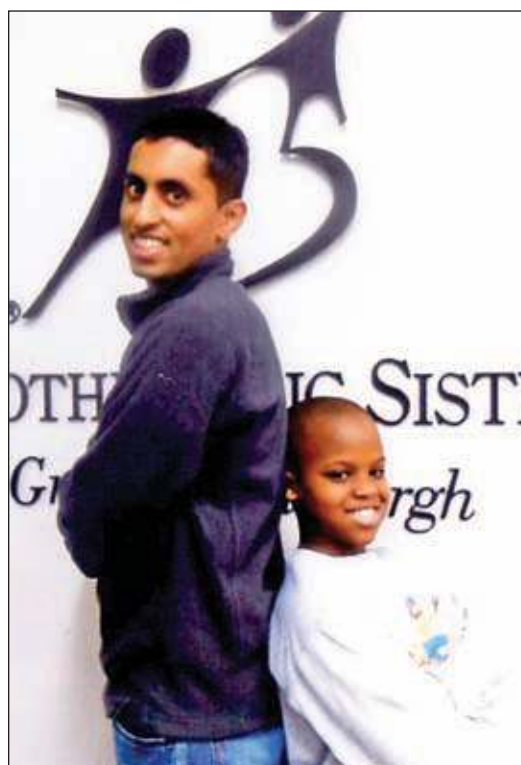


Making the Most of Life



By Dr. Prakash Jayabalan

Along with my parents, I have been fortunate to have had fantastic mentors who provided me with inspiration to further my own career as a physician.

My Ph.D. advisor at the University of Missouri and perhaps one of the largest influences in my life, Dr. James L. Cook, inspired me to become involved with the Big Brothers Big Sisters organization.

Not only is he a Big Brother himself, he had such passion in

continued on page 5

RX for Healthcare Employee Engagement



By Kimberly Abel

No industry is currently having more disruption than the healthcare industry. Yet while healthcare providers are morphing and transforming their businesses by the minute to accommodate the Affordable Healthcare Act, and legislators continue to debate the implications of the massive changes — the expectations for healthcare

continued on page 6

The Affordable Care Act and Beyond: Winners and Losers in the New Era of Healthcare

Bruised, bloodied but still standing, the Affordable Care Act (ACA) is moving forward, bringing the most sweeping changes to the American healthcare system since the establishment of Medicare and Medicaid in 1965. Signed into law in 2010, the ACA has survived a U.S. Supreme Court challenge, a national election, a rebellion by conservative legislators that shut down the government for two weeks and an embarrassing technology meltdown when the government healthcare website launched in fall 2013.

continued on page 8

IKM New Member of Prestigious Healthcare Research and Advisory Company



John Schrott

By Daniel Casciato

IKM Incorporated architects, the Pittsburgh-based architecture, planning and interior design firm, recently joined a research membership program of The Advisory Board Company, a

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The Missing Conversation



By Michael Coppola,
M.D

Primary care practitioners (PCPs) have the responsibility to uncover and address healthcare risks in the populations they serve. Today, PCPs have become accustomed to asking intimate questions of patients, “Do you feel unsafe at home?” “How many drinks do you have in a day, week or month?” and “Do you have unprotected sex?” It appears however, that a very simple conversation is not happening in the exam room: “Do you snore regularly?” or “Has anyone told you that you stop breathing in your sleep?” — and these are critical questions that can lead to reversing a serious health problem. Yet patients who complain of these symptoms are often speaking to deaf ears, as they must bring their complaints to their PCPs on multiple occasions before a diagnosis of obstructive sleep apnea (OSA) is established.

OSA is a serious medical disorder, which

negatively impacts the most significant medical conditions of adult medicine. Hypertension, highway crashes, metabolic syndrome, stroke, atrial fibrillation and excess mortality are all tied to untreated OSA. The economic burden is also significant and multiple studies have shown that each untreated person generates over \$2,000 a year in excess medical expenditures. Lost productivity, absenteeism and disability increase that number by 2.5 to 5 times. OSA is therefore no longer just a sleep disorder, but a complex medical problem whose under-recognition is creating unnecessary risk to quality of life, to the health of our patients and to our economy. Treatment has been shown to reverse many of these morbidities, resulting in immediate health care savings.

Sleep specialists have had primary responsibility for managing sleep disorders, including OSA, using complex sleep lab testing modalities evoking images of the 1931 Frankenstein movie. Continuous positive airway pressure (CPAP) therapy, the universal OSA treatment of choice, was plagued with loud machines, patient complaints, and the requirement for a sleep lab titration to determine the “optimal” pressure. This

made it difficult for primary care to engage in treatment for this condition and PCPs were forced to take a “here’s your referral” approach. The difficulty with this approach is that it has left 75% of these patients with a serious condition undiagnosed and untreated.

Millions of Americans struggle with obesity, hypertension and diabetes, yet the connection between these disorders and OSA is not foremost in the minds of PCPs. The care of diabetes, hypertension and obesity quite correctly falls within the realm of PCPs. The Patient Centered Medical Home and new value based payment models have placed the responsibility for managing chronic medical conditions squarely with the primary care office. Value based payment plans financially reward those who can efficiently improve the health of the populations they serve. The Healthcare Effectiveness Data and Information Set (HEDIS) measures, which place high value on measurable outcomes for diabetes and hypertension, drive many of these reward and rating structures. In Massachusetts, physicians are tiered according to their quality and efficiency scores for all five payers contracted with state and municipal employee plans.

It is time for PCPs to become proactive in the recognition and treatment of OSA. The American Academy of Sleep Medicine (AASM) recommends that all patients with Type II diabetes and hypertension be evaluated for sleep apnea.

Although sleep specialists play a role in caring for these patients, a dramatically increased role for PCPs is critical to addressing this condition. Simple screening tools like the STOP-BANG and Berlin questionnaires help to identify those who are at risk for the condition. Conversations during preventative care visits about habitual snoring and witnessed apneas will uncover most of the higher risk patients.

For those screened at high risk for OSA, patient centered diagnostic tests and treatments can be initiated by PCPs. Home sleep tests (HST) which measure breathing during sleep (Type III recordings) are now becoming standard care, and a recent study funded and published by the AASM found no difference patient outcomes for those randomized to HST versus a traditional sleep laboratory. Patients who test positive at home can be treated by a number of treatment options, such as newer generation CPAP devices that are often more comfortable, leading to greater compliance. And auto-titrating CPAP can be prescribed without the need for a CPAP titration study in a majority of patients.

The diagnosis and treatment of OSA is now patient centered and ideal for integration into progressive primary care practices. The improvement in quality of life for treated patients and reversal of co-morbidities will reward practices that develop OSA programs. It all begins with one simple conversation. +

Michael Coppola, M.D., is the Executive Vice President of Medical Affairs and Chief Compliance Officer at NovaSom (www.novasom.com), provider of the AccuSom® Home Sleep Test. Past President & Chief Medical Officer of the American Sleep Apnea Association, a patient advocacy group.



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continued from page 1

what he did that he helped me set my career goals higher than I ever could have imagined.

He had an approachable, open door office policy and was never too busy to talk. I genuinely felt that my future success was important to him.

I wanted to pass on his gift.

When I moved to Pittsburgh a year and a half ago for residency training at UPMC, I was searching for an opportunity to get involved with the community.

My wife and I have no extended family here.

I was drawn specifically to Big Brothers Big Sisters of Greater Pittsburgh.

Since 1965, Big Brothers Big Sisters of Greater Pittsburgh has made meaningful, professionally-supported matches between adult mentors, called "Bigs" and children, or "Littles."

The organization puts children on a path to lifelong success, changing the trajectory of their lives for the better.

Partnering with parents, volunteers and educators, the program has proven repeatedly to improve the odds that children facing adversity will achieve educational success, avoid risky behaviors and have higher aspirations, greater confidence and better relationships.

I knew becoming a mentor would provide me the opportunity to build a long-lasting mentor relationship with a child, become a good influence and, hopefully, show him

life's available opportunities and to widen his goals.

I met Tyrone over a year ago. He is a polite ten-year-old son of a hands-on, single mom who wanted her son to have a positive male influence.

As a physician, I had been around younger children, but when we were first matched through Big Brothers Big Sisters, I wasn't sure what his expectations of me as a Big Brother would be.

We felt comfortable with each other pretty much straight away. To break the ice, our first outing was to the Carnegie Science Center and SportsWorks in Pittsburgh.

I'm of British Indian origin, and Tyrone asked a lot of questions pertaining to my background.

It confirmed to me that we were equally interested in getting to know one another.

I see Tyrone about every two weeks, and we enjoy simple activities such as playing video games or heading to a burger joint for milkshakes. I genuinely sense he enjoys just hanging out.

We've visited several area attractions, like Kennywood Park, gone to Steelers games, and even attended a Monster Trucks show at Consol Energy Center which he loved!

Recently we sat in box seats, donated by Sidney Crosby, at a Pittsburgh Penguins game - an event we both found to be "awesome!"

I've taught him to play tennis and attended his school wrestling matches. This summer we plan on going kayaking.

He asks me about my work, and I'm

looking forward to bringing him to visit UPMC to learn about the research we do there.

Ironically, Tyrone has expanded my world. He's taught me how to not stress about certain things.

As chief resident in the Department of Physical Medicine and Rehabilitation at UPMC, my job can be stressful at times. Being Tyrone's mentor allows me to switch my focus, help me unwind and not think about work for a little while. It has helped me become a better, more engaged physician.

I would recommend Big Brothers Big Sisters to everyone.

To make a difference in a child's life has given me such an immense pleasure. It has truly been one of the best things of which I've even been a part.

Tyrone's future is very important to me, and I am proud of him when he makes the honor role at school.

We plan on continuing our BBBS relationship beyond graduation, and that's irrespective of whether I stay in Pittsburgh long term or not.

He's someone with whom I never want to lose touch. +

Prakash Jayabalan MD, PhD is Academic Chief Resident in the Department of Physical Medicine & Rehabilitation at University of Pittsburgh Medical Center (UPMC). He has been a proud Big Brother in the Big Brother Big Sister program of Greater Pittsburgh for the last year.

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employees remains the same — stay focused, be engaged, work harder and smarter.

But, how? How can we expect our employees to go on as usual when something so unusual is going on?

Start by saying thanks. From supervisors to support staff — saying thanks for a job well done will increase morale and performance. But while department chiefs and C-level execs always have good intentions — actually knowing how to effectively show gratitude across a large, multi-generational, diverse workforce isn't always easy.

The science of human behavior tells us that people are both rational and emotional.

The emotional side of our brain is wired to respond to appreciation.

The emotional side of our brain is what connects us to people, teams and organizations. Showing sincere, personal appreciation is appropriate and important especially in an industry experiencing so many upheavals.

No matter their role: lab technicians, nurses, medical assistants, administrators, dietitians, physicians, administrative assistants,

people want and need to feel valued and be thanked for the work they do.

And study after study shows that employee satisfaction is required for patient satisfaction and *both* are required for strong business performance.

Getting started with a workforce recognition solution doesn't have to cost a fortune or be complex.

Start small, build a strong cultural foundation and keep improving over time. Here is a basic RX prescription to follow:

KEEP RECOGNITION TIMELY, PERSONAL AND MEANINGFUL

- Recognition should be timely, personal and reflect who the employee is and what
- Make it easy by empowering managers, front-line peers and patients to provide recognition on-the-spot when they have a great experience or witness great work

PROVIDE CHOICE, VALUE AND SELECTION OF REWARDS

- Enable employees to select from a menu of reward options that include trusted brands and strong value,
- Go for employee delight, provide a vast selection of potential rewards to choose from

BE SURE RECOGNITION IS COMMENSURATE WITH PERFORMANCE

- Assess the level of effort required and if the performance was outside the scope of normal job expectations
- Evaluate the impact to the organization, including how the patient experience was affected

CELEBRATE AND SOCIALIZE

- Celebrate internally with a team lunch or dinner
- Socialize within the organization by sharing accomplishments through social media, newsletters, or a company-wide meeting

Employees who are appreciated are more engaged and engaged employees perform better, boosting health care quality and business results.

Thus, in addition to the benefits of increased retention, attracting top talent, and lower operating costs, health care leaders can include "quality of patient care" to the list of "why it's important to have satisfied, happy employees". +

Workforce recognition can be realized with one, several or a complete portfolio of programs. Examples include:

Getting Started: How to Leverage Performance Based Recognition Systems in Healthcare

14 Ways to Tell Employees They Matter and Are Important

- Milestone Recognition
- Life Celebrations
- Early Engagement - Onboarding
- Employee Referrals
- Performance Behaviors
- Performance Outcomes
- Quality
- Organizational Achievements
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- Wellness
- Team/Project Excellence
- Bright Ideas
- Hand-washing observations
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Kimberly Abel is the Vice President, Employee Solutions for Maritz Motivation Solutions www.Maritz.com, responsible for developing and communicating the company's thought leadership and point of view on workforce performance and employee recognition solutions. Her clients have repeatedly won national awards for their solutions including strategy, communications, training, certification programs, events and measurement methodologies. She can be reached at Kimberly.Abel@Maritz.com.

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But now that these crises have passed (for the most part) and the ACA's provisions are beginning to take hold, there will be unprecedented demands on healthcare providers and payers for efficiency, quality and transparency.

Healthcare consumers will have to develop a new consciousness about costs. Health systems will have to market themselves in different ways to potential patients, and all these changes will create challenges for private equity (PE) firms and others looking to invest.

The FTI Journal recently convened a blue ribbon panel of healthcare experts to share their perspectives on the ACA and to discuss how it will reshape healthcare and its stakeholders in the near future.

THE ACA TODAY

Phillip Polakoff, M.D., FTI Consulting: Nobody can argue that the American healthcare system is not in trouble. We need improved access, better care, lower costs and higher health quality. Healthcare now accounts for 18 percent of U.S. gross domestic product. That's \$3 trillion a year. Quality still is an elusive term. If you look at quality on a worldwide basis, we're not getting what we're paying for.

We're paying \$13,000 or \$14,000 per person for healthcare now. No other country is paying more than \$5,000 or \$6,000 per person. So we have some issues here.

And as the Affordable Care Act moves forward, we have to address all of them. We must deal with medical liabilities, demographic changes, mergers, consolidations, clinical integration and other changes.

So to start our discussion, the question is: What has been the biggest effect of the ACA so far on your sector?

Mollyann Brodie, Ph.D., Kaiser Family Foundation: The biggest impact has been on partisan politics. If you self-identified as a Democrat, you liked this bill; if you self-identified as a Republican, you didn't. That still is the case.

While the ACA has been on the front pages for three straight years, we've seen lots of misinformation and misunderstanding and very little change in opinion.

There's been a massive amount of media attention, yet our polls and data tell us the public still doesn't understand what the ACA actually means for business, policy, society in general or individuals.

Now that the real provisions of the ACA have started to kick in, consumers need information that will help them assess what the law actually is going to mean for them going forward.

Michael Kluger, Altaris Capital Partners: Many Americans are starting to realize that they might lose their healthcare insurance. I think that's significant for the country because it's forcing people to take stock and focus on how they can get insurance. The healthcare.gov technical problems can be fixed.

But once the benefit designs are available and people are using the marketplace, it will sink in that healthcare is not free. That's actually a good thing because you can't truly reform healthcare until people begin to value what they have and what they don't have.

Marian Dezelan, North Shore-LIJ Health System: My organization's healthcare system is the 14th largest in the United States. People see us as a hospital system, but we really are a health organization. Hospitals treat people who are sick. Health organizations try to keep people well.

Our goal now is on building a broad ambulatory network and having a large number of employed physicians who, to be part of our health system, must meet quality standards. We also are forming our own insurance company, and that's going to be a narrow network.

You're going to see more of this, especially as the very large insurers consolidate and the rest of the insurance market becomes more fragmented. Some hospitals will begin refusing to take insurance that doesn't reimburse enough, particularly if they are taking on more risk and are facing the dual pressures of controlling costs and improving the quality of care.

Likewise, the insurers will say, "If you don't give me good quality care, I won't let my members see you anymore." So I think there's a whole layer to this that the media hasn't talked about yet.

Richard Zall, Proskauer: The implementation of health reform has been so troubled that we've lost sight of the very real problems it was designed to address. Insurance reform needed to happen: Pre-existing conditions were preventing people from getting insurance, and policies were subject to lifetime limits that were cutting off consumers from insurance.

Improving access is vital: We are the only industrialized nation in the world that has so many millions of its people without insurance. We also need to control costs and to deliver better quality. The clouds surrounding the ACA launch have obscured these issues.

But it may surprise you to learn that our clients — hospitals and others on the delivery system side, along with employers — already are moving forward to reform the system.

Providers are aggressively consolidating to achieve economies of scale so lower costs and improved quality can be achieved.

Hospitals are integrating with physicians; employers and insurers are moving from a volume-based, cost-cutting model to a value-based system aimed at better outcomes.

THE ACA TOMORROW

Phillip Polakoff: What do you think will be the biggest changes in healthcare delivery over the next three years, and how will your organization address these changes — from a policy, public perception, public outreach, advocacy, education and communications perspective?

Mollyann Brodie: We are going to see some major issues arise because some states are expanding Medicaid, and others are not. In some states, you can be very poor, but you still won't get access to insurance; in other states, you can be less poor and get subsidies.

This all will play out in the public, the media and the advocacy communities.

For many, it will be a rude awakening. For example, in one of our studies, we found that undocumented Californians think the law will benefit them.

They have incredibly high expectations, and it will be interesting to see how these people and their communities react once it is realized that, in fact, the new law won't help them.

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The other big concern I see is that, for the first time, healthcare could become a real voting platform. Over the next year, as we approach the 2014 midterm elections, we will see a great deal of anxiety and strategizing on both sides over this issue.

Richard Zall: People will be paying a bigger share of their healthcare costs, and this will force them to shop more responsibly and carefully. Tools like the health exchanges and websites will assist people in comparison shopping.

Greater price transparency will help consumers decide whether they want to go to a high-cost hospital or get better results at a lower cost somewhere else. As a result, the marketplace will become more aggressive.

We also will see different models for providing care. There will be alternatives to going to the general practitioner's office and relying on a doctor to tell you what you need. We already are seeing this with innovations such as retail clinics and telehealth [healthcare delivered via videoconferencing, streaming media and other electronic tools].

And on the provider side, we're seeing a real paradigm shift, from the siloed organization with specific specialties and hospitals to more coordination and integration. That's why we're seeing a lot of transactions — both mergers and acquisitions (horizontally and vertically) — across hospital systems, home care and ambulatory care. Ultimately, this will lead to a more efficient and effective delivery system.

Michael Kluger: Today's healthcare is based on reaching out to sick people and making them better. The most complex and challenging cases bring the greatest reimbursements and margins. This will change, and health organizations will be focused not on treating illnesses but on keeping people healthy. That's a pretty dramatic shift. Providers also are starting to realize they actually have to make money at the Medicare rate.

They can't just find sick people, charge accordingly and hope there is enough margin in that total amount to subsidize everything else that has to be done. The market basket is really the Medicare rate, and the key to succeeding at that rate is to keep the population healthy. That forces a re-engineering of the provider system — using technology, outsourcing and partnering to integrate medical care. This will be like General Motors retooling in the face of foreign automobile competition. And it's this second step that will transform the system.

ROLES AND CHALLENGES FOR PRIVATE EQUITY

Phillip Polakoff: What role will private equity play in this new healthcare model? Right now, a large amount of money is sitting

on the sidelines.

Michael Kluger: Interestingly, the biggest sources of capital are the provider systems and payer networks. Their re-engineering dwarfs whatever the largest PE firm is capable of doing. As a private equity person, I can look at investing in medical devices, healthcare information technology or services, and I can follow themes within each.

The key is to find businesses that offer a good return on investment for all the constituencies of the healthcare economy: consumers, payers, employers, providers and regulators. If these constituencies all can say, "That's a good business — it's adding value to what we care about," then it's worth a look. But going forward, the risks will be greater for PE firms. For example, some players in the home care industry have thrived just by supplying high-margin infusion drugs and not worrying about administering them (that was somebody else's problem). There was a great deal of money to be made from investing in such narrow slices of healthcare, but that will be much harder to do in the future. And I think that's healthy.

Healthcare will never be free. You're in trouble if you have invested in a business that earns revenues by providing free services to the consumer without adding any real value for the other constituencies.

HOW HEALTHCARE MARKETING WILL CHANGE

Marian Dezelan: Today, for example, if you are covered under a United Healthcare plan, you probably can go to any hospital or urgent care clinic in Manhattan. You can visit whichever doctor your referring physician recommends even if it's the orthopedist he golfs with on the weekend. You can ask your friends which doctors they like and can go to them. But tomorrow, consumers will be evaluating provider quality before they even have a need for the service, which is a monumental shift in retail purchase behavior. This will affect how healthcare providers market themselves.

Currently, people don't look at evidence and facts when they decide where to seek care. Some people spend more time driving around to save a nickel on a gallon of gas than they do choosing a healthcare plan or provider. They also put a lot of stock in hospital rankings such as those in U.S. News and World Report. We've studied the methodologies used, and what's interesting is that U.S. News is looking specifically for hospitals that are the best places to go for especially complicated cases. But that's not necessarily the preference when you need a hip replacement or something more routine. But people respond to these third-party rankings, and consumers react to emotional advertising, too. +

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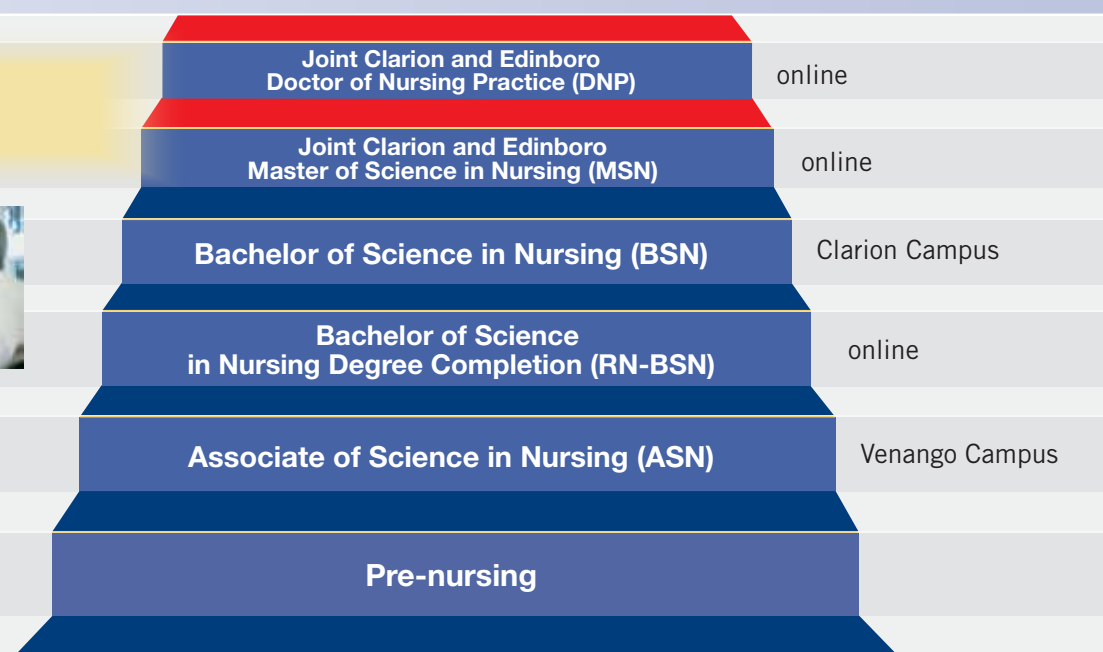
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Washington, D.C. based research, technology and consulting organization primarily utilized by healthcare organizations to identify trends, provide market analyses, and augment resources for strategy development. Ninety percent (90%) of the top 100 hospitals are members.

The Advisory Board Company was founded in 1979 and has grown into a global firm employing more than 2,200 people in nine offices on three continents. The Advisory Board is respected by the industry as a leader in developing tools that benefit the advancement of effective and efficient delivery of Healthcare services.

IKM will become a member of the Health Care Industry Committee's research membership program for architecture firms, contributing their expertise to the already accomplished group of more than 60 architecture firms participating in the membership. Through the membership, IKM will be granted access to key tools to succeed in today's complex health care environment.

"We will apply the revolutionary insights of the Advisory Board to our planning and architectural designs, helping IKM to pursue our goal of making our work some of the most comprehensive and innovative products on the market," says John Schrott, AIA, ACHA, president of IKM.

IKM's goals for the two-year membership with the Advisory Board include increasing the firm's knowledge-base at all staff levels in healthcare design and project delivery and increasing the firm's visibility as an expert in healthcare design with clients and potential clients by utilizing the Advisory Board's extensive resources in their projects.

According to Schrott, healthcare facilities are one of the most complicated building types in architecture. Each planning and design project is unique and each has to facilitate interface with multiple stakeholders and objectives. "In order to best serve our healthcare clients, it is important that IKM be as knowledgeable as possible regarding this industry," he explains.

He adds that they believe it is through that strong knowledge base that they can help lead their clients: to a more comprehensive understanding of the issues surrounding a particular design project, to a thorough exploration of the potential solutions to satisfy that project's goals and objectives, and to make an informed decision regarding the best solution.

"Becoming members of the Advisory Board provides IKM with a large pool of research and knowledge so that we can support our clients with architectural design solutions that are innovative and informed and are based on research and evidence as well as

representative of the best practices," says Schrott.

The Advisory Board membership provides IKM with white papers, predictive volume tools, modality metrics, benchmarking examples, industry trends and available research staff to address project specific questions. Their clients will benefit from this expanded knowledge base and all of their staff will be able to grow their personal skill sets more effectively and expeditiously.

"IKM will now be able to support solutions as more research based and less anecdotally and experienced base," says Schrott. "We are excited about offering this level of expertise to clients during this time of industry uncertainty. We believe this will help us to more effectively support all aspects of our clients' missions."

In addition to membership to the Advisory Board, IKM is also active in its local professional organization, the AIA - American Institute of Architects, and have been recognized nationally for its Intern Development Program where it had been awarded "Firm of the Year" designation. Many of its staff are part of the AIA's knowledge cohort, the Architecture Academy of Health.

Schrott is also a member of the American College of Healthcare Architects (ACHA) which is an advanced certification of practice. ACHA supports the advancement and recognition of the value of trained healthcare architects that support the planning and facility needs of the industry through the use of evidence based design to create patient centric solutions that are cost effective and supportive of the client's mission.

When asked to look into his crystal ball to see what changes are on the horizon over the next two years in healthcare architecture and design, Schrott believes as the healthcare industry continues to transition from a volume based to a value based reimbursement system, we will see capital investment focused on reorganizing a system's outpatient services.

"This will include a push towards developing facilities in the communities that the institution serves and co-locating the appropriate services to facilitate the shift to wellness/prevention and chronic disease management," he says.

He adds that institutions will still need to make some investment in the Acute Care Hospital with renovations that focus on gaining efficiencies and delivering the highest quality of care to an inpatient population whose acuity level will continue to increase. Facilities will continue to reform processes to support greater efficiency and less waste as reimbursements become more restricted.

"The trend of creating spaces that are welcoming and comfortable will remain the aesthetic for both in and out patient design solutions in order to help that institution to be the facility chosen by a consumer base that will be increasingly exercising their power of choice," he says.


Looking ahead to projects that IKM has in the works, Schrott says the firm will continue to see the focus on Outpatient Care Centers. "We have several on the boards at this point. As the Affordable Care Act pushes our clients towards a population health model of care we are seeing an increasing work load of off campus facilities."

There will always be some investment on the main campuses of our clients, notes Schrott.

This component of facility upgrades, with few exceptions, is focused on providing upgraded space to support more complex diagnostic and treatment spaces which are addressing the needs of an increasing acuity level of patients.

"The other area where we are seeing increasing activity is in infrastructure upgrades," he says. "The recession caused many of these projects to go on hold to preserve capital and we are now seeing some of these projects move forward."

For more information on IKM, visit www.ikminc.com. +



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Health Care Employers Can Reap Big Benefits From Employment Reviews

By Patricia E. Farrell



All it takes is one medical assistant who doesn't report the time she spends finishing her charting after hours.

Or a receptionist who takes phone calls while she eats lunch at her desk.

Or a nurse supervisor who fails to report that one of the nurses is being harassed by another staff member.

All of these situations can lead to employment lawsuits, and each case can cost a health care employer \$50,000 to \$250,000 or more.

One way that hospitals, physician's practices and other health care employers can protect themselves is to conduct regular employment reviews.

During an employment review, someone with thorough knowledge labor and employment laws and regulations, typically an attorney or team of attorneys, will analyze the company's current employment practices and office environment to identify potential liabilities that may lead to a lawsuit.

Depending on the needs of the business, an employment review will typically cover all or some of the following areas:

WAGE AND HOUR ISSUES

The Department of Labor estimates that approximately 70% of companies don't fully comply with the Fair Labor Standards Act, which sets wage and hour requirements that employers must follow.

Wage and hour lawsuits have skyrocketed in the last 20 years, and health care employers have been one of the top targeted industries.

Some common mistakes that violate wage and hour laws include:

- Incorrectly classifying workers as exempt from overtime wages.
- Failing to keep proper time records.
- Allowing hourly employees to answer emails or do other work tasks "off the clock."
- Failing to pay hourly workers for staff meetings or training programs that take place before or after their normally scheduled hours.

EMPLOYEE POLICIES AND DOCUMENTS

During an employment review, reviewers will review all written materials given to employees, such as employee handbooks, hiring agreements, confidentiality agreements, employee termination documents and other similar documents.

The reviewers examine the documents to ensure that the content and exact wording of the documents don't leave the employer vulnerable to a lawsuit.

Some examples of common issues that may be addressed include:

- Does the employee handbook have a clear policy for reporting harassment?
- Does the company's social media policy appropriately protect the company's reputation without infringing on employee's individual rights to discuss their workplace conditions?
- Does the handbook make promises about employee benefits or perks that the employer may not be able to keep in the future?

The review will also make sure that any required documents related to employee safety and employee rights are displayed in the office, as required by law.

PERSONNEL FILES

Reviewers will review the company's personnel files to ensure that the employer is collecting all necessary documentation, such as employment applications, resumes, immigration documentation, disciplinary notices, attendance records and other similar information.

In addition, the reviewers will analyze personnel files for patterns of discrimination, including unintentional discrimination.

The reviewers will look for consistency in giving promotions and raises and disciplining employees to ensure that the company is not showing signs of discrimination based on gender, race, religion, age, ethnicity or any other category prohibited by law.

EMPLOYEE INTERVIEWS

Interviews with the employees are often the most valuable part of an employment review.

Because outside attorneys conduct the interviews instead of a boss, employee interviews may re-veal huge liabilities of which the employer may be unaware.

For example, employees might report that they feel pressured not to report overtime hours.

Female employees may reveal that they think men in the office get paid more and promoted more often, or vice versa.

Or hourly employees may reveal that they often check email from home without overtime pay.

Employment reviews generally are not expensive, but they could save a health care employer tens of thousands of dollars in litigation costs and payoffs to employees.

Regular reviews, for example once every three years, may also lower insurance costs, because companies with up-to-date employment policies and practices are less risky for the insurance carrier. +

Patricia E. Farrell is a partner at Pittsburgh-based law firm Meyer, Unkovic & Scott. She focuses her practice on a broad range of legal matters related to corporate and business law, and also has substantial experience practicing real estate law. She can be reached at pef@muslaw.com.

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Population Health Management

By Kathleen Ganster

Health care is always a topic of discussion these days and one aspect receiving a fair amount of attention is “population health management.”

Health care providers from birth to end-of-life are working to manage all phases of care more effectively. With that mission in mind, these providers are focusing on providing the best possible care while managing costs. To do that, there is a need for care coordination across all modes of care settings and working as a complete team from one setting to the next to ensure the best care along with maintaining the quality of life.

That may seem like a difficult proposition.

“This focus is changing the landscape of how we think of health care. The bottom line is that we must maintain the highest quality of patient care while managing with less in reimbursements,” said Bill Gammie, Vice President of Value Based Care at Celtic Healthcare.

Unlike some providers, Celtic is embracing this new spotlight in healthcare.

“Instead of a one-time exchange between health care providers, this means an ongoing exchange. What does it mean to care for the individual as a whole and across different phases of care? For best care, it means open communication,” said Gammie.

For a hospice and home health care provider like Celtic, that means working with physicians and other providers in various phases to ensure that optimum patient care is maintained.

“The transition from acute care to post-acute care settings - hospital or other healthcare providers to home health - should be as flawless and streamlined as possible. Working as a team across the board not only makes this happen, but can also reduce readmissions and other healthcare issues,” Gammie said.

Numerous practices that Celtic has been practicing ensure this continuum. Longtime leaders in utilizing technology in providing quality healthcare, Celtic has several key tools in place to ensure ease in communication between health care providers for patient

care including: their ePortal that allows physician offices rapid and easy access to patient information; the Virtual Chronic Care program and Interactive Voice Response (IVR) that helps to facilitate health care transitions, medication and lifestyle management, and daily symptom management. Another important tool for managing ongoing patient care is the Telehealth technology that allows patients and their care givers to take an active role in their own chronic health/disease management and lifestyle maintenance.

“Acute and post-acute healthcare providers are working more closely together than ever before - and this better communication means better health care. Many of Celtic’s established health care practices ensure enhanced communication across health care providers,” said Gammie.

These tools also help address a major concern to not only health care providers but insurers - hospital readmissions.

“Of course, sometimes readmissions are unavoidable, but in many cases, they can and should be prevented,” Gammie said.

To point out the problem with readmissions, Gammie shared an alarming fact from *The Revolving Door: A report on U.S. Hospital Readmissions* (A report from the Dartmouth Atlas Project):

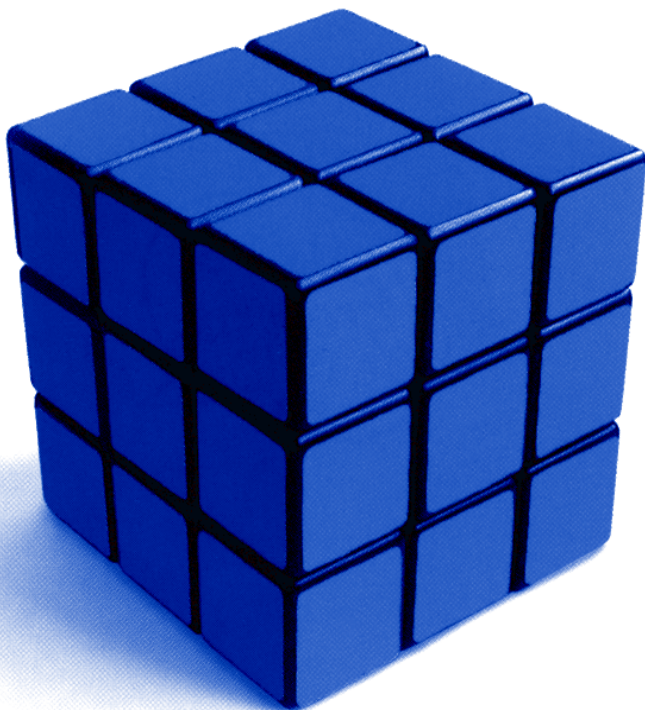
“The federal government has pegged the cost of readmissions for Medicare patients alone at \$26 billion annually, and says more than \$17 billion of it pays for return trips that need not happen if patients get the right care.”

As mentioned above, the Celtic’s Virtual Chronic Care program has helped reduce hospital readmissions for patients. Celtic has demonstrated an average 50 percent reduction in industry average for patients on virtual care with chronic conditions such as CF and COPD.

“The increased communication, coupled with better tools and measurements means if there are readmissions, we know why and how to prevent them in the future,” Gammie continued.

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Readmissions: What Looks Like a Quality Problem is Often a Process Problem



By Eric Heil

Readmissions have attracted significant attention in recent years due to the emergence of the Affordable Care Act.

Approximately \$30 billion is spent annually on potentially preventable hospital readmissions, and this growing problem is now front and center in the national conversation about the quality of healthcare.

As the healthcare industry navigates a shift to a fee-for-value environment and the number of accountable care organizations increase, readmissions are one of the first quality metrics to be targeted.

However, readmissions are just a symptom of a larger complex disease. The disease is a process problem, and the only way to truly fix the symptom is to cure the underlying disease.

Similarly, for a newly diagnosed cancer patient, an oncologist does not focus on the solely treating fatigue or pain symptoms. They concentrate on the underlying cancer through a series of complex genetic and molecular diagnostic tests, which provide valuable information.

With the diagnostic information they can better prescribe a regimen of targeted disease-modifying therapies and change the course of the disease.

Reducing readmissions is a measurable and targeted goal that can be achieved, but in order to do so attention needs to be focused on the discharge process and a commitment to change it.

DIAGNOSING THE READMISSION ROOT CAUSES: THE RIGHT INFORMATION

Diagnosing the discharge process first requires an analysis of the information used in discharge decision-making, followed by a careful look at the discharge workflow.

The right type, timing and amount of information for accurate risk-stratification must be considered when making discharge decisions. Readmissions are often attributed to clinical factors such as a specific disease like heart failure, pneumonia, or heart attacks.

However, the heart failure diagnosis is not the reason patients are readmitted.

Patients, no matter their disease, are readmitted because they cannot take care of themselves properly when they leave the hospital. It is critically important to understand the environment and the community that a patient is coming from and being sent home to.

This information does not exist in the electronic health record, the discharge instructions or the claims records. Incorporating these environmental factors at admission is what led Dr. Kathy Bowles at the University of Pennsylvania over the last decade to develop a national standard for making the proper discharge decision that is proven to reduce readmissions.

Readmissions are driven by behavioral, socio-economic, and community factors, which vary widely from patient to patient. This means that critical information regarding individual risk won't be found in EHR or claims data.

In fact, using claims data to predict risk is particularly self-defeating because it requires that patients are already high-utilizers to be flagged as risk.

If the goal is to deliver quality care at lower costs, waiting until patients are already high-utilizers is counterintuitive.

THE RIGHT TIME

Patients need more time to learn how to take care of themselves post-hospitalization. (RWJF. The Revolving Door, Feb 2013). Most patients do not receive post-acute care education or plans until discharge, which is simply too late in the process.

Each patient requires a unique set of directives regarding transportation, prescriptions, follow-up care, self-care and a host

of other variables. It is not realistic to effectively convey these directives in the moments before discharge.

Patients already feel rushed out of hospitals without a complete understanding of their condition, medication regimen or rehabilitation needs. (RWJF. The Revolving Door, Feb 2013)

Likewise, post-acute care agencies require more time to plan and schedule timely follow-up visits.

This is why evidence-based risk-stratification with the right information and post-acute care instructions must be initiated for all patients at admission.

CHANGING THE STATUS QUO

Readmissions are not a quality problem, but a process problem. Change must be supported with leadership and a focus on the discharge planning process.

Rethink the type of information used to risk-stratify patients for readmission risk.

Rethink the time point and method for starting the discharge planning process.

Change is hard, especially with processes that have been ingrained for decades.

However, without utilizing advancements in information technology, engaging the hospital staff with valuable data and innovative tools, providers are only masking the symptoms of a disease that will soon catch up to them.

Readmissions are symptomatic of a larger disease that can only be cured through process change. +

Eric Heil is the co-founder, president and chief executive officer of RightCare Solutions, Inc., an evidence-based medical technology company helping providers optimize care transitions and improve patient outcomes.

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Lean into the Challenge: Improvements Made in Physician Practices

By Lori Kauflin

IMPROVING EFFICIENCY IN PHYSICIAN OFFICES

For many physicians, it can be difficult to envision how to change their current practice into a more productive, efficient and gratifying operation. Practices are pushed to their limits, resulting in long patient wait times, overworked and frustrated staff, and physicians who are trying to balance patient needs with staying on schedule. Plus, many practices are now part of a larger healthcare system with corporate goals, new technology implementations and pressures to reduce costs and generate even more revenue.

The answer, for many providers, is taking a Lean approach within their practice. For three physician practice Offices in a large healthcare system in the Midwest, they transformed their daily processes by:

- removing redundancy
- streamlining their workflow
- focusing on improving the patient experience

By using Lean concepts, these Southern Ohio-based clinics were able to improve their operations, gain leverage in the marketplace and raise the quality of care within their community.

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These three clinics partnered with TechSolve to improve the overall experience for their patients, while boosting staff morale and increasing their capacity to serve more patients.

The three clinics worked on these service areas:

- Clinical diagnostics and treatment
- Lab testing
- Urgent care
- Evaluation
- Non-invasive diagnostic testing
- Treatment for heart-specific conditions
- Care coordination follow up

From the beginning, the three clinics were faced with many similar issues that commonly occur in physician practices. Unfortunately, the care delivery processes often receive very little attention because resource time is not adequately invested in improvement opportunities. Everyone is extremely busy, and as a result, they enter a cycle where team members become frustrated with process inefficiencies, which can easily translate into patient dissatisfaction.

COMMON CHALLENGES IN PHYSICIAN PRACTICES

- Large, overcrowded waiting rooms
- Long patient wait times
- An inability to schedule patients within a short period of time
- Decreased staff morale
- Low patient satisfaction
- Lack of organized supplies and equipment
- Inability to handle phone call volume
- Ineffective communication leading to duplication of efforts
- Insufficient information to complete tasks
- Increasing competition within the marketplace

Whether practices are part of a larger healthcare network or remain independent, the need to address issues is critical given the competitive and complex nature of today's healthcare marketplace.

ENGAGING STAFF IN LEAN

All three clinics formed teams engaging frontline employees and physicians to implement the Lean methodology within their own practices.

Each clinic delivered care in a slightly different way, yet used the same, structured approach to implement customized solutions that overcame shared obstacles.

Through a series of observations, they discovered that duplicate documentation existed throughout the chart.

By mapping the current patient experience, it became apparent that the majority of the patient's time was spent in non-value added activity, such as waiting to see a care provider or repeating their chief complaint more than once.

The rapid improvement experiments that each team performed had positive impacts on both internal and external customers.

From the nurse and physician perspective, they could provide better quality care by hearing what each other said to the patient. The patient office clerk felt a sense of pride and satisfaction, being connected to the care process in a direct way, instead of at a distant desk.

The Lean process had a clear impact on the patient experience. Patient comments were extremely positive.

They noticed the new efficiency and were vocal about the positive change. Problem areas, like the waiting rooms, as a result of the process change, experienced improved patient flow.

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Safeguarding Patient Data

By Tom Browning



Data – not only does it continue to be one of the biggest buzzwords, but its impact and possibilities for the healthcare industry continue to have many insiders excited this year.

At a time when pressure is being placed on the healthcare industry to reduce costs across the board, data continues to come up in conversation as one of the keys to success because of its potential for increased

efficiencies and effectiveness in providing more comprehensive medical care.

However, many questions still remain: how do we get our hands on it; how do we use it; how do we share it; and most importantly, how do we keep it safe? The latter being of particular importance to healthcare organizations because of the strict regulations placed on the industry and the high costs of non-compliance.

REQUIRED SAFEGUARDS

As the healthcare industry becomes more and more digital, thanks to the implementation of Electronic Healthcare Records (EHR) and Health Information Exchange (HIE), more and more patient data is being accessed electronically and available for instantaneous sharing. On one hand, this streamlined process helps to improve the quality, safety and efficiency of health care, but on the other hand, it raises many red flags as to the security of the data and, ultimately, the patient.

The U.S. Department of Health and Human Services (HHS) is feverishly trying to address security concerns by implementing rules and provisions that require strict compliance to decrease the number of data breaches each year that put sensitive patient information at risk.

In January 2013, HHS released the “HIPAA Omnibus Rule,” a set of final regulations that modified the privacy, security and enforcement protections of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, by implementing a number of provisions from the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009.

Here’s a look at some of the highlights from the Omnibus Rule in three focused areas:

PATIENT RIGHTS

- Patients can request access to their medical records in electronic form
- Patients must be notified if their Protected Health Information (PHI) is subject to breach

PRIVACY PROTECTIONS

- Prohibits sale of an individual’s private information without their consent, and details new limits on how patient data can be used in marketing and fundraising efforts
- To assess if patient information has been comprised, the liable entity must conduct a risk assessment

ENFORCEMENT

- Any breach, regardless of its content, must be treated as a breach whereas in the past incidents were considered exceptions to the rule
- Penalties for non-compliance are based on levels of negligence with a maximum penalty of \$1.5 million per violation
- Many requirements extend to business associates of health care providers, health plans and other entities that process health insurance claims, including contractors and subcontractors

While the regulations are certainly helpful in understanding the requirements and associated expectations placed on these entities, the digital world is moving at a much faster pace than the governing bodies can keep up with, and as such, the regulations can become outdated even as they’re being released. This reactive nature creates the largest challenge of all for privacy and compliance.

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REMAINING IN A CONSTANT WORKING POSTURE

For every industry, there are multiple regulating bodies, hundreds in many cases, that help proactively enforce government regulations. Organizations can obtain accreditations and certifications to ensure compliance with all current and applicable government regulations and develop a constant working posture to seamlessly adapt when new guidelines emerge.

Beyond the required safeguards, industry experts offer the following tips for compliance as it relates to data management:

- Create Data Experts - It’s always important to train all employees, but when it comes to dealing with patient data, training is paramount and ongoing with regular programs occurring on a monthly and annual basis.

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Information Technology as a Solution for Driving Outcomes and Efficiency in Stroke Care

By Scott Bachik and Susan Heck

BUILDING THE CASE FOR INFORMATION TECHNOLOGY IN STROKE CARE

The information technology (IT) explosion in America over the last 10 years has been phenomenal, though it is just beginning to have an impact in the healthcare operations arena.

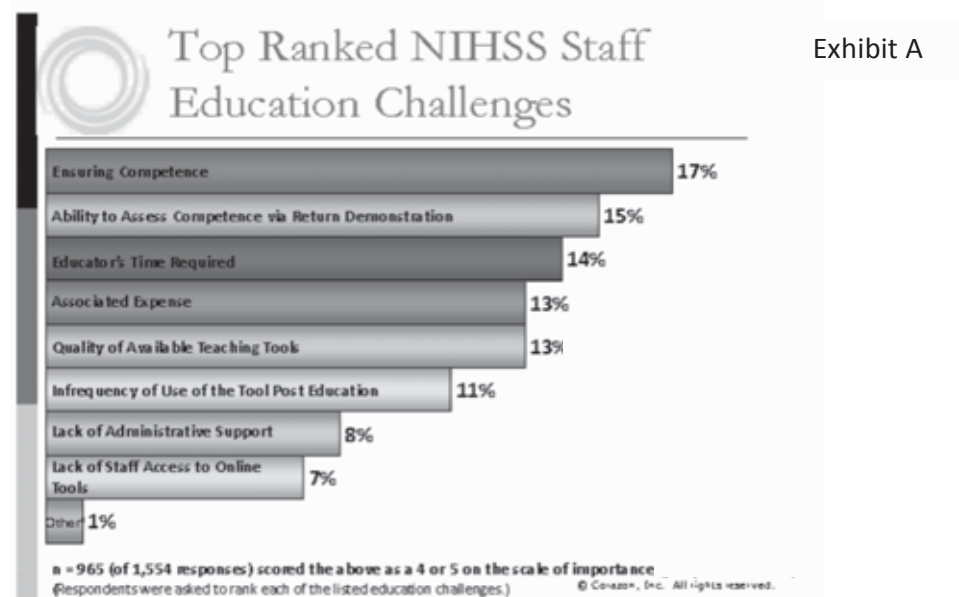
As our consulting team works with programs across the country, we find many hospitals on a journey to install electronic health records (EHRs), but very few with the clinical decision support and business intelligence tools that are required to not only support the provision of best practice care, but drive operational efficiency as well.

STARTING A STROKE CARE REVOLUTION

Corazon's initiative to revolutionize the way stroke care is delivered began with the completion of a survey in partnership with the National Stroke Association (NSA) on the usage trends of the National Institutes of Health Stroke Scale (NIHSS).

Corazon found significant opportunities to improve stroke care in hospitals across the country based on our results.

One of the most meaningful findings was related to the NIHSS assessment, and the need for ensuring competency in the consistent application of the tool. (See Exhibit "A").



Additionally, the Corazon team was observing stroke coordinators spending more time managing data and spreadsheets than working at their highest skill level managing the patient and promoting best practice care at the bedside.

The need for the industry's first innovative stroke patient management IT solution was clear. Our team used the NSA study and industry experience to eventually create a vision for a healthcare IT product — Cerebros — that would facilitate stroke care across the continuum.

Cerebros was developed to assist clinicians with delivering the highest quality of care to a large and growing acute, time-sensitive patient population.

Further, the data requirements for a certified stroke program are quite demanding! The system allows users to better manage stroke patients and provide seamless care through their entire hospital experience.

Cerebros auto-mates data collection, management, and reporting/analytics of stroke patients as well as sup-ports real-time process improvement.

Corazon believes that leveraging the power of information technology and clinical-decision analytics can transform the delivery of care.

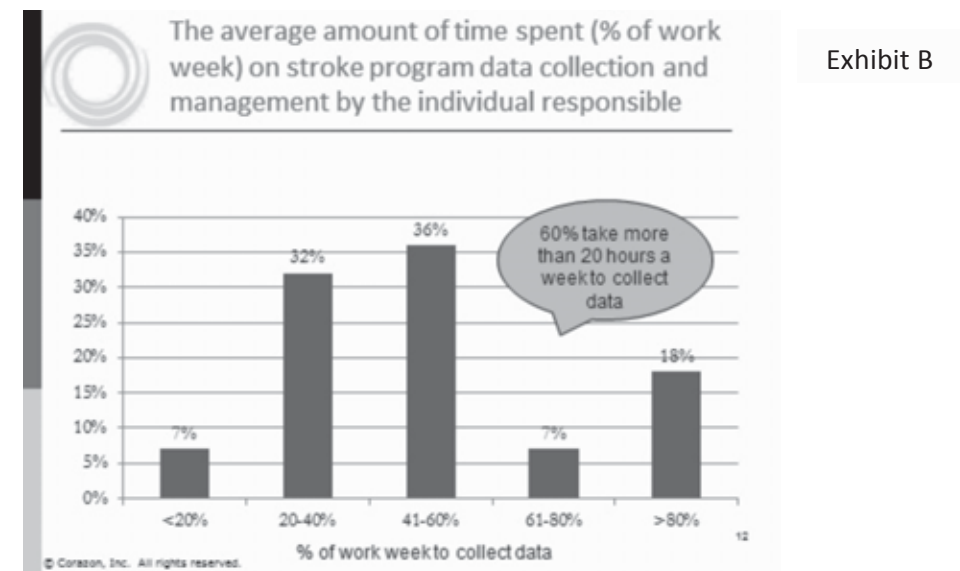
A REVIEW OF SURVEY RESULTS

In an effort to quantify the data management requirements and the complex and time consuming reporting requirements, Corazon

recently conducted a survey of stroke coordinators, which revealed that over 60% of stroke program leaders spend more than 40% of their work week just collecting stroke data. (See Exhibit "B")

They also spend an additional two days per week following-up on and correcting documentation for stroke patient fall-outs.

The old adage, "if it's not documented then it's not done" is very evident in a clinical area like stroke where strict data collection and outcomes scrutiny exists.



A CASE FOR DEMONSTRATING OUTCOMES AND EFFICIENCY

In November of 2012, Corazon was engaged to assist with the implementation of a Primary Stroke Center at Memorial Hospital in York, PA.

As in many communities nationally, recently-passed Pennsylvania legislation mandated that patients *suspected of having a stroke*, be transferred *only* to certified stroke centers.

As part of the implementation plan, Corazon incorporated Cerebros to assist in the proactive management of the stroke population.

In addition to the system's reporting and program management value, Cerebros has been a resource to Memorial's Stroke Program Coordinator as a means to access additional neurology expertise as their program grows.

The Memorial team integrated Cerebros into the entire episode of care for stroke patients, making it a valuable tool as they maintain successful outcomes.

The use of proactive technology as a way to standardize performance metrics and best practice care delivery throughout this implementation model has resulted in success for both Memorial and the patients that they serve. In addition, Memorial achieved program certification through HFAP during the summer of 2013.

The Stroke team continues to utilize Cerebros every day, for every stroke patient, to ensure that a high standard of care is consistently met. Key data is now collected real-time, and course corrections with respect to the care of an individual patient are effected when they are the most beneficial — during the acute hospital stay.

Information technology is clearly making a difference in patient outcomes at this community hospital and has provided operational efficiencies for their stroke team ... and their success can serve as an example for other sites across the country ... *Let the revolution begin!*

Scott Bachik is Senior Vice President of Corazon Inc. Susan Heck is Senior Vice President of Corazon. Corazon offers consulting, recruitment, interim management, and IT solutions to hospitals and practices in the heart, vascular, neuro, and orthopedics specialties. To learn more, call 412-364-8200 or visit www.corazoninc.com. To reach the authors, email sbachik@corazoninc.com or sheck@corazoninc.com.

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- Set Up a “Command Center” – Coordination between all parties involved is key, necessitating a “command center” to ensure an efficient and streamlined flow of data collection, sharing and integration. Often, this role is played by a third-party organization, such as a contact center.

- Open Communication Channels – All parties need to be aligned when it comes to data sharing, which calls for open communication across multiple channels.

Creating an open dialogue between all stakeholders is critical for successful data management.

- Enlist a Trusted Partner – With the high risks involved when dealing with patient data, it’s a good idea to enlist a trusted partner to provide expertise in a particular aspect of the data management process, or to serve as the “command center” as listed above.

Whoever organizations choose as their partner, they must ensure they have a strong commitment to compliance and data security.

- Rely on Industry Accreditations – Industry accreditations help ensure that organizations are complying with the associated regulations.

It’s a best practice to apply for all applicable accreditations to ensure full compliance, and to evaluate any and all partners based on those same accreditations especially now that all business associates will be held liable. +

As the Director of Corporate Compliance and Security, Tom Browning is responsible for the Quality Management System and Privacy program at Telerx. Additionally, he is the subject matter expert for all security related matters, including internal investigations, breaches, and privacy safeguards for sensitive program areas. He assures compliance with client expectations, Telerx corporate and program level policies and Standard Operating Procedures (SOP), and adherence to state and federal regulations. Tom also oversees the HIPAA program, EHNAC Accreditation, contracts, and M&A due diligence and integration. He serves as Managing Representative of Telerx’s ISO 9001 Quality Management System, and as the overseer of Privacy.

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Triage Systems – What Type Is Best for Your Hospital?



By Tracey Graham, MSN, NP-C

Triage comes in many forms, and hospitals across the globe approach it differently.

Triage can involve one or two stages or go up to even five levels. The most common approaches to triage in the US are the “traffic director” or quick look, spot check and comprehensive methods, which cover a range of intensity.

No matter the process, the most widely accepted standard is that triage should take a maximum of 5 minutes (the Emergency Nurses Association advises 2-5 minutes).

Studies show that triage times increase as the age demographic rises and when vital signs are completed as a part of triage (2).

However, nursing experience levels did not affect triage times, presumably because triage protocols and algorithms map the course of every patient seen, regardless of the staff involved. Hospital design also plays role; the design of the space ultimately affects the movement of patients, staff and materials.

The triage process is fairly simple. Concerns arise, however, when a queue of patients waiting to be seen starts to build.

Then the question becomes how long is too long for the last patient to be seen?

If 10 people are waiting, is a door-to-triage time of 50 minutes acceptable? Is there a way to improve that time through better facility design?

TRIAGE: A QUICK HISTORY

Interestingly, the triage system was not widely documented until the late 1980s. In 1989, Gerry FitzGerald originated, penned and published one of the original triage systems. It became known as the Ipswich Triage Scale, which over the next five years evolved into the now readily accepted Australian Triage Schedule (ATS). The ATS became the basis for additional triage methods, including the Canadian Triage and Acuity Scale (CTAS) and its pediatric version, which uses a combination of physiologic measures and symptom complexes to assign a triage score to children using a five-level scale. This system of triage has proved to be a reliable, predictable source of outcomes and ED resources.

In 1997 emergency departments in Great Britain introduced the National Triage Scale Based Manchester Triage Scale. This form of triage integrated the use of algorithms; however, the research suggests that there are differing local interpretations and it has yet to be a Gold Standard. Sweden also introduced a five-level Medical Emergency Triage and Treatment System that employs algorithms based on vital signs.

In 1999, the Emergency Severity Index (ESI) was established with the goals of getting patients seen faster and to truly understand the resources required in the emergency department based on patient volumes and acuity levels. After some refinements, the ESI is now one of the most often used systems of triage in the US.

How CAN You CHOOSE?

Given the variety of options, which system may be best for your hospital? Research has determined that a hospital's triage system is dependent on the facility, culture and patient mix index. The Emergency Nurses Association and American College of Emergency Physicians recommend and support a five-tier triage system, particularly highlighting the CTAS and ESI. However, studies suggest that there needs to be further study and strict formal guidelines for both triage and the education of triage nurses to ensure standardized care and predictability of outcomes, admissions and resources required in the ED.

Looking at your current design and process will help you determine if there is a need or opportunity to enhance either or both to maximize efficiency. Research has shown that point of care supplies and quick access to CT and radiology has reduced length of stays and improved patient and staff satisfaction. Value stream mapping can also help identify areas of operational need. Perhaps new furniture options or institution of a protocol or policy is all you need to reach a solution and ensure your approach to triage helps treat patients most effectively and efficiently.

- Agency for Healthcare research and Quality (AHRQ) <http://www.ahrq.gov/professionals/systems/hospital/esi/index.html>

- Canadian Triage and Acuity Scale (CTAS) <http://caep.ca/resources/ctas>

- Emergency Nurses Association <http://www.ena.org/Pages/default.aspx>

- Emergency Severity Index (ESI) <http://esitriage.org/algorithm.asp?LastClicked=algorithm>

- National Triage Scale Based Manchester Triage Scale (NTS) <http://webcast.hrsa.gov/archives/mchb/emsc/20100325/AnnotatedBibPedsTriage.2006.pdf> +

Tracey Graham is a Nurse Practitioner and healthcare consultant for Stantec based in the company's Washington, DC office.

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Painful Diabetic Neuropathy: Another Option for Patients

By Shai N. Gozani, M.D., Ph.D.

Painful diabetic neuropathy (PDN) is characterized by burning, stabbing or shooting pain in the feet or legs. Primarily caused by diabetes-related nerve degeneration, it affects one quarter of all diabetes patients. In addition to chronic pain, many patients also have insomnia, anxiety and depression. PDN patients tend to have a low quality of life and are among the heaviest users of health care resources.

PDN patients are potential beneficiaries of the SENSUS™ Pain Management System, a new wearable neurostimulation technology developed by NeuroMetrix, Inc. Unlike pain medications—which can be hard for patients to tolerate—SENSUS is both easy and convenient for patients to use. It is non-invasive and worn on the leg, just below the knee, and is activated by simply pressing a button. Whenever the patient needs pain relief, they activate the device and it will comfortably stimulate the sensory nerves in their legs. Each session lasts 60 minutes with pain relief starting in about 10 minutes, and often lasting 30 minutes following the end of the session. The mechanism of action is thought to relate to increased levels of endogenous opioids that act through the delta opioid receptor to block pain signal transmission in the spinal cord.

This approach to pain management offers several benefits to patients. First and foremost, it offers fast-acting relief from chronic pain. Second, it is non-narcotic and non-addictive, without significant side effects. Third, the easy, one-button control means patients do not have to fumble with advanced instrumentation. Furthermore, the device is lightweight and low-profile, and can even be worn under clothing.

Patients who have used SENSUS describe the stimulation it generates as a buzzing or light pressure sensation; patients are in control and can reduce the intensity if it feels uncomfortable. Many who have been prescribed the device have spoken positively about it. “The first time, it only took 10 minutes before the pain went away,” says one. “My pain level went from an ‘8 out of 10’ to a ‘2’ or ‘3’. I’m getting as much or more relief using SENSUS than I was taking pills,” adds a second user. A third adds: “I’m noticing in the morning, I’m able to get up and around much easier than I was before, without experiencing the excruciating pain.... I sometimes forget [SENSUS] is even there. When I activate it, I feel like I can do just about anything. It gives me a level of relief I wasn’t experiencing with anything else.”

One of the major advantages of SENSUS is its benefit to patients suffering from insomnia secondary to PDN. Because of its convenient size and shape, the device can be worn to bed; it is the only transcutaneous electrical nerve stimulator cleared for overnight use by the FDA. This allows those with PDN to better fall asleep and get a good night’s rest—which is critical for people with diabetes.

Physicians prescribe SENSUS and the device is provided by a medical supplier. Whether prescribed by itself or in conjunction with common pain medications like gabapentin, pregabalin and duloxetine, SENSUS can be a source of on-demand pain relief for PDN patients at the push of a button.

If you are interested in learning more about SENSUS or wish to prescribe it for your PDN patients, please visit SENSUSRx.com. +

Shai N. Gozani, M.D., Ph.D. is President and Chief Executive Officer of NeuroMetrix, Inc., a medical device company focused on treatment and management of chronic pain and peripheral neuropathies.



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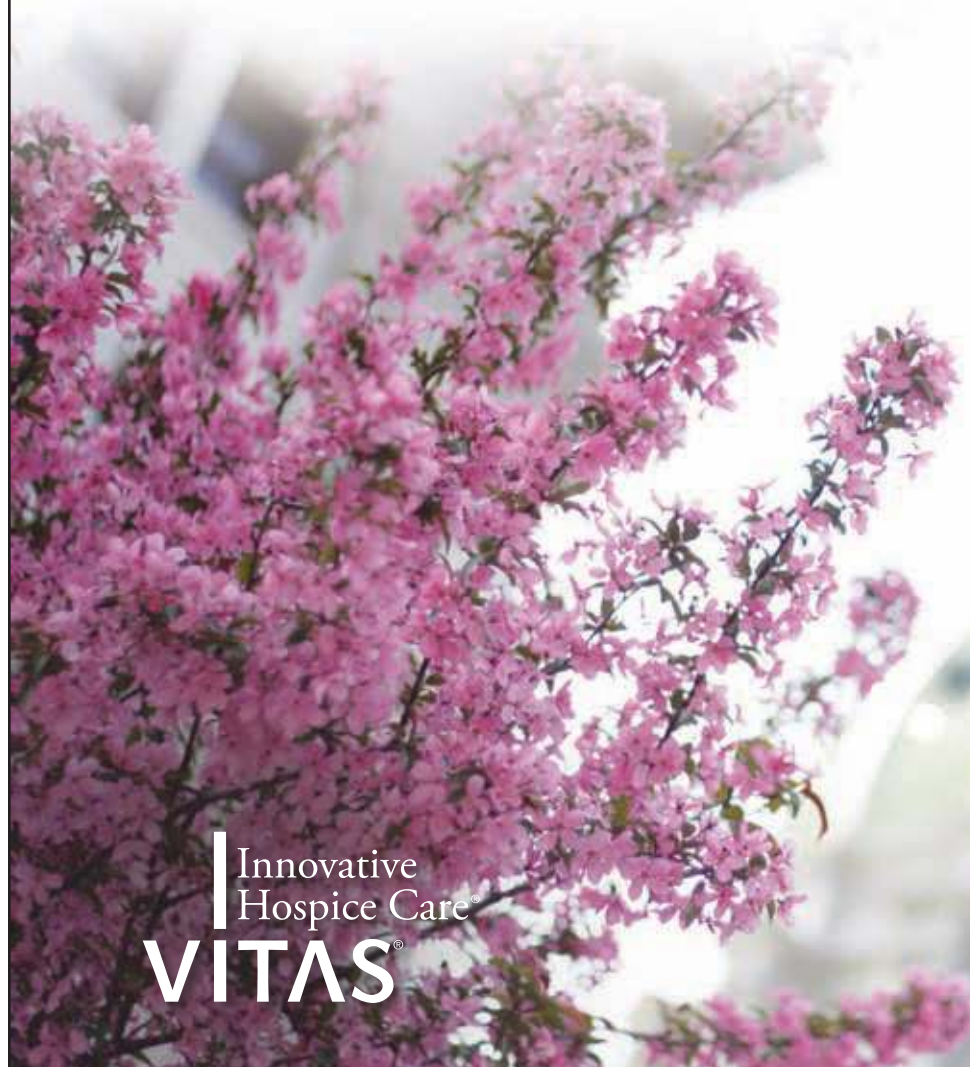
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The Memory Care Unit at Kane Scott Fills Growing Need

Kane Scott, one of the four Allegheny County-owned skilled nursing and rehabilitation facilities, is pleased to announce the opening of its memory care unit in Spring 2014. The unit is designed to provide specialized, 24-hour care that is tailored specifically to seniors with Alzheimer's and other forms of dementia.

The unit features 45 secure Medicaid approved beds. The home-like atmosphere offers residents the opportunity to enjoy a dining area, laundry services, an in-house personal hair care area, and a spot for indoor gardening. Residents will also have access to the facility's family conference room, rehabilitation services and physicians' clinic.

The Memory Care Unit at Kane Scott offers a foundation of experienced specialty care in affiliation with UPMC/Western Psychiatric Institute and Clinic. This care is provided under the direction of Dr. LalithKumar K. Solai, Chief of Geriatric Psychiatry, and Dr. Mohamed Ismael, Geriatric Psychiatrist. Dr. Solai has been the geriatric psychiatrist at the highly regarded Kane Glen Hazel memory and structured care unit since 2005.

"Families play a vital role in the transitioning of a person to a long term care facility," said Dr. Solai. "At the Kane Scott Memory Care Unit, our plan is to partner with our families in order to enhance the quality of care and the quality of life of the resident."

In addition to 24/7 nursing care, active programming will be available throughout the day on the unit to allow residents to stay engaged and socially active. Research on aging shows that well designed activities programs can help to sustain mental function in patients with Alzheimers or related dementia type disorders. Trained Recreational Therapists will work closely with the residents to promote well-being



and provide opportunities to find happiness and meaning. Supervised activities will include music therapy, pet involvement, crafts, exercises, horticulture, reminiscence therapy, spiritual services and supervised off unit activities and trips.

"In addition to a full day of programming, there will also be areas in the unit that are set up for the safe engagement in activities such as gardening and household routines," said Neil Bowser, Administrator at Kane Scott. Bowser has a background in Therapeutic Recreation and also has experience at the Kane Glen Hazel specialty units.

Memory loss is associated with dementia, a decline in mental ability. Dementia has a variety of causes, but about 60 - 80 percent of the cases stem from Alzheimer's disease. The disease is most common among the oldest seniors. About 45% of those

over 85 have Alzheimer's disease. Dementia is a multi-faceted disease and often carries a huge financial and emotional liability for families and loved ones.

The burden for caring for a loved one often falls on an unpaid, untrained caregiver trying their best to provide the necessary care for the patient and at the same time care for their own needs. When the disease becomes unmanageable at home, many families turn to Kane to help care for their loved one.

"Our specialty units at Kane Glen Hazel are typically full most of the time" says Dennis Biondo, Executive Director at the Kane Regional Centers. "The county recognizes that as our population ages there will be a need for more units like Glen Hazel's, and we were fortunate to be able to add a new unit at Kane Scott to help aid this need."

Kane Scott has 314 licensed beds and is situated in the wooden valley between Mt. Lebanon and Scott Township. The center is a prime example of the expanding services offered at Kane. In addition to the new Memory Care Unit, Kane Scott also has a Transitional Care Unit. The TCU is designed for shorter stays and more intense therapy. It boasts private rooms, a TV, a phone and a private bathroom. Therapy is provided seven days a week in a therapy gym that is located on the unit. To schedule a tour please call 412-422-KANE or visit kaneismorethanable.com

TIPS for Focusing on the Patient Experience

By Djamel Bayliche

Today's healthcare environment is no doubt a changing landscape – with new regulations, alternative reimbursement models, and innovations in clinical care. This continuous transformation of our healthcare system places increasing responsibility in the hands of patients and their loved ones, who are realizing that, now more than ever, they have choices about the care they receive. This shift has encouraged providers to understand the importance of ensuring that patient and family needs are not only met, but exceeded. A new reality is emerging: patient experience is a defining characteristic of true quality care.

Fortunately, tremendous opportunities exist for providers seeking to create a competitive advantage in their market or industry niche through excellent patient experience. When focusing on patient experience as a competitive advantage, consider the following Corazon TIPS that will help ensure success in this important effort:

1. Cover the Basics. Patients tend to judge their experience based on how they are treated as unique individuals and the empathy shown by everyone encountered. Very few patient consumers understand the complex treatments and technologies involved in care delivery, or the high level of clinical skills required, or even the multi-faceted behind-the-scenes operations of a hospital. But everyone understands and recognizes the basics of being cared for – a clean room, kind staff, clear communications, etc. Published satisfaction scores across the country reveal that nearly 30% of patients would not recommend a hospital or care provider to their family, friends, or neighbors purely based on their experience. From purely a patient perspective, excellent clinical intervention can easily be trumped by an overall poor patient experience based on a lack of comfort.

2. Consider the Full Continuum. "Experience" is not limited to



encounters with clinicians. In fact, the overall hospital experience begins before the patient even arrives. For instance, difficulty scheduling an appointment has the potential to cloud the perception prior to the actual visit that has yet to occur! Patient experience encompasses all interactions between the patient and their family members at every touch point...from the parking lot attendant, to the physician, to the bedside caregiver, to the Finance representative. Corazon recommends creating a sense of awareness and culture that ensures everyone directly or indirectly involved in the care process look at everything they do through the eyes of the patient and family. Every touch point should be expected to act as a care giver, and also view themselves as such.

3. Ask for feedback and follow-through. Do you know or do you seek to know how your patients and their family feel about the services you provide? Do you listen to their concerns? And if so, what strategies are you employing to address patient complaints? These are just a few of the questions that can lead to overall improvements in the components of patient experience, no matter how minor. Hospital or program leaders might be unaware of issues that exist – patients will voice their opinion; only the most progressive hospitals use the data to their advantage to make real and substantial change.

4. Don't Underestimate the Value of Education. Focus should be placed on setting realistic patient expectations, ensuring better patient preparation, and facilitating education throughout the continuum of care. Empathizing with patient and family uncertainty, fear, or skepticism about a procedure, and providing the resources or materials to ease any concerns will do much to create a safe environment where a patient feels comfortable with and confident about the care they will receive.

Today, it is no longer acceptable for providers to be content with excellent clinicians and the most up-to-date facilities and technology... Creating a positive patient experience has become the new pinnacle of quality. The healthcare market currently represents 18% of the nation's GDP and it is projected to reach 34% by 2040. Given the depth and breadth of this industry, every American will impact and be impacted by the healthcare market. Thus, it is in our best interest as a society that patient exposure to healthcare services is a positive experience.

Further, the demand for better patient experience will continue to increase with emphasis on care delivery that is tailored to a patient's unique schedule and needs, rather than provider schedules and/or process limitations. The providers who respond to these patient needs will be the ones who reap the rewards of the new paradigm shift in the healthcare delivery system. +

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Feel Good Fridays

By Barbara Ivanko



Who doesn't look forward to Fridays? Whether you have special weekend plans with your family, or are just grateful for the end of a stressful week, Fridays have a certain magic to them.

It's probably the one weekday where most of us embrace getting out of bed and getting the day started.

Just knowing it's Friday can make us feel happy, motivated and energetic. After all, it has its own saying ("TGIF") and even a restaurant chain named after it.

It is in that spirit that we have launched a new feature on our Family Hospice and Palliative Care Facebook page, called: "Feel Good Friday", represented by the hashtag #FGF. #FGF is consistent with Family Hospice's desire as an organization to make the most of life and affirm patients, caregivers, benefactors, volunteers and staff.

Every Friday, Family Hospice posts a "feel good" story that we hope will serve to inspire our audience and help them start the weekend with a smile.

Anyone is welcome to share a #FGF story on our Facebook page — whether it be a story from the media or a personal experience.

Our initial #FGF posting was a story KDKA-TV did about Hunter McGowan, a senior swimmer at Norwin High School.

Legally blind and legally deaf, Hunter continues to swim competitively thanks to the support of his teammates and coach.

Family Hospice has also featured a #FGF posting about Myles Eckert, an eight year-old Ohio boy who found \$20 in a Cracker Barrel parking lot.

While most kids may celebrate the find with the purchase of a video game, Myles decided to pay it forward.

The son of a soldier who was killed in Iraq when Myles was an infant, this impressive kid decided to give the money to a soldier he spotted inside the restaurant.

He wrapped it in a note that read "My daddy was a soldier and is now in Heaven ... Thank you for your service."

And then there was the #FGF story from WTAE of a Penn Hills high school student and her prom dress.

Because of her family's situation, the dress she wanted was too expensive.



Reason to feel good: Family Hospice patient Theresa Bombara recently celebrated her 100th birthday.

wphealthcarenews.com

An anonymous bride in the same store overheard the family's conversation about the need for a less expensive alternative and decided to be a "prom angel", paying for the girl's dress, no questions asked.

These are just a few examples of the kind of things that make us feel good.

Every day, we continue to be inspired by our patients and their loved ones.

The courage, love, support and caring spirit they show is beyond measure.

Hospice patients, their caregivers and loved ones are truly special.

They allow us to enter their lives at the most fragile of times. By sharing their wishes, their stories, or even their smiles, they inspire us. They truly make us "feel good" about what we do.

I would like to extend an invitation to you to share your #FeelGoodFriday with us at www.Facebook.com/FamilyHospicePA.

Whether it be something personal or something you came across in the news, we welcome your contributions as we try to do our part to share good news and inspire others.

Our Family Hospice staff often says that the work we do is "a calling." I could not agree more. I remain grateful for those who allow us to serve them and those who support our mission.

Our team continues to be inspired by the kind of events we witness daily.

And now, we have another reason to embrace Fridays. +

Barbara Ivanko is President and CEO of Family Hospice and Palliative Care. She has more than 20 years' experience in the health care and hospice and is an active member of the National Hospice and Palliative Care Organization. She may be reached at bivanko@familyhospice.com or (412) 572-8800. Family Hospice and Palliative Care is a non-profit organization serving nine counties in Western Pennsylvania. More information at www.FamilyHospice.com and www.facebook.com/FamilyHospicePA.

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Outsourcing Trends in Life Sciences – Why These Partnerships Matter

By Kevin Connolly



Healthcare insiders know that the industry is undergoing unprecedented change and companies and providers alike must adjust to new challenges and opportunities.

Although outsourcing of various services was always a standard industry practice, there has been a recent, noticeable shift in the type and the number of services companies are delegating to third-party vendors.

Some of the key drivers of outsourcing include staff and cost pressures, the desire to enhance focus on core business processes and the ability to rapidly deploy critical new programs.

By partnering with trained, compliant and specialized third parties, pharmaceutical and life sciences companies can increase efficiency and effectiveness and better balance cost and value.

KEY OUTSOURCING TRENDS

According to outsourcing experts, below are a few of the biggest outsourcing trends in the pharmaceutical and healthcare industries:

- **Pharmacovigilance** - As more companies recognize the importance of effective drug safety in ensuring patient safety, product integrity and company reputation, they also recognize the immense cost savings and efficiency that can be achieved by outsourcing pharmacovigilance services to an expert provider. The Transparency Market Research report found the global pharmacovigilance market to reach a market worth of \$5 billion in 2019, and with good reason as these third-party partners have the ability to balance high quality adverse event processing and reporting with unpredictable volumes, all while meeting new needs

in signaling, surveillance and risk management.

- **Patient Support** - In their efforts to connect with patients and differentiate from the competition, pharmaceutical companies are marketing themselves as “more than the pill,” with the desire to more fully engage with patients taking their medication. However, developing these support services can come with a hefty price tag, take valuable time and can stray from the company’s core business. With the help of a customer care partner, pharmaceutical companies can now offer multi-channel engagement support, such as support lines with highly-trained professionals, including nurses and pharmacists.

- **Access & Reimbursement** - Both pharmaceutical manufacturers and healthcare companies are challenged to streamline the complex process of Access and Reimbursement (A&R) services and to deliver quick, accurate and cost-effective solutions to patients and providers alike.

With the implementation of the Affordable Care Act, as more Americans receive coverage, healthcare and pharmaceutical companies will have increased opportunities to provide A&R services to a larger population. Outsourcing A&R services to a third-party partner can reduce case management time and overlap, mitigating patient and provider frustrations while increasing efficiency and minimizing cost. By assisting patients to better understand their insurance coverage or helping them find other available cost-savings resources, knowledgeable third-party A&R experts can improve patient lives and health outcomes.

- **Healthcare IT** - According to MarketsandMarkets, the healthcare IT outsourcing market will be worth \$50.4 billion by 2018. Healthcare providers are increasingly becoming more comfortable with the use and adoption of cloud computing and as a result, more are turning to IT outsourcing services and solutions. By utilizing third-party, HIPAA compliant partners, providers are able to benefit from expert resources while effectively managing costs. Some organizations outsource their information management systems and others choose key applications such as billing, customer relationship management and IT Help Desk Support.

- **Social Media Management/Community Management** - The pharmaceutical industry has taken a slow and cautious approach to monitoring, engaging and responding to social media posts. Just recently the FDA circulated recommended guidelines on how to appropriately and compliantly participate in this relatively new phenomenon.

Pharmaceutical companies are now entering into this communication medium, often with the help of innovative and experienced outsourced partners with established (and compliant) platforms for monitoring, analyzing, responding and reporting this activity. Staying within approved promotional guidelines will be an ongoing objective and experienced outsource partners will be positively positioned to meet this challenge.

THE BOTTOM LINE

The role of a third-party outsourcing partner is becoming larger, more integrated and more critical than ever before. By turning to outsourcing partners for a variety of services, healthcare and pharmaceutical companies are better able to channel their resources and efforts toward their core critical business processes and, most importantly - the patient. +

As the Vice President, Healthcare ConneXions, Kevin Connolly is responsible for the development, execution and management of new healthcare related services at Telerx. He is a seasoned executive with extensive pharmaceutical sales and marketing experience. Kevin began his career with Bristol-Myers Squibb, spending a dozen years in sales and marketing management positions. He subsequently held leadership positions in companies like Excerpta Medica (a Reed Elsevier company), Wolters Kluwer Health, Cardinal Health and more recently PDI, Inc. where he successfully managed their Diversified Marketing Services portfolio of businesses. Kevin has a BS in Commerce (Marketing Management) from Rider University.

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What Is Population Health?

By Mark Pastin

Somewhere along the road to healthcare reform, the term “population health” entered our vocabulary. How can anyone oppose something called population health? But before we join the parade, shouldn’t we ask what population health is?

In its most natural meaning, population health is no more or less than the health of the people in a population. But this could also be called people health. Or just plain health. On this reading, the way to foster population health is to make the individual people in the population healthier. But if all “population health” means is making people healthier, why the new term? And what could it mean if it is not about making individuals healthier?

Another way of reading “population health” is that it means making people healthier on average. This is supported by the fact that proponents of population health frequently cite the statistic that 10% of the people on Medicare use 70% of its resources. Do people who cite this statistic expect more than 10% of the Medicare population to be critically ill at a given time? Would it better if more Medicare beneficiaries were critically ill so that 30% of the people on Medicare used 70% of the resources?

The problem with making people healthier on average is that it probably means making some people less healthy in the interests of the greatest good of the greatest number. That is fine if you are part of the greatest number, but not so good if you are one of the expensively ill. Surely this cannot be what is intended by “population health.”

To untangle the concept of population health, you need two other bits of healthcare reform jargon -- the “medical home” and “population health management.”

The medical home is supposed to keep you from seeking expensive second opinions and care options by “coordinating” your care. Who needs the Cyber Knife if a plain old knife works almost as well? But how is the medical home, which is usually a physician practice, to find time to do all of this “coordinating”? The plan is to have nonphysicians deliver more of the services. Now

the problem is that nonphysicians, for all of their merits, are not physicians. They have a lower level of training, which someone -- presumably a nonphysician -- deems to be enough. This, of course, is the Euro model that everyone says we are not emulating.

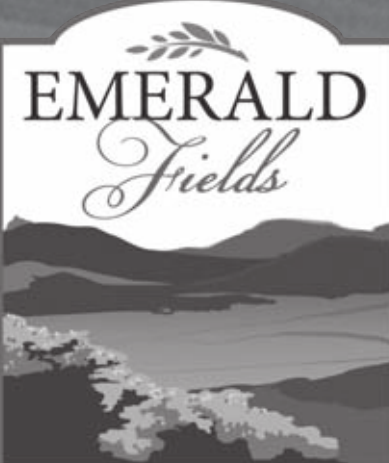
Maybe the payoff comes in the term “population health management.” This seems to be what we used to call “public health.” The idea is to get people to abandon unhealthy lifestyles and seek medical attention before they end up in the emergency room. This is to be accomplished by giving people more face time with medical professionals who will coax them into better conduct. Public health is obviously commendable, but it is unclear whether people will spend more time being obediently instructed by nurses or PAs.

One of the reasons people avoid interacting with the healthcare system until they end up in an emergency room is that the modern medical experience diminishes our individuality. When we speak of population health, as opposed to individual health, we further dehumanize the healthcare process.

Folks are so invested in population health and its related nomenclature, such as “Accountable Care Organization,” that it will be hard to get disinterested data on whether population health delivers benefits. If the outcomes are not good, this will not only signal medical failure; it will signal the failure of healthcare reform.


So who is going to collect data showing a higher error rate in diagnosis if more of it is handled by nurses and PAs? Who wants to find out if there are more deaths when healthcare professionals are rewarded for steering patients away from ERs? Perhaps we would accomplish more if we called our efforts to improve healthcare “people-focused healthcare.” If we improve the health of people, the population will take care of itself. ✚

Mark Pastin PhD (www.markpastin.com) is President of the Health Ethics Trust, an educational, training, and advisory organization for healthcare organizations and professionals, and author of Make an Ethical Difference (Berrett-Koehler, November 2013), in which he advocates an innovative ethics-based approach to healthcare reform.



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Ten Practical Ways to Prepare for ICD-10



By Ryan Secan, MD

ICD-10. If you work in healthcare, chances are you can't go a day without hearing about the October 1st, 2014 mandated transition to the ICD-10 codeset. "ICD" stands for International Classification of Diseases, created by the World Health Organization in 1948. While pretty much the rest of the world has been using ICD-10, which contains 69,000 diagnosis codes, for the past decade, the US has stayed with an older version, ICD-9 (14,000 diagnosis codes), since the late 1970s. Though ICD-10 will provide physicians with greater granularity when it comes to describing a patient's condition(s), it also comes with significant administrative costs and training requirements for physicians and support staff alike.

In 2009, George W. Bush signed a law making ICD-10 mandatory. The codeset was originally to be adopted by the US in 2011, then 2013, and now, 2014. While many in the medical community hope/wish/predict another respite is yet to come, the Centers for Medicare and Medicaid Services (CMS) have been quite vocal of late that there will be no more delays to the October 1st, 2014 implementation date.

So if ICD-10 has you losing sleep at night (a recent Workgroup for Electronic Data Interchange [WEDI] ICD-10 Readiness Survey found that about 50% of surveyed health care providers had yet to complete an ICD-10 impact assessment), with about only nine months to go, here is a top-ten list aimed to jumpstart your ICD-10 implementation process.

10. Accept the fact that ICD-10 is coming

While it's true that pressure from groups like the AMA (who fervently oppose the implementation of ICD-10 given the potential impact to physician productivity and reimbursement) could delay the transition date, as each day goes by, that seems less and less likely (especially given that in December CMS extended the period for

attesting to Meaningful Use stage 2 through 2016, a one-year delay and less on provider groups' plates for 2014). So it's time to move beyond denial, anger, bargaining and make your way to acceptance.

9. Investigate available CMS resources and connect with peers on groups and listservs

Given that the usage of ICD-10 for documenting patient conditions is a mandate from the government, agencies such as CMS have been pretty good about making tools available to aid organizations with how to plan for the transition. In addition, many industry associations have their own ICD-10 FAQs and resources publicly available. Start to spend a little time each day digging into the best approach for transition, educational resources, testing plans and so forth that is applicable to an organization of your size and type of specialty.

8. Evaluate the impact on your group by assessing utilization of ICD-9 codes used for patient billing

One effective way to understand more about the impact of ICD-10 on your group is to do an analysis of what your providers code for in ICD-9. Run a diagnosis frequency report out of your billing system to get a handle on what your most common diagnosis codes are – depending on your group's specialty this may be broad or narrow, but will give you a starting place for what coding might look like in ICD-10.

7. Based on #8, seek guidance on the most appropriate crosswalk tool/option for your group – forward or backward

For many groups that feel behind in terms of physician training and education, the path of least resistance may appear to be a tool that converts an ICD-9 code into an ICD-10 code. This is referred to as "General Equivalence Mappings" (GEMs). While any group can download a GEMs table for free, this is not an exact crosswalk because one-to-one matching is not always possible given there are many more codes in ICD-10 than in ICD-9. The opposite approach is to map backwards from I-10 to I-9 via the "ICD-10 Reimbursement Mappings" table. This is a preferred approach since it places the practice square into the world of ICD-10 coding



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while the backwards mapping can be used as a “cross-check” for what was intended.

6. If your billing/charge capture is paper-based, evaluate alternatives for an electronic solution

While most groups are using electronic medical records for office-based billing, providers that provide care in the hospitals still often find themselves using paper note cards to document charges. This is simply not feasible in the world of ICD-10. It is not too late to investigate electronic options for charge capture. Many of these coding support tools can be run on a provider's smartphone or embed into an existing clinical system, readily fitting into a physician's daily workflow.

5. Request readiness statements from all vendors that touch diagnosis coding

The average physician practice may have upwards of ten plus systems that store or process diagnosis codes. It is critical to have a handle on where each system vendor is in terms of ICD-10 readiness and what will be made available in terms of testing environments, upgrades, and training. And be sure to ask for contingency plans should a vendor fail to have ICD-10 remediation complete by October 1st.

4. Identify coding staff to serve as ICD-10 knowledge sources and clinical staff to potentially serve as early adopters

If it is not financially possible to train an entire business office staff on ICD-10, make sure at least one coding expert is trained and can deliver training to other staff. There are several coding experts and consultants available to deliver web-based or on-site training while industry associations such as AHIMA and AAPC offer coding certification courses as well as web seminars on topics related to specific specialties. On the physician front, try and identify ideally one provider per specialty to adopt the codeset early, perhaps via dual-coding workflow, in order to help bring other providers on board and serve as a training resource.

3. Create a timeline for live usage that gets practice buy-in

Once you have created a plan for coding, gotten a sense for vendor readiness, and established a plan for training, it's time to put the timeline together for when your group will be fully up on ICD-10. For many groups that won't be until October 1st, so be sure

to have milestones along the way. Determine now what amount of charge lag will be acceptable the first few weeks of October and block time each day to confer with physicians around charting or charges that seem problematic.

2. Set the expectation of possible yet hopefully short-term impact to workflow and reimbursement

It is widely known that when Canada introduced ICD-10 back about ten years ago, coder productivity dropped by 40% and took years to rebound. Hopefully the impact won't be so dramatic here, but the reality is, there will be a deceleration to most revenue cycles for some period of time as well as the potential for more denials and greater days in A/R as payers determine policies. So that means billing for every dollar now, and billing things right the first time while rules are still well understood.

1. I'm not kidding. ICD-10 really is coming. See Number 10. +

Ryan Secan, MD is Chief Medical Officer of MedAptus, Inc. For more information, visit www.medaptus.com.

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A Guide to Managing the Off-Campus Facility Move



By Marisa Manley

There is a strong trend among hospitals and medical/healthcare complexes to move high-demand healthcare services, such as urgent care, ambulatory care, and primary care, to smaller, dispersed, easily accessible locations.

An off-campus facility can be a branch or affiliate of the hospital or leased by the hospital to doctors who operate the site as independent practitioners.

Often, a portion of the facility, such as an urgent care center, is branded and operated by the hospital.

Here is a guide to planning and managing an off-campus move.

WHY MOVE OFF CAMPUS?

An off-campus move can help increase patient counts, build market share, and improve visibility among prospective patients.

A hospital may put a facility in a community to increase the hospital's visibility and provide needed services.

When patients use the facility, they think well of the hospital and return in the future.

In addition, the ambulatory care facility may become an entry point for services which reside in the hospital – either because they are more specialized or because they require in-patient care.

Off-campus locations can reach a more affluent market while enabling patients to conveniently use needed services.

A recent study reveals why hospitals push into affluent communities – to “pull well-insured patients to flagship facilities.”

BEST FACILITY TYPES TO MOVE

In a survey, 531 healthcare executives foresaw future growth for:

- outpatient facilities (16%)
- primary care clinics (14%)
- urgent care centers (14%)

These ambulatory-care facilities are prime candidates because they represent a low-cost, patient-friendly delivery mechanism.

Orthopedic, obstetrics/gynecology, behavioral health, and family practice services are other excellent off-campus moves.

Primary care is highly amenable to an off-campus move because it is less technically demanding than other service types.

If a facility will have capital-intensive equipment and technology requirements, moving that facility off campus may be counterproductive.

PLANNING THE MOVE

A practice group's leaders must start with a plan – allocating time and resources to each project phase.

Allow time to quantify space needs, search for a site, analyze all financial and operational terms, negotiate a lease or purchase, design alterations, secure permits, and complete construction or

alterations.

Managers must realistically assess the need to reconfigure and rehabilitate the space, providing adequate administrative offices and clinical and laboratory areas.

When a lease is the solution, managers are well-advised to negotiate with the landlord to obtain funds for the needed buildout.

Building ownership will seldom fund this fully – however, landlord contributions are a valuable source of additional capital; with effective negotiation, it is reasonable to expect landlord funding for fifty percent of the cost.

The funds available for the buildout will be a function of competition in the market, the length of the lease and alternatives available to building ownership.

Based on requests for proposals (RFPs), the project leader selects a well-qualified architect and general contractor (GC) and negotiates needed agreements and budgets.

Challenges can include bringing utilities to the site and assuring the landlord is timely in completing agreed-upon base-building and structural work.

As part of initial programming, managers should systematically assess the specific technical requirements of the new facility.

Any building considered must meet the HVAC and electrical needs of the service to be offered, including enough slab-to-slab height for adequate HVAC flow.

For a lab, and certain clinical operations, for instance those related to reproductive health, managers should provide a location away from fumes and outside air conditions which could taint the lab environment.

If the functions are particularly sensitive, HVAC with HEPA standard air filtration may be needed, as well as a site upwind of highways, factories, or potential contaminants.

For some sensitive laboratory and clinical operations, avoiding excessive vibration – caused by highways, railroads or local anomalies – may also be necessary.

Managers need to assure elevators and emergency generators meet requirements.

Also needed: sufficient electrical capacity for day-to-day needs, which may be substantially more than previous non-medical uses.

For primary care facilities, you may not need an emergency generator, but consider whether this may give your facility an advantage over others.

Accessibility for people traveling to the facility from out of town is a must, including adequate parking.

REACHING TARGET PATIENTS

Practice leaders should consider the best ways to reach sought-after patients.

Staff must understand the need to build a reputation for a welcoming and warm atmosphere, and physical elements of the public areas should contribute to this goal. Patients expect competent medical care when they visit a doctor; increasingly they also demand a positive experience.

Positioning the off-site facility is also important in reaching patients. Will the facility share the hospital's name? How will the hospital affiliation be presented, if at all?

SHOULD YOU DO IT?

As the pressure to control the cost of health care delivery accelerates, more facilities will move off campus, especially primary care and preventive care services.

Contributing to the trend will be baby boomers' demand for improved, more convenient services.

Families, including children, will increasingly visit urgent care centers to receive quick, friendly, effective, affordable care. Hospital executives must create a cost-effective, patient-friendly real estate platform. They must use tested project management methods and proceed correctly, step by step, to assure successful off-campus strategies.

Marisa Manley is president, Healthcare Real Estate Advisors (www.hcreadvisors.com, HCREA), a healthcare real estate advisory firm. She founded the firm in 2009.

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The New Addicts

By Michael Campbell



There is a stereotype image of a drug addict. They are young, unkempt and irresponsible. Their life has never been one of self-discipline, significant accomplishments, or responsible positions.

This is an image most often associated with youth, and certainly not your mother or grandmother.

But it is the generation of seniors that is now joining the ranks of the addicted.

Alice had a full and busy life until her children moved away and she took early retirement from her job.

She thought she would enjoy the leisure time to pursue her hobbies, and was unprepared for the loneliness and loss of purpose that crept into each day.

Her doctor prescribed an antidepressant, and when she spoke of her insomnia, he gave her a sleeping pill.

In time these medications became Alice's best friends; she used them, and then abused them. A grandmother of four became a drug addict at age 64.

At St. Joseph Institute we receive a growing number of calls from children concerned about their parents. They are alarmed by growing mood swings, increased isolation, confusion, and irritability.

The person who they once looked to for guidance now has changed places, and is in need of help.

Aging can become the fertile ground for addiction. The aches and pains of getting older are often being treated with opiates that open the doors to addiction.

(Some researchers claim that no one can take an opiate for more than 12 weeks without becoming addicted and experience the symptoms of withdrawal.)

Grief, anxiety, depression, loneliness and insomnia are commonly treated by doctors with "coping drugs."

The patient is medicated to manage life, rather than encouraged to build a new life that fills the voids, and accepts the changes that come with getting older.

A recent report from John Hopkins cited "substantial and increasing" concern for addictive behavior among seniors. Seniors take on average 4 to 9 prescription medications each day. 25% of seniors use prescription psychoactive medications with the potential to be used or abused. This represents a significant potential for addiction before adding alcohol into the mix.

Today's seniors represent a generation where alcohol has always been a common and accepted part of their lives. Now they are adding in medications at a rate that exceeds all previous generations. Mixing alcohol with benzodiazepines, opiates and stimulants is all too frequent.

These are deadly cocktails that lead to progressively deeper addictive behavior and greater risk.

Recently we approved a woman in her early sixties for inpatient treatment. Sadly, a few days before arriving, she was rushed to the hospital and died.

Antidepressants, sleeping pills and alcohol had proven to be a deadly combination.

The senior decades have been described as the "golden years." However, drug and alcohol abuse are destroying their potential. As healthcare professions we must realize the importance of helping people adjust to these years and find new meaning and purpose. If we continue to medicate them, and not alert them to the dangers of addressing the problems of aging with a growing number of medications, we do no service.

Addiction robs the joy from a generation that deserves to experience the rewards from decades of work and hard fought experience. We have an obligation to ensure that addiction does not destroy the final chapters. +

Michael Campbell is the President and Co-Founder of St. Joseph Institute, a leading center for drug and alcohol treatment near State College, PA.

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Wendy Long is a Senior Care Advisor & owner of Solutions for Independence. Solutions for Independence is a trusted leader in providing comprehensive care management, consulting & fiduciary services to seniors & their families. The program helps to allow seniors to live independently, no matter where they call home.



Wendy is a trusted resource in the elder care market. Through her program, she has offered consulting & care management services in the Pittsburgh area for over 15 years. The care management services have helped hundreds of older adults and their families cope with the demands and challenges of aging. As a professional care manager, Wendy provides peace of mind to families while ensuring their elderly parent(s) is functioning safely in the best environment.

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Cura Hospitality Appoints Lockner to Director of Partnership Development



Becky Lockner

Cura Hospitality recently announced the appointment of Becky Lockner to director of partnership development. Lockner will be responsible for developing Cura’s senior living business throughout our marketing region, promoting exceptional dining and service, LivingLife wellness and clinical care expertise. Most recently, she served as director of business development for Holleran, a market research firm that effectively provides satisfaction and engagement research, organizational assessments, leadership evaluations, and focus group facilitation to many of the largest and most progressive continuing care retirement communities in the country. Earlier in her career at Holleran, Lockner served as client relations manager and senior living consultant. Her

experience in senior living services will forge excellent partnerships with administrators who seek to enhance the lives of older adults. A graduate of Mount Saint Mary’s College in Maryland, Becky and her family reside in York County, PA. A member of Eat’n Park Hospitality Group, Cura Hospitality is a highly responsive and innovative dining services and hospitality provider dedicated to a mission of Enhancing Life Around Great Food. Cura serves over 50 senior living communities and hospitals in the mid-Atlantic region. Cura’s culinary, guest service and clinical professionals provide hospitality and clinical care to more than 20,000 residents, patients and guests each day. Visit us at www.curahospitality.com. +

continued from page 14

The staff could predict the rhythm necessary to make critical decisions. The waiting rooms were no longer overcrowded, as empty chairs often filled the space. The overall impact in each medical office has taken effect across the entire organization. The overall impact of using Lean for process improvements was experienced at all of the three clinics, resulting in an increase in capacity to see more patients per day, improvements in patient flow and an increase in patient and staff satisfaction. Moving away from a disjointed system, the staff was better able to care for and educate the patient through the coordinated delivery of care. Physicians were able to complete documentation before the end of the day, an experience several had not had a long time. Patients no longer had extensive wait times and were able to tell their story to the team at one time. Plus, from the network’s perspective, costs had been reduced,

Results			
	Center A	Center B	Center C
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Average Experience Time (min.) After	44	43	54
Add'l Annual Capacity Realized	292	132	273
Estimated Total Savings =			\$423,892.00

while increasing revenues generated by seeing additional patients. In addition to achieving an estimated \$423,892.00 in hard dollar savings, the organization benefited from patient loyalty, improving their image within the community. Physician practices are playing a critical role in the changing healthcare landscape. It is pertinent that large healthcare networks and independent groups alike make moves toward patient-centered models and increased revenue opportunities to remain competitive and in a position to deliver top notch care. Lean process improvement is a unique approach because it empowers those closest to the work to improve it continuously – not in just one big project. Small, incremental, and consistent improvement through teamwork will drive better quality, while simultaneously removing unnecessary, and often costly, activity. + Lori Kauflin is a Healthcare Consultant with TechSolve. For more information, visit www.techsolve.org.

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Leadership Profile: Charles Tullius, M.D.

Organization: Pre Med Assistance

Title: Founder and CEO

Education: Serra Catholic High School (with Honors), 1981, Saint Francis College (Magna Cum Laude), 1985; Jefferson Medical College, 1989

First Job: Delivering flowers for Flowers with Imagination in Elizabeth, PA

Your Philosophy of Success: Be kind and gracious to as many people around you as possible. Treat everyone with dignity. Don't ask people to do anything you wouldn't do yourself. Lead by example. Make up for any perceived deficiencies with hard work- and do it with a smile on your face.

Favorite Books: 1984 by George Orwell

Who are some of your mentors: My mentor in medicine is my cousin, Larry Mulkerin, M.D. (Pitt Med, '62). At age 78, he's still teaching, and writing a weekly column for the daily newspaper in his town. Trained as a radiation oncologist, Larry not only has an encyclopedic knowledge of his specialty, but is current and relevant on many other topics in medicine. He was also a Green Beret, stationed in the Middle East in the mid 1960's. He's traveled the world caring for patients, all while being a dedicated family man. He's recently published a novel, too. For work ethic, I saw my father put in long hours in the steel mill, but still had time to manage my baseball team. He always said that he didn't want me to have to do what he did.

Accomplishment you are most proud of: graduating from medical school.

What do you like to do with your free time: keep in touch with old friends, play golf and travel with my wife, Michelle.

Biggest challenge confronting healthcare today: People come to the United States from all over the world for our healthcare. We have to make sure our quality of medicine doesn't end up like theirs. We don't confront "end of life" issues very well. The massive cost of medical education is very rarely talked about in the debate either.

Would you like to submit your own leadership profile? Email Daniel Casciato at writer@danielcasciato.com for more information. +



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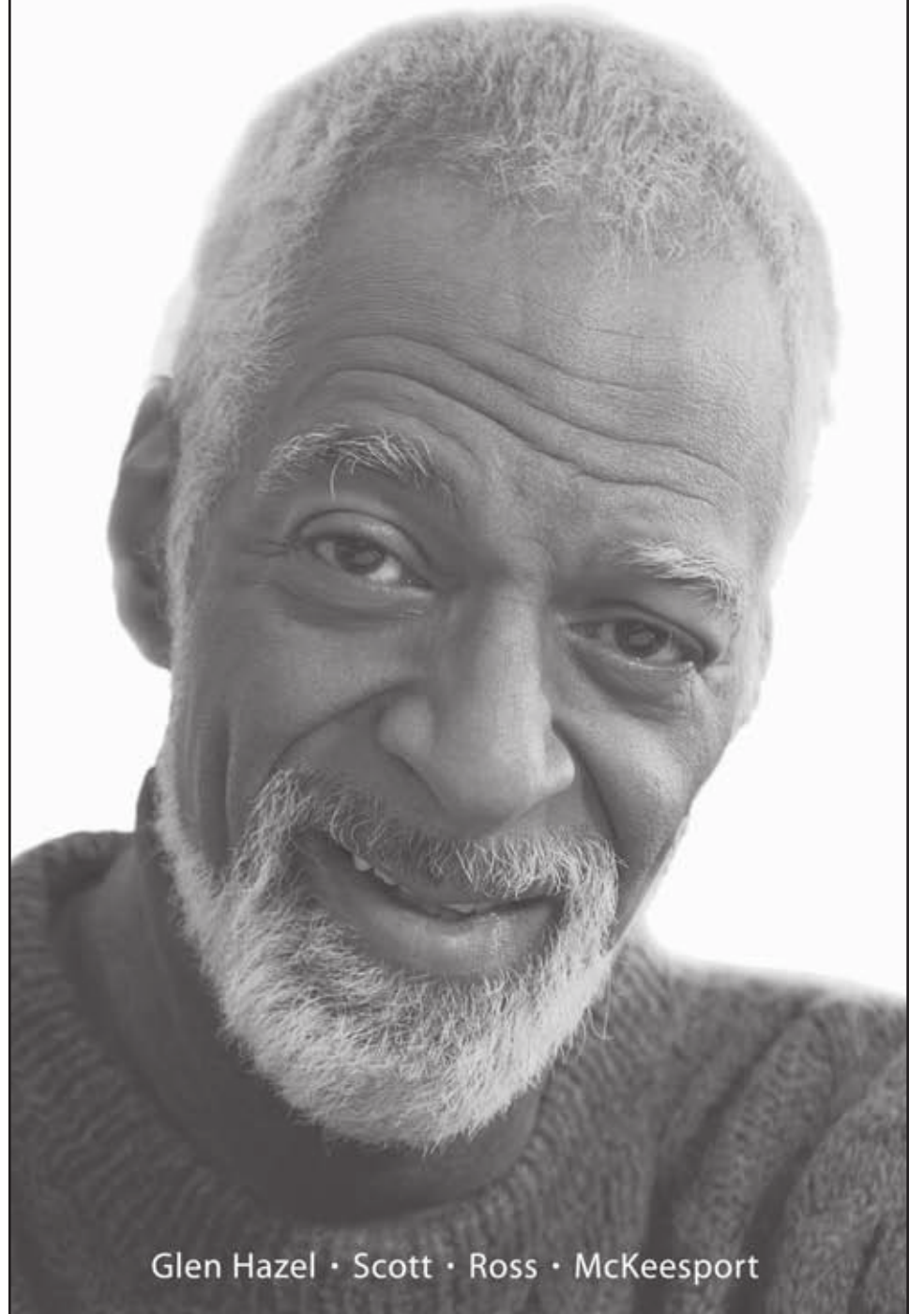
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A New Model to Improve Financial Outcomes for Facilities

By **Scott McCall** and **Michael J. Kessler**

You are familiar with the concept of coordinated care for better patient health outcomes. What you might not be familiar with, but what this article will describe, is a new approach to help healthcare facilities achieve better financial outcomes. For simplicity, we'll refer to this model as Coordinated Consulting. The underlying concept for Coordinated Consulting is similar to coordinated care: take a holistic approach to improving the condition of your facility by coordinating the business consultants working with the facility to improve operations. The goal of coordinated consulting is improved outcomes and results.

THE PRIMARY CHALLENGE: REIMBURSEMENTS

In recent years most facilities have seen their incomes decline as a result of Medicare and Medicaid reductions. The first major reduction came in the fourth quarter of 2011, with Medicare reimbursements reduced by 11.1%. Federal and State reimbursement modules for skilled and long-term care nursing services have not only become more complex in recent years, they have not kept up with inflation. And although Medicaid reimbursement methodologies vary from state to state, the clear trend nationally is budgeted increases that don't outpace inflation, or rate freezes altogether.

These reimbursement reductions have also contributed to staffing challenges just when Nursing Homes are working to fill nursing full time equivalents. And although there is no single answer, there are ways facilities can navigate this complex landscape. The first step is to evaluate your current operations for opportunities to implement process improvements for increased efficiencies.

- Is the therapy department capturing all the Medicare Part B revenue that is currently possible? If you have a large long-term care population, there is possibly additional Medicare Part B therapy revenue that can be captured.
- Have the proper procedures been worked out to make sure prescription drugs are covered by the Medicare Part D formulary? This issue alone could add up to tens of thousands of dollars or even hundreds of thousands of dollars for larger facilities.
- Are Medicare bad debt logs properly completed for uncollectible Medicare Part A Co-Insurance?
- Are non-dual eligible residents reported on the bad debt logs for reimbursement?

The next step, from a clinical standpoint, is determining if the right policies and procedures are in place for proper and accurate MDS documentation. Case-Mix Index (CMI) drives reimbursement in certain reimbursement modules, so this is extremely important. Documentation also drives Medicare RUG scores, so facilities should benchmark their Medicare RUG scores to comparable facilities, to identify revenue enhancement opportunities.

THE NEW CHALLENGE: HEALTHCARE REFORM

After several years of debate and legal challenges, it would appear that healthcare reform is here to stay. This new set of rules creates a new set of challenges for healthcare facilities that manage large staffs comprised of full-time, full-time equivalent, part-time and variable hour workers. These designations are important and must be managed under

new rules that outline a timely and complex process for establishing, managing and reporting employment status and measurement periods. HR departments are charged with more complex compliance and reporting responsibilities under the Affordable Care Act (ACA), but in most cases will not be given additional resources to keep pace with these new administrative obligations.

A timely example of new administrative responsibilities is the Exchange Notice that must be given to all Employees by October 1, 2013 – as well as all employees hired after this date, within 14 days of their start date. If a facility offers similar coverage to all employees, the distribution of this notice is the same across all employees with one Exchange Notice. However, if the facility has several classes of employees for whom coverage and cost varies, different versions of the Notice, specific to those classes, must be prepared and distributed according to those classes. Preparing this notice and responding to the questions it will prompt is just a small example of how new compliance and reporting responsibilities can strain limited administrative resources.

When you add to the administrative burdens the new taxes and costs of traditional, fully-funded, defined benefit group health plans under ACA, it is easy to understand why facilities are facing tough decisions about how to manage the costs of their group health insurance plans while offering employees meaningful benefits. To offset these new costs and administrative responsibilities, facilities must begin to consider new options for how they administer, fund and define group health plans to remain competitive and to maximize their insurance cost investment.

COORDINATED CONSULTING FOR IMPROVED OUTCOMES

With new and changing challenges across a variety of fronts, facilities are looking for affordable ways to improve operational efficiencies, patient outcomes and financial performance. These fronts are inter-connected and changes to one area impact other areas, either positively or negatively. Unfortunately, with reimbursement cuts and added compliance responsibilities, most facilities have had to cut back on the consulting services that they once employed to help them overcome complex, cross-departmental challenges.

Fortunately, a new business model is emerging to help facilities access and pay for valuable consulting services. Not only does this new model provide financial advantages, it delivers operational advantages because it offers a team of experts working in a coordinated fashion to help the facility implement targeted and priority action items to improve its performance.

The HDH Group is taking the lead to create this new model, helping facilities overcome complex business challenges by creating teams of industry experts to help improve processes across the organization, including: billings; reimbursements; compliance; employee benefits and administration; safety; workers' compensation; risk management; loss prevention; and training.

Serving as the business team leader, HDH Group is implementing this new business solutions model to extend a facility's typical insurance investment to go beyond insurance and include priority process-improvement initiatives. The result for facilities is a more affordable and connected strategy for improving and protecting operations, while creating a safer environment for residents and employees.

CONCLUSION

Skilled and long-term care facilities are looking for better ways to improve how they manage their operations to overcome reimbursement and compliance challenges. The HDH Group is working with industry experts like Carbis Walker and others to deliver advanced business solutions that meet facilities' operational and financial needs.

The HDH Group's innovative Coordinated Consulting solutions model is designed to extend a facilities' insurance investment to deliver more than insurance by including targeted business process improvements. This cross-functional model is focused on reducing risks, improving efficiencies and safety, lowering costs and claims, and maximizing investments in human capital management in order to attract and retain productive staff, which together work to improve the overall operations of the facility and its financial outcomes. +

Scott McCall is Vice President, Healthcare of HDH Group. Michael J. Kessler, CPA, is Manager, Healthcare Services of Carbis Walker, LLP. For more information, contact Scott McCall of HDH Group at 800-434-7760 or scott@hdhgroup.com.



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20 Years of Community Service — A Service with National Accreditation

The national Commission for the Accreditation of Ambulance Services (CAAS) certification signified that the Elizabeth Twp. service has met the “gold standard” determined by the ambulance industry to be essential as a modern emergency medical services provider.

These standards often exceed those established by state or local regulation. The CAAS standards are designed to increase operational efficiency and clinical quality, while decreasing risk and liability to the organization.

Having chest pains? Call EMS. The Elizabeth Township and neighboring residents have a service that prides itself for a “one minute out the door” policy. There ambulances have direct electronic communication link to the hospital.

The Emergency Room physician is reading your vital signs sent from the EMS ambulance. When you arrive at the hospital, they know a great deal about you and your basic needs. This helps to provide the ER Doctor to prepare for immediate care for your recovery.

Elizabeth Twp. Area Emergency Medical Services (ETAEMS) celebrated completing 20 years of service. Above is the picture of one of two stations utilized by this EMS.

They provide: life support, ambulance and transport services for Elizabeth Twp. also 4 neighboring communities (Elizabeth Boro, Liberty Boro, Versailles Boro and Advance Life Support for Lincoln Boro). The EMS has 36 professionals and 11 vehicles that are state-of-the-art and the service is considered by CAAS as being ranked in the top 1% best in the country.

“This recognition does not come easy,” stated Jim Surman, Vice President of ETAEMS. “The following are some of the activities that puts us in the top one percent of EMS services for quality in the country:

Staff are all routinely required to complete in-service training for all new equipment, medical supplies and procedures though-out the year to assure the highest quality of service to our community. For example, we added a new medication for children with respiratory problems called Racemic Eprinephrine.

Our Continuous Quality Improvement (CQI) Committee is very active and requires education for this new drug as well as all new medications, equipment and medical procedures.

Our staff have attended EMS Command School training by the County EMS Council.

We are certified by the PA Dept. of Health as a Continuing Education

Sponsor Site. Our staff have participated in “Response to Active Shooter Incidents,” in addition to “Meth Lab Awareness” training sponsored by the PA DEA.

Our staff, this past year have received awards from: our State Representative, the Allegheny County EMS Council, as well as our staff have received a scholarship for Paramedic Training just to name a few accomplishments.

The Journal for Emergency Medical Services has recognized our staff for the development of new safety equipment that will help the entire industry and the journal has recognized us for our participation in the Superstorm Sandy disaster.

Our community outreach is unprecedented in our industry. As an example, our outreach last year included for residents: Flu Shots, Toys-for-Tots, a health safety poster contest at the Elizabeth Twp. School District, CPR classes at our station as well as for our Police & Fire departments, the School Districts, local businesses and other organizations. We have participated in many “Health Fairs,” provide coverage at football games and conducted “Mock Crash” events.

Our Specialty Teams became actively involved with the SHACOG Critical Incident Response Team (CIRT), participated with the Regional Honor Guard at various County, Region and State events, actively participated with the Critical Incident Stress Management Team through the Allegheny County EMS Council and participated in exercises coordinated by FEMA nationally and the states PEMA program as part of the PA Region 4 EMS Strike Team.”

“So as you can imagine, quality service does not just happen, but is a process and commitment by Chief Chris Dell, the management and staff of the entire organization,” stated Surman. “Dave Graham, the President of our Board, has stressed to Chris, in many of our Board meetings, if there is a choice of deciding between quality and cost, quality is to take precedent. We will somehow find the means to make it happen.”

Surman added, “And over the past 20 years, the Elizabeth Township EMS have been able to do just that, provide the best quality emergency care for our community and still maintain the viability and growth of the organization.”

The EMS is asking the communities of Elizabeth Township, Elizabeth Boro, Liberty Boro and Versailles Boro residents to renew membership in the “Help Us, Help You” Ambulance Subscription Drive underway. Call: 412-751-0919 for details. +

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

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Established in 1893, The Children's Home of Pittsburgh is an independent non-profit organization whose purpose is to promote the health and well-being of infants and children through services which establish and strengthen the family. The Children's Home has three programs: a licensed infant Adoption program, Child's Way® day care for medically fragile children, birth to age 21, and a 24-bed Pediatric Specialty Hospital, providing acute care for children ages birth to 21, transitioning from hospital to home. Additionally, our Family Living Area provides families with amenities to help make our hospital feel more like home, allowing them to stay overnight with their child. For more information, visit www.childrenshomepgh.org.

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ST. BARNABAS HEALTH SYSTEM

RNs, LPNs, Home Care Companions, Personal Care, Attendants, Hospice Aides, Dietary Aides. St. Barnabas Health System frequently has job openings at its three retirement communities, three living assistance facilities, two nursing homes, and an outpatient medical center that includes general medicine, rehab therapy, a dental practice, home care and hospice. Campuses are located in Gibsonia, Allegheny County, and Valencia, Butler County. Enjoy great pay and benefits in the fantastic suburban setting. Both campuses are a convenient drive from the Pennsylvania Turnpike, Routes 8, 19 and 228, and Interstates 79 and 279. Contact Margaret Horton, Executive Director of Human Resources, St. Barnabas Health System, 5830 Meridian Road, Gibsonia, PA 15044. 724-444-JOBS; mhorton@stbarnabashealthsystem.com, www.stbarnabashealthsystem.com.

EXTENDED CARE & ASSISTED LIVING



ASBURY HEIGHTS

For over a century, Asbury Heights, operated by United Methodist Services for the Aging, has been providing high-quality compassionate care to older adults in Southwestern Pennsylvania. Asbury Heights is a faith-based, non-profit charitable organization located in Mt. Lebanon. Through various accommodations, services and amenities, the needs of independent living residents can be met. For residents requiring more care, the continuing care community also offers personal care, nursing and rehabilitative care and memory support specialty care. Our Nursing and Rehabilitation Center has received a 5 Star Rating from the Centers for Medicare and Medicaid Services. The Health and Wellness Center is headed by a board certified, fellowship trained geriatrician. Two of our physicians were listed in 2012 Best Doctors by Pittsburgh Magazine. Residents may be treated by on-site specialists or retain their own physicians. Rehabilitative therapies are also available on-site. A variety of payment options are available to fit individual financial situations. The application process is very quick and easy and does not obligate the applicant in any way. For more information, please call 412-341-1030 and ask for Loretta Hoglund for independent living; Darla Cook for nursing admissions, or Lisa Powell for personal care. Visit our website at www.asburyheights.org.

OAKLEAF PERSONAL CARE HOME

"It's great to be home!"

Nestled in a country setting in a residential area of Baldwin Borough, Oakleaf Personal Care Home provides quality, compassionate care to adults who need assistance with activities of daily living. As we strive to enhance the quality of life of our residents, our staff constantly assesses their strengths and needs as we help them strike that fine balance between dependence and independence. Oakleaf offers private and shared rooms, all located on one floor. Our home includes a spacious, sky-lighted dining room, library, television lounges, sitting areas and an activity room. Our fenced-in courtyard, which features a gazebo, provides our residents with a quiet place to enjoy the outdoors, socialize with family and friends, and participate in planned activities. Upon admission, the warmth of our surroundings and the caring attitude of our staff combine to make Oakleaf a place residents quickly call "home". Please call for additional information, stop by for a tour or visit us on our website. www.oakleaf-personalcarehome.com.

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Equal Housing Opportunity



PRESBYTERIAN SENIORCARE

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

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

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

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

For more information about Presbyterian SeniorCare, please call 1-877-PSC-6500 or visit www.SrCare.org.

ST. BARNABAS HEALTH SYSTEM

Regardless of what lifestyle option a senior needs, St. Barnabas Health System has a variety of choices to fulfill that need. Independent living options include The Village at St. Barnabas apartments, The Woodlands at St. Barnabas and White Tail Ridge carriage homes, and The Washington Place at St. Barnabas efficiency apartments. Living assistance is available at The Arbors at St. Barnabas in Gibsonia and Valencia. Twenty-four hour skilled care is provided at St. Barnabas Nursing Home and Valencia Woods at St. Barnabas. St. Barnabas Medical Center is an outpatient facility that includes physicians, chiropractors, general medicine, rehab therapy, a dental practice, home care, memory care and hospice. The system's charitable arm, St. Barnabas Charities, conducts extensive fundraising activities, including operating the Kean Theatre and Rudolph Auto Repair. St. Barnabas' campuses are located in Gibsonia, Allegheny County, and Valencia, Butler County. For more information, call 724-443-0700 or visit www.stbarnabashealthsystem.com.

WESTMORELAND MANOR

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

Carla M. Kish, Director of Admissions

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ANOVA HOME HEALTH AND HOSPICE

Anova Healthcare Services is a Medicare-certified agency that has specialized care in home health, hospice & palliative care, and private duty. Anova concentrates their care within seven counties in South Western PA. Through Anova's team approach, they have developed a patient-first focus that truly separates their service from other agencies in the area. Home Health care is short term acute care given by nurses and therapists in the home. Private duty offers care such as companionship, medication management and transportation services. Hospice is available for people facing life limiting conditions. With these three types of care, Anova is able to offer a continuum of care that allows a patient to find help with every condition or treatment that they may need. Anova's goal is to provide care to enable loved ones to remain independent wherever they call home. Anova Knows healthcare ... Get to know Anova! 1229 Silver Lane, Suite 201 Pittsburgh, PA 15136 1580 Broad Avenue Ext., Suite 2 Belle Vernon, PA 15012 1-877-266-8232



BAYADA HOME HEALTH CARE

Since 1975, BAYADA Home Health Care has been helping people of all ages have a safe home life with comfort, independence, and dignity. We believe our clients come first and our employees are our greatest asset. Every level of care is supervised by a registered nurse (RN) clinical manager and all of our services are provided with 24-hour clinical support. BAYADA Home Health Care assists adults and seniors who need nursing care and assistive care services at home or in the hospital. BAYADA Pediatrics—a specialty of BAYADA Home Health Care—specializes in helping children of all ages with complex needs to cope with illness or injury at home and at school. www.bayada.com



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INTERIM HEALTHCARE HOME CARE AND HOSPICE

Interim HealthCare is a national comprehensive provider of health care personnel and services. Interim HealthCare has provided home nursing care to patients since 1966 and has grown to over 300 locations throughout America. Interim HealthCare of Pittsburgh began operations in 1972 to meet the home health needs of patients and families throughout southwestern Pennsylvania and northern West Virginia and now has offices in Pittsburgh, Johnstown, Somerset, Altoona, Erie, Meadville, Uniontown and Morgantown and Bridgeport WV. IHC of Pittsburgh has been a certified Medicare and Medicaid home health agency since 1982 and a certified Hospice since 2009. We provide a broad range of home health services to meet the individual patient's needs - from simple companionship to specialty IV care and ventilator dependent care to hospice care - from a single home visit to 24 hour a day care. IHC has extensive experience in working with facility discharge planners and health insurance case managers to effect the safe and successful discharge and maintenance of patients in their home. For more information or patient referral, call 800-447-2030. Fax 412 436-2215 1789 S. Braddock, Pittsburgh, PA 15218 www.interimhealthcare.com

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MEDI HOME HEALTH AND HOSPICE

Medi Home Health and Hospice, a division of Medical Services of America, Inc., has a unique concept "total home health care." We provide a full-service healthcare solution to ensure the best patient care possible. Every area of service is managed and staffed by qualified professionals, trained and experienced in their respective fields. Surrounded by family, friends and things that turn a house into a home is what home care is all about. Our home health care manages numerous aspects of our patients' medical needs. Our Hospice care is about helping individuals and their families' share the best days possible as they deal with a life-limiting illness. Most benefits pay for hospice care with no cost to you or your family. Caring for people. Caring for you. For more information or for patient referral please call 1-866-273-6334.

PSA HEALTHCARE

At PSA Healthcare, we believe children are the best cared for in a nurturing environment, where they can be surrounded by loving family members. We are passionate about working with families and caregivers to facilitate keeping medically fragile children in their homes to receive care. PSA Healthcare is managed by the most experienced clinicians, nurses who put caring before all else. Our nurses are dedicated to treating each patient with the same care they would want their own loved ones to receive. PSA is a CHAP accredited, Medicare certified home health care agency providing pediatric private duty (RN/LPN) and skilled nursing visits in Pittsburgh and 10 surrounding counties. The Pittsburgh location has been providing trusted care since 1996, for more information call 412-322-4140 or email scoleman@psakids.com.



SOLUTIONS FOR INDEPENDENCE

Solutions for Independence offers several services to seniors and their families. These services include but are not limited to assistance, with health care decisions, physician appointments, medication management & acting as a liaison between clients, their families and their physicians. We also provide assistance with long-term-care decisions including housing, assisted living/nursing home options, insurance and government benefits programs. We can also act as power of attorney or legal representative.

The guidance and direction we offer to seniors and their families is invaluable. At times it is very difficult to navigate the healthcare system, make long-term care decisions, and understand the aging process. Our advisors can help and offer piece of mind to the families we assist that their loved ones needs are well taken care of. For more information visit www.solutionsforindependence.com, email wendy@solutionsforindependence.com, or call 412.999.7892.

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THE CHILDREN'S INSTITUTE

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

For more information, please call 412-420-2400

The Children's Institute
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PUBLIC HEALTH SERVICES

ALLEGHENY COUNTY HEALTH DEPARTMENT

The Allegheny County Health Department serves the 1.3 million residents of Allegheny County and is dedicated to promoting individual and community wellness; preventing injury, illness, disability and premature death; and protecting the public from the harmful effects of biological, chemical and physical hazards within the environment. Services are available through the following programs: Air Quality, Childhood Lead Poisoning Prevention; Chronic Disease Prevention; Environmental Toxins/Pollution Prevention; Food Safety; Housing/ Community Environment; Infectious Disease Control; Injury Prevention; Maternal and Child Health; Women, Infants and Children (WIC) Nutrition; Plumbing; Public Drinking Water; Recycling; Sexually Transmitted Diseases/AIDS/HIV; Three Rivers Wet Weather Demonstration Project; Tobacco Free Allegheny; Traffic Safety; Tuberculosis; and Waste Management. Ronald E. Voorhees, MD, MPH, Acting Director. 333 Forbes Avenue, Pittsburgh, PA 15213 Phone 412-687-ACHD Fax: 412-578-8325 www.achd.net

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HEALTHCARE EVENT AND MEETING GUIDE

Longwood at Oakmont Hosts Dr. Carl: Hope and Healing for Brains and Bodies

Thursday, April 3, 11:00 a.m.
Longwood at Oakmont, 500 Route 909, Verona, PA 15147
RSVP: 1-877-435-7857 or www.LongwoodAtOakmont.com/spring

Alzheimer’s Education Series: Quality Time When Visiting

Presented by Lois Lutz from the Greater Pennsylvania Alzheimer’s Association
Lunch and discussion are free of charge
Wednesday, April 9, 11:30 a.m.—1:00 p.m.
Presbyterian SeniorCare in the Atrium at Westminster Place, 1215 Hulton Road, Oakmont, PA 15139
RSVP by Friday, April 4.
Contact Jennifer Marasco at 412.826.6536 or jmarasco@srcare.org.

Practical Interventions for Autism: Evidence, Practice, Schools, and Families

Hosted by The Connections Autism Program of Sharon Regional Health System
Thursday, April 17, from 8:00 a.m. to 12:30 p.m.
Sharon Regional’s School of Nursing, 740 East State Street, Sharon
Program is free unless CEUs are desired then a \$20 fee applies.
Call 724-983-5518 or 800-346-7997.

Alzheimer’s Education Series: Quality Time When Visiting: Communication Strategies

Presented by Lois Lutz from the Greater Pennsylvania Alzheimer’s Association
Wednesday, May 21
Presbyterian SeniorCare in the Atrium at Westminster Place, 1215 Hulton Road, Oakmont, PA 15139
11:30 a.m.—1:00 p.m.
RSVP by Friday, May 16
Contact Jennifer Marasco at 412.826.6536 or jmarasco@srcare.org.

Longwood at Oakmont hosts Jessica Walliser: “No Fuss” Gardening

Wednesday, May 7
11:00 a.m.
Longwood at Oakmont, 500 Route 909, Verona, PA 15147
Call 1-877-435-7857 or visit www.LongwoodAtOakmont.com/spring.

Highmark’s Walk for a Healthy Community

Saturday, May 17
Stage AE on the North Shore
Register at www.walkforahealthycommunity.org

The Pennsylvania Osteopathic Medical Association’s 106th Annual Clinical Assembly and Scientific Seminar

April 30-May 3
Valley Forge Convention Center in King of Prussia
Forty AOA CME credits are anticipated (34 Category 1A credits and 6 Category 1B credits).
Register at twww.poma.org.

Andy Russell Celebrity Classic


May 15-16
Heinz Field East Club Lounge, Allegheny Country Club
Call 412-802-8256 or visit andyrussell.org.

TEMS Training at Penn State Fayette, The Eberly Campus

June 19-23
Registration will start in March.
Class size is limited.
Call or email Sherry L. Nicholson at 724-430-4217 or sln177@psu.edu.

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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New Breast Density Law in Pennsylvania

On November 6, 2013, the Breast Density Notification Act was signed into law. The act requires all mammogram reports to include information regarding breast density.

Federal law currently mandates that each woman who goes for a mammogram receives a letter explaining her test results. Thanks to the Breast Density Notification Act, Pennsylvania now requires that information about a patient's breast density be included in the letter as well.

"The law states women must now be made aware of their breast density," explains Saadia H. Khan, DO, director of the breast center at ACMH and member of the Foundation Radiology Group. "The new breast density law is meant for women to be aware of their breast density and how that affects their overall risk for breast cancer. It should encourage detailed conversations with their practitioners about the implications of their breast density and consideration for the use of another modality to evaluate someone with dense breasts. This could also segue into more detailed patient history and assessment of other risk factors that could place a patient at higher risk for breast cancer."

According to a study by the American College of Radiology Imaging Network (ACRIN), approximately 40% of women have dense breasts. This density can be a critical factor in breast cancer detection. Specifically, dense breasts decrease the sensitivity to detect cancers on mammograms by up to 20%. Dr. Khan elaborates: "Mammography has been clinically

proven to save lives.

But in a woman with dense breasts, it's less effective at detecting cancers. Women with dense breasts benefit from a 'second look.' This could be done utilizing different technologies, such as breast MRI or ultrasound." Fortunately, ACMH Hospital continues to offer the latest technology in breast cancer detection for patients with dense breasts, including both breast MRI and Automated Breast Volume Scanner (ABVS). Dr. Khan explains that "ABVS or 3D breast ultrasound allows diffuse ultrasound evaluation of dense breasts - another way to 'see through' the dense fibrocystic tissue." Starting in January 2014, ACMH Hospital has been meeting the new Pennsylvania breast density requirements thanks to the ABVS system and the 3D ultrasound technology it provides.

It is important to note that breast ultrasounds are not designed to replace the annual mammography. A trial recently conducted by ACRIN shows that there is a significant benefit to supplementing a standard mammography with an ultrasound for high-risk women. "Mammography is still the gold standard for breast evaluation," states Dr. Khan. "Ultrasound does not replace mammography in a woman with dense breasts. The two modalities in conjunction allow for a complete and optimal evaluation of dense breasts."

The new breast density law allows for a comprehensive evaluation of dense breasts and a multifaceted approach to women's breast health, including the radiologist, practitioner and patient. This empowers the patient with full knowledge of her breast density, overall breast health, and risk for breast cancer. +



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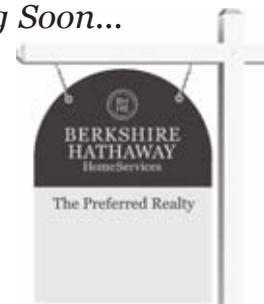
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