburgh Region


James D. Luketich

The Allegheny County Medical Society (ACMS) presented **James D. Luketich, MD, FACS,** with the Ralph C. Wilde Leadership Award during the ACMS Foundation Gala, *Pittsburgh Proud*, its annual community awards and fundraising gala at the Omni William Penn Hotel on April 6.

The Ralph C. Wilde Leadership Award recognizes a physician who demonstrates exceptional skill in their clinical care of patients and dedication to the ideals of the medical profession as teacher or profession leader.

Dr. Luketich is a leader in thoracic and esophageal surgeries at a national and international level. He has made significant contributions to the development and refinement of minimally invasive techniques to perform numerous complex operations, including performing more than 1,500 minimally invasive esophagectomies.

He has dedicated his career to teaching and education, in addition to clinical surgery and research. He has been chief of the Heart, Lung and Esophageal Surgery Institute at the University of Pittsburgh Medical Center since 2005. He is the associate director, Surgical Affairs, University of Pittsburgh Cancer Institute and the director, Mark Ravitch/Leon C. Hirsh Center for Minimally Invasive Surgery. In addition, Dr. Luketich was named to the prestigious Henry T. Bahnson Chair of Cardiothoracic Surgery and is currently serving as the inaugural chairman of the Cardiothoracic Department of Surgery at the University of Pittsburgh School of Medicine.

He is the principal investigator or co-investigator on numerous research grants and has published more than 750 peer-reviewed manuscripts, invited reviews, textbook chapters, editorials and abstracts combined. He is frequently invited as an honored speaker around the world to present topics that relate to his research and minimally invasive techniques.

Dr. Luketich presented the results of more than 1,000 patients who had undergone minimally invasive esophagectomy in Pittsburgh, with a very low mortality rate, at the annual conference of the American Surgical Association in 2011, establishing the region as a world leader in the care of these patients. He has also published the largest series of minimally invasive surgery for complex esophageal disorders such as giant paraesophageal hernias, achalasia, and patients with complex GERD. He works closely with his vice chairmen, Rod Landreneau, MD and Victor Morell, MD, who oversee other aspects of the department including lung cancer and cardiovascular diseases, respectively.

He is a member of numerous professional and surgical societies including the American Surgical Association, Society of Surgical Oncology, American Association for Thoracic Surgery, Pennsylvania Oncologic Society, Society of American Gastrointestinal Endoscopic Surgeons, American College of Gastroenterology, Society of Laparoendoscopic Surgeons and more.

Dr. Luketich received his master's degree in biochemistry from Vanderbilt University in 1980 and his medical degree in 1986 from the Medical College of Pennsylvania in Philadelphia. He completed his general surgery residency in 1992 at the Hospital at the University of Pennsylvania, where he was the chief resident of surgery from 1992-1993. He completed his cardiothoracic and thoracic training at New York Hospital, Cornell Medical Center and the Memorial Sloan-Kettering Cancer Center in New York.

Dr. Luketich resides in Fox Chapel with his wife Christine and their two youngest children, Samuel and Alex. Their older children, Robert, Patricia and Derek all maintain strong Pittsburgh ties as well.

Western Pennsylvania Kidney Support Groups Honored with Community Health Award

The Allegheny County Medical Society (ACMS) presented the Western Pennsylvania Kidney Support Groups with the Benjamin Rush Community Organization Award during the ACMS Foundation Gala, *Pittsburgh Proud*, its annual community awards and fundraising gala on April 6.

Established in 1947, the Benjamin Rush Community Organization Award recognizes a company, institution, organization or agency that is successfully addressing a community health issue.

The Western Pennsylvania Kidney Support Groups was founded in 2010 to offer support, companionship, understanding, information, networking, hope and peace of mind for those with kidney disease, dialysis patients, kidney and kidney/pancreas transplant recipients, those waiting for a transplant and caregivers.

The organization provides an outlet in small group settings for those individuals to share their experiences and strives to empower others to face the trials and tribulations of kidney disease with courage, determination and confidence.

Twice a year, in the spring and fall, the Western Pennsylvania Kidney Support Groups co-sponsor educational seminars dealing with chronic kidney disease, dialysis and renal transplantation. The organization works with UPMC, Allegheny General Hospital, and the area dialysis centers to help support those patients on dialysis who are awaiting kidney and kidney / pancreas transplants.

Originally, the support group was established more than a decade ago under the auspices of what was then the National Kidney Foundation of Western Pennsylvania. Today, the Western PA Kidney Support Groups operate as a separate not-for-profit organization and has evolved into seven chapters — Pittsburgh West, Pittsburgh East, Cranberry, Imperial, Westmoreland County, Kittanning and a pediatric group in Hermitage — with over 400 participants and a growing demand for more groups. Plans are underway to form chapters in Erie and Altoona.

HONOR ROLL

Noted Forbes Regional Hospital Cardiothoracic Surgeon Receives AHA Peter J. Safar Pulse of Pittsburgh Award


Ronald V. Pellegrini

The American Heart Association, Allegheny Division has named **Ronald V. Pellegrini, MD,** a distinguished cardiothoracic surgeon from the West Penn Allegheny Health System Cardiovascular Institute at Forbes Regional Hospital, recipient of the 2013 Peter J. Safar Pulse of Pittsburgh Award. The award was presented at the 2013 Pittsburgh Heart Ball on February 23, at the David L. Lawrence Convention Center.

Over a span of 40 years as one of western Pennsylvania's most respected cardiac surgeons, Dr. Pellegrini has put his imprint on the advancement of cardiac surgery at most of Pittsburgh's major health institutions, first at Mercy Hospital – as Chief of Surgery and its Division of Cardiovascular Surgery, then at the University of Pittsburgh – as Director of Adult Acquired Heart Disease, Clinical Assistant Professor of Surgery and Director of Adult Cardiac Surgery, and finally now at West Penn Allegheny's Forbes Regional.

Recognized locally and nationally for his outstanding surgical skills and innovation, Dr. Pellegrini is equally celebrated as an exceptional teacher who has helped train a generation of surgical residents and cardiovascular surgical fellows.

From the earliest days of his medical career in Pittsburgh, Dr. Pellegrini has helped raise the bar for cardiac surgery in the region. In 1974, he led the team implanting the first commercial intra-aortic balloon pump – expanding the availability of what was then a pioneering heart assist technology. He also established and served as medical director of Duquesne University's Perfusion Program, which at the time was one of the few such training programs in the country.

Dr. Pellegrini is perhaps best known for his contribution to the advancement of mitral valve surgery in Pittsburgh. Recognizing a growing volume of patients in the region with mitral valve disease, he traveled to France to learn the latest techniques in mitral valve repair from the renowned cardiac surgeon Alain Carpentier, MD, Ph.D. - considered the "father of modern mitral valve repair." Dr. Pellegrini brought his new expertise in mitral valve repair home to western Pennsylvania, offering patients a pioneering new approach to their problem and ultimately training other local surgeons in the technique.

As the founder of Three Rivers Cardiac Institute, Dr. Pellegrini is also credited with expanding the availability of cardiac surgery services in growing communities around Pittsburgh, creating half a dozen high quality cardiac surgical programs at hospitals throughout Western Pennsylvania. Among those programs he established include those at Washington Hospital, Passavant Hospital, Butler Hospital and St. Clair Hospital.

Academically, Dr. Pellegrini has also made important contributions to his field. He has published nearly 50 papers in peer-reviewed literature, including some of medicine's most prestigious journals, and has presented lectures and research at over 100 regional and national professional meetings. In 2008, in recognition of his accomplishments, Dr. Pellegrini received an Honorary Doctor of Science Degree from his alma mater, Washington and Jefferson College. During his 11 years as Chief of Adult Cardiac Surgery at Pitt, he won the Cardiothoracic Surgery Faculty of the Year Award three times.

For more information, visit www.heart.org.

Healthcare Professionals in the News

Reformed Presbyterian Woman's Association Names New Chief Operating Officer and Nursing Home Administrator


Rebecca Brady

Rebecca Brady has joined the staff of the Reformed Presbyterian Home as Chief Operating Officer and Nursing Home Administrator. Ms. Brady's hiring, effective March 18, was announced by the Reformed Presbyterian Woman's Association, the governing Board.

A resident of Bethel Park, Brady has more than 25 years of leadership experience in the combined fields of insurance, financial planning and healthcare operations and previously served as the Regional Director of Operations, Real Estate and Expense Control for CIGNA HealthCare.

Brady holds a B.S. in Business Management from Robert Morris University and obtained her Nursing Home Administrator's license from the Pennsylvania State Board of Examiners of Nursing Home Administration. She began her relationship with the Reformed Presbyterian Home in 2012 while completing an Administrator-in-Training program on campus.

Caring for seniors since 1897, Reformed Presbyterian Home is a Continuing Care Retirement Community, offering several living options: personal care, skilled nursing care and stylish, low-maintenance apartments. The Home also offers short-term rehabilitation services. Located in the Perry Hilltop neighborhood on Pittsburgh's Northside, Reformed Presbyterian Home is convenient to Downtown and North Hills communities.

For more information, visit www.rphome.org.

Health Care Event & Meeting Guide

St. Barnabas Charities 113th Founder's Day Celebration
Thursday, May 2
St. Barnabas Nursing Home, 5827 Meridian Road.
Visit www.stbarnabashealthsystem.com

ELITE Summer Simulation Workshop
June 6-7
Hilton Garden Inn, Pittsburgh University Place
Details at www.nursing.pitt.edu/elite/workshops.jsp.

Ohio Valley General Hospital 28th Annual Golf Fundrive
Monday, June 10
Allegheny Country Club in Sewickley
Call 412-777-6359 or email ahrabik@ohiovalleyhospital.org.

Health Care Event & Meeting Guide

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

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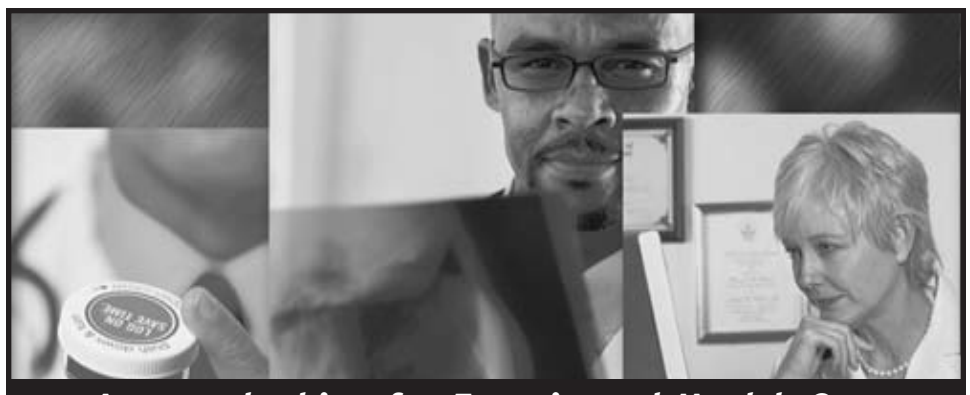

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Or visit us at Baptist Homes
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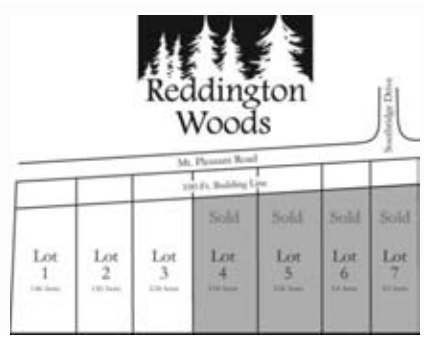

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Robotic Surgery at Forbes Regional Hospital Advances Healthcare in the Eastern Suburbs

For Mary Valentine, 69, of Murrysville, the difference between traditional open surgery and robotic-assisted minimally invasive surgery was remarkable. Ms. Valentine had a robotic-assisted hysterectomy and bladder repair surgery at Forbes Regional Hospital in January, under the care of surgeon Mark Rubino, MD.

"Typically someone at Mary's age with this type of surgery would need four to six weeks to fully recover," said Dr. Rubino, Chief Medical Officer at Forbes. "She was a very educated patient, however, who explored her options and decided a robotic minimally invasive technique was worth pursuing."

She was discharged in less than 24 hours after her procedure and back to normal activities within seven days of her surgery, Dr. Rubino said.

Mary's biggest fear was the unknown. "I did not know what to expect, but after discussing the robotic procedure and its benefits with Dr. Rubino I felt much more comfortable," she said.

Mary's husband, Raymond, was also very supportive and did his homework in researching the new technology prior to Mary making a decision. He too was amazed at her quick recovery.

"The hardest part was that she was trying to do too much because she felt well enough. I could not believe it," he said. Mary took only ibuprofen for the pain the following day and never had to fill the prescription for stronger pain killers.

"I feel great and I am just very thankful for the care I received at Forbes," she said.

One year in, the robotic surgery program at Forbes Regional continues to grow. To date, Forbes physicians have completed 170 robot-assisted surgeries. The most common procedures performed robotically are colon resections, single site cholecystectomies, hysterectomies and other gynecological procedures, such as endometriosis resections.

Last year, Forbes became just the second hospital in the region (joining sister institution Allegheny General Hospital) to launch a robotic cardiac surgery program, using the technology to perform single vessel bypass procedures. Moving forward, the hospital plans to expand its thoracic and urological robotic surgery capabilities as well.

Eight physicians at Forbes have been certified to perform robotic procedures; James McCormick, MD, colorectal surgery; Peter Naman, MD, surgery; Mark Rubino, MD gynecology; Diem Nguyen, MD, gynecology; Mike Pelekanos, MD, gynecology; Bernard Peticca, MD, gynecology; Michael Culig, MD, cardiothoracic surgery; and Leonard Selednik, MD, gynecology.

Originally developed by NASA for operating remotely on astronauts in space and used by the Department of Defense to operate on soldiers in the battlefield, the da Vinci System is comprised of two primary components, a remote console that accommodates the surgeon and a five armed robot that is positioned at the patient's side.

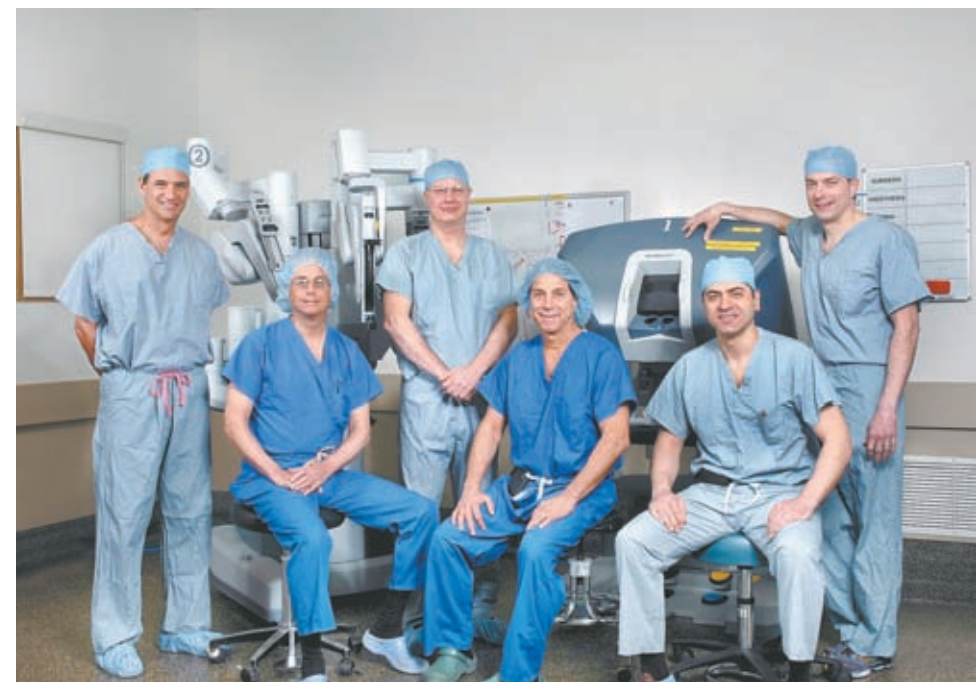
Sitting comfortably at the console several feet away from the operating room table, the surgeon maneuvers da Vinci's robotic arms and views the surgical field through a high resolution, three dimensional endoscopic camera mounted on one of them.

The System seamlessly and precisely translates the surgeon's natural hand, wrist and finger movements from controls at the console to the robotic surgical instruments inside the body. A specially trained surgical team stationed at the bedside helps facilitate the operation.

"We have known for decades that laparoscopic and minimally invasive surgical approaches for colon and rectal surgery produce far better outcomes than traditional open, large-incision surgery. Robotic technology advances this capability tremendously, providing vastly improved visualization of the operative field and superior dexterity that allows movement of surgical instruments in areas that have often been considered difficult to access," said Dr. McCormick, Vice Chair, Department of Surgery at Forbes.

"The da Vinci Robotic Surgical System frankly allows me to offer a better procedure with a better outcome to more patients," he said.

For more information, visit www.wpahs.org.



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UNITY TWP 2002 HIGHLAND DRIVE $475,000

This incredible home with custom oak trim and plaster mouldings throughout. Was built by Tom Hudock. Soaring ceilings in the living and dining rooms. 25x11 sunroom to better enjoy the private back yard. Oversized, heated garage Impressive 2 story foyer with 2 chandeliers, expansive mountain views, neutral decor, huge basement- ideal for finishing!

UNITY TWP 130 LAKEWOOD ROAD $495,000

Gorgeous 2 story brick home with gated entrance. Hardwood floor 2 story entry. Open 2 story family room with gas fireplace. Island eat-in kitchen with tons of storage space and room to prepare family meals. 1st floor den/office for working from home, Beautiful master suite with large walk- in closet in bath. Incredible loft area for additional family room/play room. Great space in lower level allows for entertaining in the game room and exercise room/play room as well.

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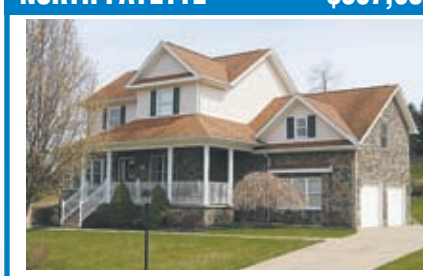

Exciting design in Stonebridge, island kitchen w/ solid surface island, ss appliances & plantation shutters, sun room with 2 window walls, deck & level yard.

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PINE TOWNSHIP $545,000

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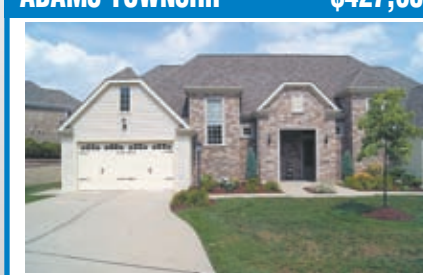

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Children's Hospital Study Reveals Success Rate of Minimally Invasive Surgical Approaches in Infants

Around the Region

Blockage between the kidney and the ureter in infants can be successfully repaired with minimally invasive surgical approaches, according to a Children's Hospital of Pittsburgh of UPMC study. The findings are published in the April issue of *The Journal of Urology*.

Ureteropelvic junction (UPJ) obstruction is the most common obstructive urinary system disease in infants, according to senior investigator Michael Ost, M.D., chief, Division of Pediatric Urology at Children's Hospital. The problem typically has been repaired with a procedure called pyeloplasty, in which an incision is made in the infant's side to reach and remove scar tissue where the kidney meets the ureter, the tube that carries urine to the bladder.

The minimally invasive approach – called transperitoneal laparoscopic pyeloplasty, which can also be done with robot assistance – has emerged as a safe, effective alternative to the standard open pyeloplasty. Both laparoscopic and open pyeloplasty have comparable effectiveness in pediatric patients, but the role of infants is less well defined.

"This population can be challenging to treat laparascopically because of the small size of the abdomen and caliber of the ureter," Dr. Ost said.

His team reviewed records of 29 children younger than 12 months old treated with transperitoneal laparoscopic pyeloplasty for UPJ obstruction from May 2005 to February 2012.

Of the 24 patients for whom follow-up data was available, 22 (92 percent) had successful repairs. Two patients required a second, open procedure to correct the obstruction.

"Our results show the laparoscopic approach is a safe and effective option for the surgical management of UPJ obstruction in the infant population," said Dr. Ost. "Our early experience reveals a developing success rate comparable to that of other treatment modalities with minimal morbidity."

For more information, visit http://www.chp.edu/minimally+invasive+surgery.

Jane and Rick

Jane and Rick were new grandparents and avid walkers. Jane suffered extensive injuries when she was hit by a car. After several surgeries, she transferred to HCR ManorCare where she received intensive medical and rehabilitation services to help regain her ability to care for herself and learn to walk again.

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