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Piñon On The Move

FROM THE PRESIDENT

The Legacy of James P. Smith

By Jeff Jerebker | *President, Piñon Management*

*"I look into the eyes of my merciful friend
And then I ask myself, 'Is this the end?'
Memories linger, sad yet sweet
And I think of the souls in heaven who we'll meet"*

Bob Dylan | *'Cross the Green Mountain*

I was coming out of the best years of my life when my family and I moved to Denver in the summer of '74. The prior two and a half years we were living in rural Pennsylvania, in a small spiritual commune where we grew our own organic vegetables, baked our own bread, meditated daily, read spiritual books, raised children, and needed little in money. Life had a peaceful and serene rhythm and the chaos of the outside world seemed a long way off.

We befriended a Quaker commune some 20 miles away and together we started a school, for my son as well as other children who were approaching that age. It is that project that taught me the Quaker way of learning circles, consensus development and the blessings of true humility.

As fate would have it, my wife on a visit to Denver experienced a Waldorf school run by the disciples of Guru Maharaj-Ji. Upon her return she believed, and I reluctantly concurred, that Denver was our place to go. Interestingly, a Quaker family that we were hanging out with also moved to Denver.

Once in Denver, I needed a "real" job and fell back on my professional accounting experience. I applied for a CFO position in a small management company that operated five nursing homes. Little did I realize what a life-changing event that was to be.

The One Question Interview

It was a family management company and I was interviewed by the eldest son, Jerry Smith, who was the operational director. After an extensive screening-out interview, he told me to wait and I would be next interviewed by the owner – his father – James P. Smith. There were bad economic times in Denver and many people were applying for this job. Many were ahead of me, waiting to be interviewed by "Jim", as I patiently waited.

It had been a while since I last had a job interview and I "cleaned up my act" by shaving my beard, cutting my hair and dressing in a tie and jacket.



Okay, it was my turn. I nervously went into the office where a white-haired, thin gentleman told me to sit down. He asked me one question about the role of the CFO in a company that operates nursing homes. I don't remember what I replied, but all I know is that he immediately offered the job to me if I wanted it – and when could I start? WOW! I went home and told my wife that I got hired by a one-question interview and that my new boss was obviously not a “normal” guy. (I considered that a huge plus.)

For the next five years I worked for a man who was way ahead of his time. His vision of resident empowerment,

underpinnings of his “madness.” There were three exceptions – namely, myself, David Stang and Alice Letang. The three of us really admired and were inspired by Jim's vision and absorbed his wisdom like sponges. As I have been recently reminiscing with David, we were the blessed ones. We were free to learn from Jim, and we enjoyed him. Jim was not only a philosophical and pedantic leader, he also had a hilarious Charlie Chaplinesque way about him. He was a classic non-conformist in an all too conformist profession.

Despite these attributes, Jim had a couple of adversaries that were difficult to surmount. One was that

assisted living facilities. Jim had three full-time physical therapists, three full-time occupational therapists, and one speech therapist on staff as well as a full-time discharge planner. A true interdisciplinary team with a rehab and return to home philosophy was the cornerstone of this remarkable facility.

Due to the high Medicare utilization, census fluctuated from the mid-teens to the high 30's. To manage that, I researched the fiscal intermediaries rules and discovered the Periodic Interim Payment plan, whereby reimbursement would be predictable over a three month period with quarterly reconciliations. I immediately

“ A man too far ahead of his time is an unrecognized man in his own time. ”

CNA participation in care planning, psychosocial programming and rehabilitation was beyond any reference point or any organized movement. Back in the mid-70's there was no Eden Alternative, no Live Oak Institute, no Pioneer Network. Jim was truly the proverbial lone voice in the wilderness. Was anybody listening?

Among his own peers, many admired him for his vision, but all doubted its practicality. Among his own organization of management leaders and NHAs, most saw his imperfections and benignly spoke of his visions. His family members were protective of Jim and were always concerned about his money management skills (an admitted weakness). Most NHAs experienced Jim as bizarre and unpredictable, not comprehending the philosophical

he was way too far ahead of his time, meaning that there was no support system for his vision in the outside community. (A key exception to this would be Virginia Fraser.) The second adversary was his own deficits in day to day management, as Jim was a pure visionary and not a sophisticated operator.

Julia Temple North

A prime example of Jim's vision was Julia Temple North in Lakewood, Colorado. Developed by Jim in the early 70's, this 42 bed skilled nursing home was 100% Medicare certified. The residents there were mostly Medicare with a handful of private pays. This facility was rehab and discharge focused. The average length of stay was approximately 45 days. 85-92% of all discharges went back to home. Please remember that back then there were no HCBS nor

applied for it and I was informed by Blue Cross that they were not set up for it for nursing homes – only for hospitals. Julia Temple North was the first nursing home to apply for this. Nevertheless I persisted and Julia Temple North eventually did get on the PIP plan, which allowed it to operate for a few more years.

Everett Court

Another example of a Jim Smith-led facility way ahead of its time (the late 70's) was Everett Court. This facility's resident population consisted of alcoholics, chronic mentally ill, and other behaviorally challenged individuals. Jim forsook the hegemony of the medical model and instilled a strong psychosocial and resident empowerment model. He established a community advisory board for this facility consisting of business people, internal employees (myself) and a

graduate student named Virginia Fraser. Everett Court admitted residents no other nursing home could manage, and despite an amazing success in creating a program for its residents, it had two fatal flaws. One was that it was way too far ahead of its time (sound familiar?), and two, it did have clinical challenges.

The Health Department ended up closing Everett Court despite the success of creating home for people where none before were able to do so. Prior to this, Virginia Fraser was appointed to the State Ombudsman position for Colorado and had resigned from the Community Advisory Board. In an act of principled defiance, Ms. Fraser, along with many residents, protested the action by the Department of Health. Ms. Fraser for the next twenty years or so became the embodiment of independent

resident advocacy regardless of its political implications, a principle that has eroded since her departure from that role.

Fifteen years later or so, when Paul Daraghy succeeded Mildred Simmons at Health, I had a meeting with Mr. Daraghy. During the meeting he looked at me and said, "I believe the Health Department was wrong about Everett Court." Remarkable!

Jim Smith retired a few years after the Everett Court debacle and passed on his legacy, selling most of his business to me and a few NHA's including David Stang and Alice Letang.

Jim never received any recognition for his contributions from his professional peers. No Vesta Bowden Award, no Alan Buckingham Award, no anything. A man too far ahead of his time is an unrecognized man in his own time.

However, Piñon has received numerous awards. I received the Vesta Bowden in 1995; Virginia Fraser also received the Vesta Bowden, in 1986; and David Stang became the first Piñon NHA to receive the NHA of the Year Award for his amazing work at Spearly, a direct descendant of Everett Court.

Piñon honored Jim Smith at its 25th anniversary party in 2004 for his amazing contributions, insights and vision. His family was there, including Jerry Smith. In attendance – among others – was Virginia Fraser. David Stang and I co-hosted the award ceremony. It all came together.

Presently Jim is suffering from some serious ailments. David and I visited him at his home and Jim, while bedridden, was in good spirits. We all reflected and reminisced in front of his two eldest daughters. His is a life that has meant something to many, many people. ■

LTC Providing Critical Services in a Strategy for Health Care Reform for Seniors: Collaboration Between Piñon Management and CFMC

By Fred Feinsod MD, CMD | *Medical Director, Piñon Management*

Health care reform will directly affect the medical care that seniors receive. It is critical that our approach to health care reform be wise and reflect what we have learned over the past decade in caring for the frail and elderly.

Health care reform is change that improves a system by rendering it more cost-effective, responsive, and beneficial. The goal is better care for less money. In contrast, indiscriminant and "across-the-top" budget cuts can be problematic. Blind cost cuts are dangerous and can eliminate critical services, thereby increasing the risk for poor care and negative outcome.

Cost containment programs have worked in the past but have not been given widespread attention because of current governmental regulation and system inertia. Geriatricians in Colorado have admitted elderly HMO patients with acute medical problems directly to LTC facilities with excellent treatment outcomes. Evercare has used direct LTC admission for community-dwelling seniors with similar success.

Using these successes as a backdrop, rational health care reform should identify areas of cost inefficiency and poor clinical outcomes so as to minimize them. Central to this scrutiny is hospital care for frail, elderly patients. Hospitals have been effective in treating elderly patients who have required major surgery, ICU monitoring, and clinical stabilization.

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However, hospital care is expensive and negative outcomes are not infrequent (pressure sores, multiple medications that increase risk for confusion and falls, restraints, nutrition deprivation, de-conditioning, and exposure to dangerous pathogens). When intensive treatment is not required, sub-acute units in LTC facilities can provide acute care for seniors more efficiently than hospitals. Care delivered in LTC facilities is OBRA-guided so that dangerous medications are minimized, nutrition and function are scrutinized, and overall quality of life is preserved. Cost savings in sub-acute care as compared to hospital care can be as high as 75 percent.

Therefore, cost-efficient health care reform would be a system in which acutely ill elderly patients residing in the community (LTC, ALF, Independent Living, and personal residences) would be admitted directly (from an ER) to LTC sub acute units rather than to hospitals.

To this end, Piñon Management is collaborating with the Colorado Foundation for Medical Care (CFMC) to create such a demonstration project. Central to this project will be the sub acute unit at Christopher House backed up by the sub acute unit at Highline Rehabilitation and Care Community.

The goal of this collaboration is to demonstrate the critical role for LTC in a new strategy for health care reform that will better serve frail elderly populations. This project will measure clinical outcome, re-admission rates, patient satisfaction, and resource utilization including cost of care.

Integral to this project are the fundamental principles in “transitions of care” such as patient-transition coaches, patient education, patient participation in medical decisions (integrated medical model), and patient home support and supervision.

It is our participation in such demonstration models that craft the future for LTC and insure essential care of our elderly populations. Reviews at the highest levels of CMS and professional organizations (AHCA, AMDA, etc.) which create direction and strategy depend upon the insight and vision at the local level. ■



The Role of Colorado Foundation for Medical Care in Care Transitions, and the Collaboration with Piñon Management

By Diane Evans | *OTR, Intervention Specialist* and
By Melanie Kaup | *Project Coordinator, Colorado Foundation for Medical Care*

The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. Research has shown that poor communication between care settings has led to multiple medication discrepancies, inadequate patient education, and a delay in follow-up care. A hospitalization within 30 days of discharge, not foreseen at discharge, often signals

failure of the transition from hospital to another source of care. About 80% of Medicare patient re-hospitalizations appear to be unplanned. Clinical trials have shown that a quarter of re-hospitalizations are currently preventable.

Colorado Foundation for Medical Care (CFMC) is a Quality Improvement Organization (QIO) under the direction of Centers for Medicare

& Medicaid Services (CMS) that works with healthcare providers, consumers and stakeholder groups to refine care delivery systems to ensure patients, particularly from underserved populations, receive adequate care. CMS funded 14 QIO communities nationwide, including Colorado, to work on the Care Transitions Project, which promotes seamless transitions from the hospital to home, skilled nursing facility, or home health care.



The inadequate transfer of information, lack of standard known processes, and lack of patient activation are three areas of improvement that have been driving the project.

The definitive goal of the Care Transitions Project is to reduce re-hospitalization rates by 2% in the northwest Denver community. In addition, the project is working towards increasing communication between settings in regards to the discharge and admission of shared patient populations, provider follow up post discharge, medication reconciliation and management, and lastly, increasing the quality and coordination of care.

The Colorado Care Transitions Project focuses on a target community made up of 44 zip codes in the northwest Denver area. This community has an estimated population of 250,000 residing in two counties, expecting a growth of eight to nine percent in

the population older than 85 by the year 2011.¹ The patients in this community are served by two hospitals, five long-term care facilities, two rehabilitation hospitals, and twenty-six skilled nursing facilities.

In aiming to accomplish the goals for the Care Transitions Project, CFMC has begun implementing several models in the community, including Dr. Eric Coleman's Care Transitions Intervention (CTI™) program. The CTI™ program is a patient-centered, multi-disciplinary coaching intervention that seeks to improve transitional care by providing patients with tools and training that promote knowledge and self-management skills as they move across multiple settings and practitioners.

Another intervention that CFMC is working on is community-wide implementation of the Personal Health Record (PHR), which can also be used in conjunction with CTI™.

The PHR is a tool designed for the patient to help them manage their personal health care. A critical component of the PHR is the Medication and Supplement Records form, the primary purpose of which is to have the ability to track any medication discrepancies the patient may have.

INTERACT, another model that CFMC is utilizing in our community, is designed to improve the quality of nursing home care by providing tools and resources to staff that will help to reduce avoidable acute care transfers. The program is built around a number of practical tools designed to: aid in the early identification of a resident change of status; guide staff through a comprehensive resident assessment when a change has been identified; improve documentation around resident change in condition; and enhance communication with other health care providers about a resident change of status.

CFMC is pleased to be partnering with Piñon Management, and specifically Christopher House, on these initiatives. CFMC is participating on the Piñon Care Transitions Committee, as well as working with Christopher House to implement the coaching model of CTI™, and potentially use of the Personal Health Record and INTERACT model. Also CMFC is collaborating with Piñon to create a demonstration project that validates the critical role for LTC and potential new strategy of patient care for improved quality and resource allocation. ■

This material was prepared by CFMC, the Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

¹Denver Regional Council of Governments Area Agency on Aging, Four-Year Area Plan 2007-2011, available online at: www.drcog.org

Piñon's Care Transition Services: Taking Care of Personal Needs

By Nancy Schwalm | *Chief Business Operations Officer, Piñon Management*

Many of us have experienced an acute care stay, whether it was an unexpected trip to the emergency room, or a planned surgery. I myself have had the “pleasure” of a tonsillectomy at age 6, a cyst removed at age 18, and pneumonia at age 25, all of which resulted in several days of bed rest in my small community hospital in Nebraska. Today’s patient is experiencing far more outpatient surgeries, and if an acute stay is required, the length of stay has been, in many cases and for many diagnoses, greatly reduced. For the frail elderly and individuals with disabilities, the transition during a time of acute illness can be an

Piñon Management has focused on the growing need for professional caregiving staff to develop better awareness, sensitivity and problem solving skills when working with the individual “in transition.” As the National Transitions of Care Coalition (NTOCC) has identified, “it is when patients transition between these settings that dangerous situations may arise – not through any fault of the professionals involved but because the system is very complex with no clearly defined specific responsibilities for effective patient hand-offs.” NTOCC was formed in 2006, bringing together thought leaders, patient advocates, and health care

Piñon nursing homes offer extensive social work services to assess all psychosocial and discharge needs as quickly as possible to assist in identifying community resources that can seamlessly continue transitional services once the individual returns home. Piñon’s Clinical Liaisons and nursing staff work closely with hospital and community health providers to obtain and provide comprehensive health information. Piñon also offers free concierge services through Elder Concierge Services for individuals who come to our metro Denver nursing homes from the hospital. A trained and caring concierge staff member can assist in providing transportation, packing belongings,

Piñon nursing homes offer extensive social work services to assess all psychosocial and discharge needs as quickly as possible to assist in identifying community resources that can seamlessly continue transitional services once the individual returns home.

overwhelming experience, filled with urgent decision-making and information overload. Coupled with physical discomfort, increased post-surgery weakness, and the normal disorientation experienced in an unfamiliar environment, the hospitalized individual faces a myriad of personal needs. For individuals needing a short-term stay in a nursing home, these transition issues also are a frequent occurrence.

providers from various care settings dedicated to improving the quality of care coordination and communication when patients are transferred from one level of care to another, studying the transitional challenges and identifying tools which can help improve transitions of care. Piñon Management is utilizing NTOCC resources, and additionally developing its own internal systems and services to address transition of care needs.

tracking paperwork needs and many other services that can help to assure a smooth transition. As consumers I believe we all hope to and should expect this type of professional caring as we navigate our health care system together. ■

Smooth Moves Between Care Settings: Caring For Consumers

By Karyn Leible, MD, CMD | *Chief Clinical Officer, Piñon Management*

Care for seniors is complex and often involves settings from community-based care, hospitals, and home care to assisted living and nursing facilities. As someone gets sicker or better, they may move from setting to setting; and it is important to have good communication/information between these settings.

Why are successful transitions of care (TOCs) between settings important? Most elderly people take many medications and have many diseases and/or health problems. Stopping a drug or other treatment suddenly can cause problems. This can happen if staff at the different settings don't tell each other everything they need to know about a resident/patient when he/she goes from one place to another. Communication gaps can result in medication problems, extra trips to the hospital or emergency room, missed tests, and other situations.

When TOCs are handled well, staff at each setting get the information needed to provide quality care, prevent medication problems, keep the resident/patient safe, and make sure that the person's wishes are respected.

Many facilities have special forms and other tools to make sure that TOCs are effective. You can work with your physician to make sure that he/she has all the information about your family member/friend so that he/she can share this with others when this person moves between settings.

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Piñon Welcomes Bruce Odenthal to Our Team

By Jane Runge | *Sales and Marketing Specialist, Piñon Management*

Piñon Management is pleased to add another distinguished "veteran" in the Colorado long-term care arena to our team of top leaders. Bruce Odenthal will be serving as Piñon's Vice President of Operations and team leader for Piñon's multidisciplinary Operations Team. Bruce was born and raised in Minnesota – and yes, he is a Minnesota Vikings fan!

He went to college in Lincoln, Nebraska, where he met his wife and started a family after graduation. Bruce is very proud of his family. He has a son who is graduating with his BSN in May and a daughter graduating a year later with a degree in international business.

Bruce has had expansive career opportunities over his 28 years

in long-term care. He has had the opportunity to be a certified nurse assistant, a nurse, a nursing home administrator since 1986, and an Operations Vice President. Bruce has been an active member of the Colorado Health Care Association and is a past member of their Board of Directors.

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Questions to Ask Your Physician:

- When might my family member/friend need to go to another setting? What paperwork should go with them?
- How can I be sure that an advance directive or living will is honored at a new setting?
- How will you communicate information about my family member/friend with the staff/practitioners at the new setting?

What You Can Do:

- Make sure that the physician knows about all medications – including over-the counter ones – that your family member/friend is taking.
- Make sure your family member/friend has a current advance directive or living will. Review/update it after a change in condition, such as diagnosis of a new illness or a hospital stay.
- Talk to the physician/staff at the new setting about any special needs or concerns your family member/friend has.
- Bring something familiar (such as a photograph) to the new setting to make your family member/friend feel more at home.
- Ask the discharging provider to do a “live hand-off” via phone or to leave information on how he/she can be reached with questions.

For More Information:

- *White Paper: Improving Care Transitions from the Nursing Facility to a Community-Based Setting:* www.amda.com/governance/whitepapers/transitions_of_care.cfm
- *Change is Needed in Care Transitions:* [www.caringfortheages.com/article/S1526-4114\(08\)60260-7/fulltext](http://www.caringfortheages.com/article/S1526-4114(08)60260-7/fulltext)
- *National Transitions of Care Coalition:* www.ntocc.org or 501-225-2229
- *Transforming Care at the Bedside:* www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm?TabId=3
- *We Can Do This Better:* www.ahcancal.org/News/publication/Provider/CoverSep2008.pdf ■

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I had the chance to sit down with Bruce and ask him some questions:

Tell us why you chose to work for Piñon Management?

Bruce: I wanted to join Piñon because of the size of the company, its reputation and the flexibility in program development that it allows me to pursue.

How has your experience in this new role been so far?

Bruce: The experience has been great! I have received a warm welcome. Everyone is receptive to new ideas and strategies.

Why is your position important?

Bruce: My position is important since my primary task is to assist the administrators in locating resources to improve services to the teams in the homes. I can assist them in allocating and structuring their assets to improve resident outcomes.

What is the most exciting part of your job?

Bruce: The most exciting aspect of my job is seeing a building become successful in enriching the residents' lives, and seeing that hard work validated by the residents and families.

What do you see as your biggest challenge in your job?

Bruce: I see the biggest challenge as the ever shrinking dollar that we are reimbursed for with corresponding increases in expectations by the customer, the regulators and the staff.

Working in Long Term Care we all have met many special residents. Tell us about one.

Bruce: My special resident memory was in the last nursing home I operated. She would say a Rosary for me each day knowing that I was not Catholic. She said there was hope for me in my conversion. ■

Piñon on the Move – February 2010

By Heather TerHark | *Director of Sales and Marketing, Piñon Management*

Maxine Roby Appointed Chairperson of Colorado Nursing Home Culture Change Accountability Board

Maxine Roby, Nursing Home Administrator at Piñon's Rowan Community, has been appointed the Chairperson of the Colorado Nursing Home Culture Change Accountability Board for 2010. The Board was appointed by Governor Ritter in accordance with HB 1196, which designated a portion of Civil Monetary Penalty funds to be used to promote culture change and quality of life for residents of nursing homes. The goal of the Board is to achieve quality of life that is replicable and sustainable by nursing homes in Colorado. In 2010 the Board will award grants totaling \$200,000. For more information regarding the application process for Civil Monetary Distribution Grants, go to the website of the Colorado Culture Change Coalition at www.coculturechange.org. The Coalition is serving as an administrative partner for the Accountability Board.

Nancy Schwalm to Serve as Senior Examiner for AHCA Quality Award

Nancy Schwalm, Chief Business Operations Officer at Piñon, has been selected to serve as a Senior Examiner Team Leader for the American Health Care Quality Awards for 2010. Nancy joined the ACHA Quality Award Examiners in 2009, serving as

reviewer for Step 2 Quality Awards from across the US provider community. Piñon Management has 4 Bronze (Step 1) ACHA Quality Award winning homes. For more information about the AHCA Quality Award Process, contact Colorado Health Care Association at 303-861-8228, or Nancy Schwalm at Piñon Management.

Brookshire House Circle of Friends

Brookshire House's new validation group called "Circle of Friends" was featured as part of the Voices of Caregivers in the January 2010 Prime Time for Seniors Newspaper. The purpose of the group is to relive past pleasure, resolve unfinished conflicts from the past, relieve boredom and stress by stimulating sensory memories, and retreat from painful, present-day feelings of uselessness and loneliness. This is a group of residents caring for each other. Brookshire offers a premiere Memory Care community, with on-staff Dementia Care Specialists, Validation Therapy certified staff and trained Eden Associates. To learn more about the Circle of Friends program, call Elizabeth Schulte, Administrator at Brookshire, at 303-756-1546.

Rowan Employee Program Featured in Provider Magazine

Rowan Community's employee recognition programs were featured in the November Provider article

Recognition and Gratitude Make Big Impact.

This Eden-certified facility has implemented programs to boost employee satisfaction. "It's really the little things that make a difference," says Maxine Roby, Rowan's administrator. Among other things, she has hired a massage therapist for two hours each week to give rubdowns to facility staff on the house, along with making sure extra meals and a pantry of donated food are available for staff, having an employee no-interest loan program, having an on-site barber shop and beauty salon, and a tuition program for employees.

Jane Runge Appointed to Jeremy Bloom's Wish of a Lifetime Board of Directors

Jane Runge, Marketing and Sales Specialist at Piñon, has been appointed to serve on the Wish of a Lifetime Foundation (JBWL) Board of Directors, established by two-time Olympic skier and former NFL player Jeremy Bloom. Bloom, a local Colorado resident, set up his nonprofit foundation in living honor of his grandmother, Donna. Jane has been an active volunteer on behalf of JBWL for the past couple of years and has been instrumental in helping Piñon Management host Jeremy at a Piñon educational seminar, as well as involving Piñon homes and residents in the recent "Young at Heart Chorus" event in Denver, which benefitted JBWL.

Christopher House Featured in December Prime Time for Seniors Newspaper

Christopher House was featured in the December 2009 Prime Time for Seniors Newspaper as part of "Culture Change...Transforms Nursing Homes" submitted by Carol Bonney, freelance writer specializing in gerontology. Christopher House was metro Denver's first Eden Alternative, Inc. registered home, offers a personalized home environment with pets, an active Resident Council, many community events, extensive menu options, and a strong focus on rehabilitation and wellness. Christopher House is part of the national Quality First campaign through the American Health Care Association, and the Advancing Excellence campaign.

Pinon Hosts Wound, Ostomy and Continence Nurses (WOCN)

Piñon Management's Business Development team hosted the Rocky Mountain Wound Care Nurses at an after hours networking and educational Forum on November 19th at the Piñon corporate office. Dr. Karyn Leible, Piñon Chief Clinical Officer, was the featured speaker, presenting on new trends and clinical practice in wound care and showcasing Piñon Management's wound care specialty programs and services. Piñon Management is hosting regular networking and educational events for our professional health care community partners. To join us at our monthly "After Hours" events, contact Heather TerHark at 303-987-3088. In April, Piñon Management will host the Case Management Society of America (CMSA) local chapter of Case Managers.

Piñon Turns 30!

Piñon Management celebrated its 30th anniversary on December 10th with Piñon staff and many community partners and agencies honoring Jeff Jerebker as Founder, CEO and President of Piñon Management and Piñon's innovative and successful part of national long term care leadership. Rowan Community staff performed an international program on ways different countries honor their elders. Special guest speakers included Sarah Rowan, Board member for Eden Alternative, Inc., and Gilbert Cruz, former State of Kansas Long-Term Care Ombudsman, sharing about their experience and partnership with Piñon. The evening's festivities included over 150 guests and featured a slide show tribute featuring Piñon's 30 years, designed by Marcia Brenowitz, NHA at North Star Community. ■

STAY TUNED FOR UPCOMING EVENTS WITH PIÑON MANAGEMENT

Christopher House is hosting an Easter Egg Hunt and light brunch on Saturday, April 3 from 10am to noon. Contact Judy Kraus at 303-421-2272 for more information.

The Rocky Mountain Chapter of the Case Managers Society of America (CMSA) will hold their April meeting at the Piñon Management corporate office on Tuesday, April 13. Dr. Karyn Leible, Dr. Fred Feinsod and Diane Evans of CFMC will speak on Transitions of Care. For more information, contact Heather TerHark at 303-987-3088.

Piñon Management will host Eden Associate Training April 27-29 at the corporate office. Contact Evy Cugelman at 303-883-9264 for more information regarding this introduction to the 10 Principles of the Eden Alternative.

Listen to The Caring Generation show on 630am KHOW radio, Sundays from 10am to noon. Jeff Jerebker, Piñon Management founder and CEO will be featured on an upcoming program.

Mark your calendar for Piñon Management's annual Art with a Heart event on Wednesday April 21 from 4:30pm – 6:30pm at the Piñon corporate office. Residents from all Piñon-managed homes contribute the art to be auctioned for the benefit of the National Multiple Sclerosis Society's MS Walk, to be held this year on Saturday, May 1 in Denver's City Park. For more information regarding Art with a Heart, contact Jane Runge at 303-987-3088. ■

Piñon Management's 30th Anniversary Celebration and International Impact on Elder Care



Guest of honor Sarah Rowan, Eden Alternative™ Board of Directors member, speaks about her journey into long term care.



Jeff Jerebker, Piñon Management founder and CEO, is honored in the Indonesian tradition.



Staff members from the Rowan Community listen with Jeff as Tom Bidell, member of the Fairacres Manor ownership team, speaks about their experiences with Piñon. Rowan staff members, from left to right, are Proscovia Tugume from Uganda, Marion Blado from England, Betty Macias from Mexico, Marheppy Simbolon from Indonesia, Fannie Nkhoma from Zambia, and Brenda Mwakamui from Zambia. Zitha Isimang from Palau is not pictured.



Proscovia Tugume, CNA from the Rowan Community, honors Jeff in the Ugandan tradition.



PIÑON

We Bring Life to Long-term Care

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Karyn Leible, RN, MD, CMD, *Chief Clinical Officer*
Nancy Fox, NHA, *Chief Life Enhancement Officer*
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Paula Henry, LCSW, *Quality Improvement Specialist*
Marie Stern, MSW, *Quality Improvement Specialist*
Meredith Eder, CTRS, *Quality Improvement Specialist*
Jeanne Wolf, CTRS, *Quality Improvement Specialist*
D.J. Cook, RN, BSN, CCVM, CLNC, *Quality Improvement Specialist*
Kathy Skaggs, RN, *Quality Improvement Specialist*
Amalie Marsolek, RN, *Quality Improvement Specialist*
Sandy Ransom, RN, *Culture Change Specialist*
Evy Cugelman, RN, BA, *Culture Change Specialist*
Sarah Bogucki, PHR, *Human Resources Coordinator*
Carol Schilf, RN, *Clinical Liaison*
Michelle Schneider, *Clinical Liaison*
Susan Delgado, *Clinical Liaison*
Nancy DelPrete, *Sales & Marketing Specialist*

Jane Runge, *Sales & Marketing Specialist*
Janice O'Kane, *Corporate Controller*
Mary Koretke, *Director of Reimbursement*
Jeff Perotti, *Accounting Manager*
Sandy Starman, *Accounting Manager*
Teresa Gallo, *Accounting Manager*
Yen Van, *Accounting Manager*
Becky Reid, *Financial Field Analyst*
Lori Leahy, *Financial Field Analyst*
Tracy Nickelson, *Financial Field Analyst*
Amy Arment, *Financial Field Analyst*
Jennifer Manchego-Pena, *A/R Specialist*
Robyn Herman, *Director of Information Systems*
Cassie Edwards, *Systems Administrator*
Pam Moore, *Administrative Assistant*
Diane Henthorn, *Corporate Office Manager*
Sherry Nuanes, *Administrative Assistant*
Scott Bell, RN, NHA, *Amberwood Court Care Center*
Elizabeth Schulte, NHA, *Brookshire House*
Stacey Love, MS, LPC, NHA, *Christopher House*
Mary Pfalzgraff, NHA, *Colorow Care Center*
Kathy Mekelburg, NHA, *Fairacres Manor*
Sara Taylor, NHA, *Highline Rehabilitation and Care Center*
LaVonda Cathcart, NHA, *Holly Nursing Care Center*
Kathy Correa, NHA, *Laguna Rainbow Elder Care*
Marcia Brenowitz, NHA, *North Star Community*
Holly Raymer, NHA, *Parkview Care Center*
Maxine Roby, NHA, *Rowan Community*
Hollie Hoyle, NHA, *Sierra Healthcare Community*
Connie Kohl, NHA, *Valley View Health Care Center*