PHA Members Jazz It Up in New Orleans During the Successful 9th Annual Conference...
WE CAN HELP.

- Do you have confidence in your coding?
- Are your payor contracts any good?
- Are you collecting all the revenue you should in a timely manner?
- Are you able to deal with the new regulations and your upcoming accreditation?

If any of these issues keep you up at night, call SMP today and let us help you. We will work to understand your issues and give you just the help you need. We are a physician owned company and have dealt with all of the issues you may be facing.

Contact us today and put your mind at ease.

ph. 605.335.4207

Todd Flickema:
tflickema@smpsd.com

www.smpsd.com

Surgical Management Professionals, LLC
Up Front
4  The President's Perspective
5  Executive View
6  Comments from Capitol Hill

Feature
8  Optimizing Financial Performance through Effective Use of Information Technology
13 Back to the Basics: EMR Guidelines for Physician-Owned Hospitals
15 ABC’s & D’s of Implementing an Electronic Medical Record

In Depth
16 To Tweet or Not to Tweet: How & When to Use New Media & Social Media

PHA Profiles
20 Hospital Profile: Mountain View Hospital
23 Industry Leader Profile: Nueterra Healthcare
26 Corporate Profile: Health Capital Consultants
28 Physician Profile: John Harvey, MD

New on the Scene
31 The Surgical Specialty Center at Coordinated Health – Allentown, Pennsylvania

News & Views
32 PHA 9th Annual Conference A Big Success
34 PHA News in Brief
34 Buyers Guide
Some Members of Congress had a terrific August recess. For others it was a nightmare. Last summer, a Colorado congressman had 14 citizens in attendance at his town hall meeting. This year there were more than 400. What could possibly have caused such a dramatic increase? 4 words- The Health Care Bill.

Across the country, in red, blue and purple districts, people became aggressively engaged in the democratic process. Many Representatives were astonished to see the visceral opposition to a piece of legislation that they thought would be widely supported by their constituents. Concepts originally written off as extreme, were soon recognized as broad and deep opposition to the health bill that is currently being debated in Congress.

I believe this happened for 3 reasons: First, many Americans were greatly concerned about the Federal government making rapid and profound changes to something as personal and important as their healthcare. Second, many were frustrated and angry about either the perception or reality of being excluded from the process of reform. Third, many were justifiably anxious and confused about a 1,300 page bill that their Congressman couldn’t honestly say they had read, let alone understood.

What many Congressmen learned the hard way was the value of listening to their constituents before endorsing sweeping legislation. In this instance, legislators discovered that while most Americans believe health reform is required, they want assurances that their healthcare will be of high quality and that it will be delivered in a personal, efficient and humane way. In short, there is skepticism that a healthcare system engineered by the federal government can deliver these things.

So…maybe a good way to reform healthcare is to begin by listening very carefully to the American healthcare consumer.

In the very week that the town hall meetings were reaching their emotional zenith, a known consumer authority released their first national hospital survey and report. The national group based its ratings on the federal government’s Hospital Consumer Assessment of Healthcare Providers and Systems or HCAHPS survey. The survey is completed by patients shortly after discharge from the hospital. Nationally, over 1 million surveys have been completed and submitted to the Centers for Medicare and Medicaid Services.

Categories of the survey include:
• Communication with doctors and nurses
• Pain control
• How often help was received when needed
• Cleanliness and quietness of rooms
• Information about new medications
• Information about discharge
• Whether the patient would recommend the hospital to family and friends
• The patient’s overall rating of their experience

Nationally, physician hospitals performed spectacularly in the ratings. In virtually every state that physician hospitals are allowed to operate (non CON states), physician hospitals were solidly at the top of the list of hospitals that consumers preferred. A few examples:

- Arizona- #1 plus 4 of the top 5
- Indiana- #1 and #2 plus 4 of the top 5
- Kansas- #1-5 Plus 10 of the top 13
- Louisiana- The top 9 are ALL physician hospitals
- Oklahoma- #1 plus 8 of the top 10
- Texas- #1-3 plus 16 of the top 26
- And my very own hospital, Animas Surgical Hospital in Durango, Colorado… ranked #1 in the state.

Since physician hospitals represent about 240 of the 5,800 hospitals in America, statistically they were wildly, disproportionately represented as the highest rated facilities.

So…why in the world would one of the goals of the Healthcare Bill be to shut down what the consumer says are the best hospitals in our nation? Therein lays the rub. And, therein lays a clue about a few of the many misguided components of this proposed legislation.

I agree with President Obama when he says: “My guiding principle is, and always has been, that consumers do better when there is choice and competition.” Let’s take the President to task, hold him to his word and fight like hell to keep developing and operating what our patients say are the best hospitals in America.

Brett Gosney
President, Physician Hospitals of America
CEO, Animas Surgical Hospital
Executive View
An Update on Physician Hospitals – Status, Growth, & Future Trends

Molly Sandvig, J.D.
Executive Director

S
ince 2006, it has been abundantly clear that opponents of physician hospitals are interested in one thing and one thing only – maintaining absolute control of hospitals. Legislation has plainly reflected that fact, including any hospital that is physician owned in all-encompassing negative legislation present in over 12 bills since 2007. Back in 2006, the American Surgical Hospital Association (ASHA) Board of Directors recognized this fact; and in 2007, ASHA became Physician Hospitals of America (PHA).

Since ASHA’s (PHA’s) origination in 2001, the association’s goal has been to represent the rights of physicians to own and to govern hospitals. As the physician hospital industry has changed, the association changed with it… and we continue to do so even now. PHA’s growth, from just over 60 hospital and corporate members when I took over in November 2005, to well over 250 hospital and corporate members in 2009, is reflective of the growing strength of our industry. PHA represents the most entrepreneurial and forward-thinking physicians in the country. With such talent backing this industry, I can say with confidence that no matter the opposition, physicians will continue to find appropriate means by which to stay involved in hospital ownership, governance and direct patient care.

In the remainder of this article, I wanted to provide you some general data about physician hospitals that I believe you’ll find enlightening… At this time, there are approximately 230 physician owned hospitals in existence. The breakdown of these hospitals by specialty is as follows: 134 multispecialty surgical hospitals; 43 general acute care hospitals; 20 heart hospitals; 10 orthopedic hospitals; 9 LTAC hospitals; 9 rehab hospitals; 3 psychiatric hospitals; 2 women’s hospitals; and 1 children’s hospital. In addition, we are currently aware of 123 hospitals under development. These include 69 multi-specialty surgical hospitals; 18 rehab hospitals; 17 general acute care hospitals; 13 orthopedic hospitals; 3 heart hospitals; 2 psychiatric hospitals; and 1 women’s hospital.

Even in the face of political duress, physicians recognize the need to directly affect patient care. The continued growth of physician hospitals is impressive… and patients and communities are the biggest beneficiaries of this growth! In 2009, 27 new physician hospitals are scheduled to open. In addition, 40 hospitals plan to open in 2010; 21 hospitals plan to open in 2011; 23 hospitals are scheduled to open in 2012; and 12 more hospitals are already in line to open in 2013. These numbers are encouraging and provide evidence of the extraordinary opportunities that exist in so many communities across the country to make certain that quality patient care, efficiency, and patient choice are still valued.

Here are a few additional items of interest regarding physician hospitals… For each type of physician owned hospital currently in existence, the average staffed bed size is as follows: general acute care hospitals – 233 beds; heart hospitals – 65 beds; multispecialty surgical hospitals – 40 beds; rehab hospitals – 34 beds; LTAC hospitals – 30 beds; orthopedic hospitals – 24 beds. The average number of employees at each of these hospitals is: general acute care hospital – 519 employees; heart hospital – 315 employees; multispecialty surgical hospitals – 192 employees; rehab hospital – 201 employees; LTAC hospital – 175 employees; orthopedic hospital – 187 employees.

Currently, physician owned hospitals are located in 35 states. By order of highest hospital density, these include: Texas (68), Louisiana (29), Indiana (14), Oklahoma (13), Kansas (12), California (12), Arizona (8), Ohio (8), South Dakota (7), Tennessee (7), Arkansas (5), Nebraska (4), Pennsylvania (4), Utah (4), Alabama (3), Idaho (3), Michigan (3), New Mexico (3), Wisconsin (3), Colorado (2), Georgia (2), Hawaii (2), Montana (2), Florida (1), Illinois (1), Kentucky (1), Missouri (1), North Carolina (1), North Dakota (1), Nevada (1), Oregon (1), South Carolina (1), Washington (1), West Virginia (1), and Wyoming (1).

On aggregate, physicians’ ownership interest in each of these hospitals ranges from 5% to 100%. However, of the approximately 230 existing hospitals, only 30 are 100% physician owned. In other words, at this time 87% of existing hospitals are in a joint venture with one or more partners. Of the 87% of hospitals that are jointly owned, 70 hospitals, or 35%, are partnered with other non-profit or for-profit hospitals. In examining the hospital joint ventures, it is interesting to note that there are approximately 27 development corporations involved in these projects, and, an estimated 48 non-profit and for-profit hospital systems partnered with physicians in these jointly owned hospitals.

The figures above include only those hospitals that are currently in existence. An overview of the hospitals that are under development right now solidifies the trend toward the joint venture model. Another emerging trend evident when reviewing those hospitals that are opening in 2009 and beyond, is the trend toward larger, more comprehensive hospital models – more general acute care facilities and fewer small, multi-specialty hospitals. A number of positive conclusions can be drawn from these two evident trends… I’ll let you draw your own!

One final trend calls for further examination - that of physicians taking on the burden of providing continued access to hospital care in communities that would otherwise be without. More and more often, especially in the current economic times, physicians are being called on to rescue local hospitals from bankruptcy, or from a hospital system that has run the local hospital into the ground and is letting it go. At this time, there are over 30 physician hospitals that have been “rescued” by doctors. In addition, there are approximately 15 hospitals currently under development being rescued by physicians. This is a compelling fact, to say the least.

As this data clearly demonstrates, physician hospitals have a promising future as providers of high quality, high efficiency healthcare long into the future. Physician Hospitals of America will be here to represent the interests of your hospitals no matter where they are or what form they take. If you are not yet involved with PHA, consider joining today. You will discover an entire industry aimed at the best patient care possible, networking opportunities you didn’t know existed, and a wealth of information and assistance. 

Fall 2009
Summer 2009 saw substantial movement on health care reform legislation in the House of Representatives with three committees reporting their own versions of HR 3200, the America’s Affordable Health Choices Act of 2009. Given the extensive nature of the bill, it was referred to three committees—Ways and Means, Energy and Commerce and Education and Labor. Throughout the month of August, House and Senate members heard from constituents about the legislation at some of the rowdiest town meetings in memory. Although physician ownership of hospitals was not the focal point of these “debates”, the heated action at home has had an impact on DC, particularly showing the divisions that currently exist within the Democratic party on a number of important issues in the health reform legislation. In September, the House leadership began the task of trying to pull all the pieces into one bill that could be brought to the House floor. This work is likely to continue through much of the Fall. A date for floor consideration is still distant and will not take place until the leadership feels confident that the votes are in place for a win. Dates have been announced, only to fade away, so no one can confidently predict when the House will act or even what the shape of the bill will be.

The physician ownership issue came up in all of the House committees and although no votes were taken, Democratic leaders in the committees expressed a willingness to meet and work with affected Members of both parties. Those discussions continue as of this writing. While the outcome is not known, nor is the timing for when any possible compromise might surface, the fact that discussions continue at high levels is encouraging. In the meantime, PHA members need to remain in touch with their own Members of Congress, particularly the Democrats, and encourage them to speak to the leadership about the importance of a successful resolution to this issue.

The Senate Health, Education, Labor and Pensions Committee had reported its own version of health reform legislation in July. Nothing will happen with this package until the Senate Finance Committee completes its own consideration of Chairman Max Baucus’ (D-MT) proposal. Over 500 amendments were filed and the committee has been slowly grinding through them. The effort to add a public plan that would compete with private health plans failed twice in committee, so it is likely that the Senate final bill will not include this option, even though it may well be included by the House.

Senator Baucus has included language severely limiting physician ownership, and amendments were filed against it. However, it is more likely that some progress against this language will be made during the time the Senate Majority Leader Harry Reid (D-NV) pulls together the pieces of the Senate bill. The cumulative lobbying by PHA members is having an effect as more Democratic Senators are expressing their concern over the draconian language now in the Senate and House bills. Efforts to get your true stories out need to continue to get a critical mass that will carry enough weight to force modifications of the current language.

Recognizing that PHA is having success in creating a positive dialogue on the issue, both AHA and FAH are redoubling their efforts to end physician ownership of hospitals. The Senate bill has few provisions affecting hospitals as a result of the deal they cut with the White House and the Finance Committee. Thus, they can concentrate a lot of energy on this issue in the Senate. The stories of how your patients, communities and hospital will be injured by this language must be heard. Congress doesn’t know the far reaching affects this legislation will have unless you tell them. Therefore, notwithstanding the progress made by PHA, members cannot ease up, but must maintain pressure on all of their Congressional delegations if there is to be relief in the final product that goes to the President. Congress is not likely to conclude its work on health reform legislation until late December, so PHA members need to be active right into the holiday season. Hard work could pay off with a nice gift under the tree. Slacking off will only guarantee a stocking full of coal.

Randy Fenninger, J.D., is a Senior Policy Advisor with Holland & Knight in Washington DC, and serves as PHA’s political lobbyist on Capitol Hill.

Orthopaedic Institute of Ohio
Ohio’s Premier Orthopaedic Healthcare Center
801 Medical Drive, Lima, OH 45804
1-800-225-3921
www.ioshospital.com
Anesthesia Subsidy Reduction
RETAIN CURRENT PROVIDERS
Management
PAYOR CONTRACTS
Dedicated Team

ANESTHESIOLOGY
for Hospitals

Time to Compare Online
• Anesthesia financials
• Staffing models
• Complimentary proposal

www.ahphealthcare.com
1-800-945-6133
Information technology provides healthcare leadership significant opportunity to monitor and enable improvements in operational, clinical and financial performance. There are, however, critical prerequisites to transform screens and data into actionable decision-making business intelligence. Absent these prerequisites, your investment in information technology will be relegated to lower levels of benefit realization. Before making a substantial investment, proper planning and engagement of key stakeholders is essential.

1. Prerequisite Essentials for Success

Obviously, there are a number of considerations that come into play when selecting software. Software demonstrations present a façade of turnkey solutions, with a pretense of immediate ROI from investments in ERP, clinical, perioperative and ancillary healthcare information systems. To achieve the promised outcomes, the following prerequisites must be met:

The Operational Blueprint – Beginning With the End in Mind

The accuracy of the operational blueprint determines whether an organization will truly benefit from an addition or change in healthcare technology. Conversely, the absence of a blueprint poses tremendous risk. In fact, an organization without a completed and accepted blueprint driven by key stakeholders has no business in the selection process at all.

The blueprint represents leadership’s vision of business operations through workflow diagrams, process narratives and balanced scorecards. When completed, the blueprint should reflect an optimized balance of operational, clinical and financial performance. The scorecards within the blueprint should identify quantifiable targets for key performance indicators, not exclusive to financial performance. For instance, decreased turnover time represents an improvement in customer service through improved surgeon satisfaction, not to mention a positive financial ROI.

It is imperative to configure the software to meet blueprint processes as opposed to retrofitting processes to software requirements. The former provides the only opportunity to realize the benefits you were promised.

Gap Assessment

Software is only an enabler that transforms tasks into IT processes. Software is built to meet 80% of industry requirements and therefore poses gaps. Each gap has associated cost in dollars, time, long-term constraints and user-adoption. A detailed gap analysis is critical, and perhaps the most important activity within software selection. Instead of becoming enamored by the screens and reports, the organization’s challenge is to focus on the 20% that differentiates their entry from others. Many work-aro...
2. Financial Performance Management

Financial analysis requires a clear understanding of cause-effect relationships between aggregate measures and drill-down contribution attributes. High-level benchmarks provide a summary of performance. How this performance was achieved requires drilling down into operational sub-components. Both high-level benchmarks and derivatives require sound assessments and trending to ascertain potential prescription for improvement.

Assessing Profitability

The value of EBIT or any primary profitability measure is determined by its accuracy, relevance and drill-down capabilities. Unless a legitimate and reasonable benchmark is available for comparison, the value of a measure is incomplete. For instance, an EBIT measure of X% is vague without a comparative benchmark to assess the health of the measure. Employ benchmark metrics with ‘like’ organizations, such as those with similar case-, acuity- and payer-mix.

2a. Revenue Measures and Drivers

Dissecting profitability begins with revenue. Dashboards require revenue composites and influencers, such as outpatient revenue and revenue/case type. Reviewing revenue attributes, such as contributions by procedure, physician or payer-type, provides a clearer picture. Trending revenue over time allows predictability, provided case volume and revenue per case remain reasonably stable. Net revenue is often used as a point of reference, providing assessments of other business performance metrics. It is important to understand the differences in gross and net revenue, as well as how each is derived.

Payer-Mix

Gross and net revenue trends tied to Medicare, Medicaid and other payer sources are critical for accurate budgeting. They also clarify why one entity’s revenues are greater than another’s. For this reason, the information system’s chart of accounts needs to reflect revenue broken out by payer type, which should be prominent on the dashboard.

Revenue Cycle Management

The ability to measure and manage A/R serves as a beacon to revenue cycle management. The operational blueprint should illustrate the financial improvement equivalent per A/R day improvement, culminating in ROI when targets are met. By drilling down on A/R information, the organization will have a more holistic illustration of collection management.

Charge Capture and Coding

Accurate coding is of course a requirement for optimized reimbursement. The information system can be configured to minimize the efforts of coding tied to various procedures. In implementing a new system, the coder should be encouraged to pay closer attention to clinical documentation and incremental charges outside the standard procedure. This process needs to be simple and intuitive for reimbursement maximization.

Operating Room Management

As the OR is the organization’s primary source of revenue, implementation of a perioperative management information system can greatly impact profitability. However, information systems also enable patient safety through conflict checking, and increasing the timeliness of information from an EHR and RIS/PACS system, and anesthesia system. An effective supply chain management system gets the right supplies to the OR on time and an instrument asset management system plays a key role in improving readiness and accuracy. Although integration is complex, each system can provide levels of satisfaction to the surgeon, nurse, staff member and patient, and is highly rewarding in terms of service and finance.

OR Utilization and Scheduling

OR utilization measures provide vital information to the executive dashboard, as effective use of the OR directly drives revenue through a potential increase in cases. So that the information system can help optimize OR suite usage, the organization must determine and utilize industry benchmarks. Clear definitions of OR availability and utilization must be defined up front. In order to accomplish this, leadership needs to understand both overall utilization and utilization within each specific OR suite. Metrics such as turnover time, late starts and case cancellations must be available to assess reasons for under-performance.

Block scheduling policies are often developed but never enforced. As the dashboard contains utilization per suite, leadership can view usage by surgeon and by group. The dashboard should alert leadership with prospective data of block targets not met. This affords proactive discussion with...
block owners to determine if their block needs to be reduced or reallocated.

**OR Considerations**

There are far too many measures and benchmarks to list. Therefore, where the organization's priorities should lie, begin with the current-state (baseline) measure and compare to the target. Determine what value is provided in terms of operational excellence, customer service, patient safety and financial performance if the target is met. Determine the value of a 5% increase in utilization and recognize the impact of 20% late first-starts on all aforementioned attributes.

As OR utilization trends higher, ensure that appropriate staff are available to support the volume increase. Inadequate staffing could lead to increased safety risks and increased patient wait time. If volume surges significantly, perform a cost-benefit analysis to determine whether another suite is needed or keeping other suites open for longer periods of time are options. The information system should fuel your analysis.

**Anesthesia Information Systems**

Following an anesthesia software implementation, perform routine audits to ensure the levels of anesthesia administered are (a) properly documented and (b) properly coded and charged. Lost revenue can be attributed to either system set-up or manual documentation error at the time of care. As deltas are large from level to level, the ability to submit appropriate documentation helps maximize reimbursement and expedite payment.

**Other Revenue Drivers**

Begin with the OR, but look at all integrating systems. Determine what workflow can be IT enabled that will help with efficiencies and effectiveness. Do not sacrifice investments in IT for a lack of understanding of its possible contributions. As you build upon your infrastructure ensure that integration of processes and data structures are as interoperable as possible.

**2b. Expense Measures and Drivers**

A financially successful organization adopts prudent cost avoidance and cost reduction strategies through the use of business intelligence. There are always opportunities to efficiently reduce cost without negatively impacting patient safety and customer service. As with revenue, expense data needs to be accessible with drill-down capability.

**Supply Chain Management (SCM)**

Supply chain management has numerous measures for purchasing power, efficiency and effectiveness. The SCM information system and policies should stress cohesion and interoperability with the perioperative management information system. A single item master file of record, as opposed to separate ordering from the OR and SCM stakeholders, helps get the right supply to the right place at the right time.

**Supply Chain Infrastructure**

Item master files (IMF) and the charge description master (CDM) are typically not managed properly leaving organizations to suffer the consequences. Cleanse and maintain the IMF to (1) avoid duplicity; (2) remove legacy items; (3) correct nomenclature; and (4) evaluate applying UNSPSC standardization.

**Perioperative Case-Costing**

Case-costing analysis typically yields large financial opportunity. National SCM organizations and reputable consulting firms can provide responsible case cost targets, which most exceed. Immediately set goals on the SCM scorecard to quantify aggregate savings and profitability by targeted case cost reduction.

Case-cost drill-down will illustrate wide cost variation among surgeons. Discuss rationale for overages with surgeons tackling the most excessive overruns first. Create a team to compare internal supply usage to industry best practices. The collection of aggregate and detailed supply usage information arms the organization with actionable data that may decrease case cost significantly.

**Preference Card Management**

Preference card management and standardization contributes to financial performance, patient safety and customer service improvement. Variability of supply usage from surgeon to surgeon should be limited. As standardization increases, case picking will become more efficient and accurate. In turn, ensuring that the correct supplies get to the OR on time will increase surgeon satisfaction and reduce late starts. Purge preference cards that have not been used within the past 18 months.

**Purchasing Power**

Cleaning the IMF and standardizing items is an exercise that will rid organizations of duplicity and unnecessary items. Item standardization provides bundling equivalents which may allow an organization to order larger quantities and increase negotiating power. IDNs, integrated delivery networks, must discuss opportunities for more significant purchasing power with global item standardization. From a patient safety perspective, working with less items increases picking accuracy.

**Front-Line Labor Management**

Labor management is always challenging, but essential. It balances customer service, operational excellence, resource utilization and promotes patient safety. This requires the right person with the right competencies and credentials needs to be at the right place at the right time. Information technology has advanced significantly to develop acuity-based scheduling for nursing staff. Proper updating of staff credentials and competencies in your Human Resources Information System (HRIS) affords modeling scenarios to match acuity.

Proper configuration of the scheduling system tied to the employee master file provides the opportunity for leadership to clearly see financial exposure as it pertains to salary and wages. Overtime and supplemental staff can be better managed when modeled.

**Overtime**

Most organizations have over-complicated salary/pay rules within their Time and Attendance and HR systems. Unwieldy pay rules expose the organization to either overpayment or overtime. This too can be simplified through proper use of IT.

**3. Other IT Investment Considerations**

There are unlimited opportunities through IT enablement. Enterprise content (document) management provides tremendous payback long-term. Instrument asset management helps track assets, but also ensures incorrect or damaged instruments are not delivered to the OR. Medication management systems are patient safety building blocks and a good investment.

An organization must be culturally ready to enter an EHR implementation. Stakeholders from every unit of the organization must be engaged in both blueprint development and implementation. Lab, pharmacy, radiology and PACS systems provide the organization a true opportunity for transformation as opposed to simply meeting a legislative requirement.
As with all systems, the blueprint and gaps must guide selection of the product. Working with an independent third-party is advisable as you work your way through the tricky process of blueprint development and gap analysis. They can help determine the ‘truth’ of vendor claims and confirm whether software interoperability exists as stated. Investment in EHR is more complex than other information systems for benefits in customer service, patient safety, operational excellence and financial performance should be realized concurrently. Do not sacrifice on training and education.

4. Summarizing
Closing Thought

Proper investments in information technology are essential for healthcare organizations to remain competitive and meet targets. Stalling warranted investments in IT contributes to the delinquency of your business. Simply put, your benefits realization is equal to the following:

Benefits Realization = (ROI) – (Total Cost of Ownership + Total Time to Value + Resources + Misery Index).

Effective setup of information systems will transform an organization when business and cultural dynamics are properly balanced. To sustain optimal financial performance, it is incumbent on the organization to make investments in operational excellence, customer service and education and development. Absent excellence in these three areas, short-term improvements in financial performance may be realized; however these improvements will not be able to be sustained. While, the overall investment of time and dollars may seem high, a flawed selection and implementation far outweighs the absence of investment in terms of opportunity loss.

Paul Faraclas, MBA is the President and CEO of CTQ Solutions, LLC, the largest patient satisfaction firm in outpatient surgery, also having many surgical hospitals as clients. CTQ is a CMS-certified HCAHPS® vendor and serves as the clinical and financial benchmarking arm for PHA.

For additional information or assistance with any of the above services please feel free to contact pffaraclas@ctqsolutions.com or visit CTQ at www.ctqsolutions.com.
Experts In Fair Market Value. Focused In Healthcare. Trusted by Clients.

Unparalleled knowledge and insight into today’s healthcare environment.

- Facility Fair Market Value Analysis
- Fair Market Value Compensation and Service Agreements
- Feasibility and Financial Analysis

www.vmghealth.com

Three Galleria Tower • 13155 Noel Rd., Ste. 2400 • Dallas, TX 214-369-4888

3100 West End Ave., Ste. 940 • Nashville, TN 615-777-7300
In today's medical environment, healthcare providers are being challenged more than ever with increased patient care standards, new government regulations and financial constraints. And, despite the passage of The American Recovery and Reinvestment Act (ARRA) of 2009, the stimulus package remains confusing and ambiguous to many hospitals.

As an electronic medical records (EMR) solutions provider, we have been working to help healthcare organizations better understand the new technology regulations as we move closer to the deadlines for EMR adoption and meaningful use criteria under the ARRA. The question is, do the same guidelines apply to all physician-owned hospitals considering the incentives for EMR implementation? The answer is yes and no.

**The Basics of ARRA and EMR:**

The stimulus act states that hospitals must be a meaningful user of a certified EMR system in the next three years to earn full annual reimbursements. According to ARRA, EMR reimbursements will begin decreasing in 2014, with further reductions in 2015. And by 2015, those who are not yet meaningful users will begin to incur penalties.

Yet, the decision isn’t just about government mandates and dollars and cents, the deployment of an EMR can improve the quality of patient care, enhance patient safety and reduce operational costs. In fact, the Mayo Clinic states that “the electronic medical record is critical to Mayo’s ability to provide efficient, coordinated, safe and high-quality care.”

**The Three Rs: Research, Review, and Results**

Despite the substantial benefits an EMR solution can provide, many U.S. hospitals still have a long way to go. Researchers from the Harvard School of Public Health, Massachusetts General Hospital and George Washington University recently released results that showed less than 2 percent of surveyed hospitals had implemented a comprehensive EMR system and less than 8 percent had a basic EMR in place.

The barriers to EMR cited by the hospitals included: inadequate capital for purchase, concerns about maintenance costs, resistance from physicians, unclear return on investment, and lack of staff with adequate IT expertise. These are concerns most physician-owned hospitals and specialty healthcare facilities can understand.

At Healthland, we’ve experienced these challenges first hand, but more importantly, we’ve experienced incredible results of EMR implementation. However, not every EMR is right for every healthcare facility, so it is critical to do your research – both in terms of ARRA mandates and selecting the appropriate EMR vendor.

**The First R - Research:**

There are many organizations that can help you begin researching the EMR process. The Health Information and Management Systems Society (HIMSS) is an excellent source of information. Heidi Echols, a member of HIMSS and partner in the law firm of McDermott Will & Emery LLP, has significant experience in EMR transactions and describes the ARRA incentives for physician-owned and specialty hospitals as the following:

**For Most Physician-Owned Hospitals:**

- Physician-owned hospitals should be eligible to receive Medicare incentives unless they are psychiatric, rehab, children’s or cancer facilities (or those with an inpatient stay greater than 25 days).
- Physician-owned hospitals could qualify for Medicaid incentives if they are acute care hospitals with at least 10 percent of the patient volume attributable to Medicaid or if they are a children’s hospital.

**For Physician-Owned Long Term Acute Care (LTAC) hospitals:**

- It is unlikely that LTAC hospitals will be eligible to receive Medicare incentives because hospitals that have an average length of stay of greater than 25 days are excluded from the incentive program.
Physician Hospitals of America

The Second R – Review

As you begin to review potential EMR vendors and solutions, the following questions can help you get to a decision that makes the most sense for your organization.

#1: Is the solution designed for your type and size of hospital?

Beware of vendors who claim to offer an EMR solution for everyone. Instead, narrow your search to those with a proven track record of specializing in solutions and support for your type of hospital. Physician-owned general hospitals may have more products from which to choose. Because, in theory, it’s true that a high-end solution can be “downsized” for specialty hospitals. However, in reality, these complex systems may be difficult to deploy on a smaller scale.

#2: Is the vendor a one-stop IT resource?

Some hospitals already possess the information technology (IT) expertise and resources to manage the full spectrum of an EMR deployment, encompassing planning, installation, data migration, training, support, and more. This allows them the opportunity to choose best-of-breed products for their information system and components. If your hospital does not have the capacity, choose a vendor with a complete product and service package to eliminate various interfaces to third party applications.

#3: What is the software and vendor flexibility?

Some EMR vendors impose rigid terms and conditions which may be undesirable. Seek out flexibility, especially at three key levels:

- Implementation — Does the vendor dictate the implementation of the solution? Some vendors adhere to the all modules coming live on day one. For many hospitals, this can be prohibitively expensive. Other vendors will allow flexibility of implementing their software module by module, as your budget allows.
- Workflows — Ideally, an EMR solution will encourage workflow improvements, helping to add more efficiency to your processes. User-friendly software and single screen access are some key areas of improved productivity.
- Documentation — Flexibility in how the solution captures documentation can go a long way. Future requirements for reporting on captured data will be an integral part of your system. Various techniques utilized by vendors for electronic forms (data capture) may or may not be able to be converted to reportable fields.

#4: Does the vendor provide adaptable technology?

Some “state-of-the-art” EMR applications are hampered by a rigid or outdated databases and programming languages. These solutions typically do not adapt well to change. Make sure you consider solutions with a flexible architecture, adaptable to the constantly evolving realm of healthcare.

#5: What is the CCHIT Certified® designation?

In 2005, the U.S. Department of Health and Human Services recognized the Certification Commission for Healthcare Information Technology (CCHIT®) as the official certification body in the United States for health information technology, including electronic health record (EHR) products, personal health record (PHR) products, and the health information exchanges (HIEs) over which they share information.

Encompassing both ambulatory and inpatient care settings, CCHIT certification means that tested EHR software meets industry standards for functionality, security and compatibility with other clinical systems. However, CCHIT has not been approved as the official ARRA certification body as of today and there may be other organization(s) assigned this responsibility. Nonetheless, there remains a possibility that CCHIT will be grandfathered in as an official certification body.

#6: Does the vendor provide third-party validation?

Virtually all EMR software vendors claim to offer “superior” products and service. But one of the most effective and reputable measures of vendor and software performance is the KLAS rating system. KLAS independently monitors performance through feedback from thousands of healthcare organizations. Visit www.klasresearch.com for more information.

#7: What do peer reviews reveal?

While KLAS ratings may be helpful with the selection process, there’s no substitute for appraisals from peers. PHA offers excellent access to hospitals with first-hand experience in implementing an EMR.

#8: Can the vendor give you a detailed projection of ROI?

Every hospital will realize a different return on investment (ROI) based on a number of factors. However, you should request from vendors a picture of average ROI, including approximately how many years it will take to fully recover your investment.

- Ask for specific metrics within their ROI formulas.
- The bottom line should show a positive financial outcome in five years or less.

The Third R – Results

An EMR system simply provides the opportunity to improve patient care and operational efficiencies. The most significant improvements can’t be measured in dollars, but rather in quality patient care.

One of our customers, Scotland County Hospital Chief of Staff Dr. Bill Dixon, said it best, “We made a commitment to EMR because this is the way medicine is going. Our patients need and deserve this quality of care.”

In choosing an EMR partner and solution, physician-owned hospitals need to carefully consider the following:
• Timing — 2015 is not very far off. A phased implementation can take up to five years to achieve, from planning through full-scale deployment.
• Implementing an EMR system prior to 2015 may enable your hospital to receive ARRA incentive payments and avoid reimbursement penalties.

Making the grade:
Many physician-owned hospitals have a different set of needs. Some vendors push “one-size-fits-all” labels on their solutions, while others cater to narrow subsets within the healthcare universe, such as hospital or clinic EMRs. By asking questions during your selection process, you can find a solution that aligns with your immediate and long-term interests.

Healthland provides additional resources to keep up-to-date on the ARRA mandates at www.healthland.com.

Angie Franks is the Senior Vice President of Sales and Market Development for Healthland. With her leadership, Healthland has grown into a leading national provider of comprehensive information systems for small size hospitals. She brings more than 19 years of experience in healthcare information technology to her role at Healthland.

The ABC’s & D’s of Implementing an Electronic Medical Record
By: Michael Knocke, Chief Information Officer, Kansas Spine Hospital

In 2002, a visionary group of physicians in Wichita were in the middle of building the Kansas Spine Hospital when they realized they had a unique opportunity to open their new facility utilizing a full electronic medical record system, thus eliminating the need for paper charts. The decision to go paperless impacted everything from the architecture of the building, to software vendor selection, to the hiring of staff. The difficulty of transitioning away from paper was eliminated by the absence of historical paper charts. However, multitudes of other challenges existed, not least of which was the paradigm shift of developing processes that were computer centric. Nearly six years after the decision to go paperless a number of valuable lessons have been learned.

Assure CCHIT Consistency
In today’s reality of the coming rewards and penalties associated with the healthcare portion of the economic recovery act a certified solution is a must. Only look at vendors that have received CCHIT certification; and make every attempt to go with a single vendor who provides a complete system which supports physician and nursing needs, as well as covers all ancillary departments. A single vendor solution is a more cost effective approach. Best of breed, where various vendor systems are chosen for differing clinical areas, may at times provide more feature richness, but in the long run fall short because of the ongoing cost and complexities of integrating disparate systems. A single-vendor system with a common user interface throughout the various software modules is a must. A single, centralized sign-on increases usability and can dramatically increase user acceptance, especially in the physician population. Along with having to remember only one new system login, the user interface and functionality needs to be the same no matter where the medical record is being accessed. Consistency is key.

Even though the interface needs to be consistent, the device types to deliver it can and should be varied. One size definitely does not fit all. Desktop computer, computers on wheels, computers at the bedside, and handheld devices all should be options supported by the vendor. No one person will like or use them all, but everyone will be comfortable with at least one way of accessing and inputting information into the EMR. This in turn will increase acceptance and use of the system.

Be conscious of how to train the various user groups
Training is another obvious but key component. Identify a team of clinical “super-users” as early in the process as possible, and put them to work training their fellow nurses and physicians. Actually, these individuals will identify themselves by how quickly they adapt to using computers in the clinical setting. Learning to navigate an EMR is most effectively taught by an individual who is well versed in the delivery of patient care, not in information technology. Computer classrooms are a good start for nurses, but providing “on-the-floor” training is a key to success. For physicians, training labs are ineffective. Individualized training provided by a “super-user” who understands the EMR from the physician perspective is necessary to get this user group comfortable working without the familiar paper chart.

Continuity of system access is a must
Business continuity and disaster recovery take on more importance than ever. Downtime is no longer an acceptable option in a paperless environment. Adequate redundancy will definitely add cost, but no EMR should be implemented without it.

Don’t feel compelled to computerize everything
Finally, paper is not a bad thing, so don’t be afraid to use it; just don’t keep it around long. Tests have proven some paper processes still maintain an edge in process efficiency. So in those cases, spend the time developing solid processes to make this information readily available by quickly scanning these documents into the medical record.
To Tweet or Not to Tweet:
How & When to Use New Media & Social Media


First thing: “Don’t Panic”

The admonition “don’t panic” was introduced into the culture in the late 1970s. That was before the Internet, email, web sites, Twitter, Facebook, YouTube and all the rest started taking over mass communications. But it was good advice then, and it is an even better concept to hold onto now. Over the past 30 years, there has been an extraordinary amount of change in how we communicate. The sheer volume of information is staggering, and the jury is still out on what effects this will have on us humans over the long run. For the purposes of this discussion, however, we will set aside whether being able to Tweet a brief message to the entire Western world is a good thing or a bad thing. We’re not going to comment on whether the under-26 crowd has lost its ability to sit quietly for more than 10 seconds without a video screen, text messaging or iPod.

In the world of strategic communications, the challenge is in being able to utilize all the various tools, toys, tactics and techniques in the service of a very old-fashioned, low-tech goal: communicating a message to an audience that produces an intended result. In that sense, the skills necessary to effectively communicate are not that much different from those required 30 or 40 years ago. One must be more focused on how the audience receives our messages, rather than how we send them; what language they hear in, instead of what language we speak in; and what channels of communication are available to a particular audience, not the channels we might wish to use.

In other words, effective communication, especially if the intention is to persuade, requires us to put the audience’s needs and wants ahead of our own. So you can see why, in the face of an extraordinary change in the nature of those communication needs and wants, we say first thing: “Don’t panic.”

The Changing Media Landscape

The Internet has changed the way we communicate as individuals, businesses and organizations. Over the past two years more than 125 newspapers have shut down their print operations and moved online; more than 25,000 newspaper jobs have been cut. There are now blogs on every subject imaginable, some with daily readership higher than major newspapers. More than 100 million users joined Facebook over the last year. And, on average, there are more than 235 million searches on Google each day.

For the media consumer, there have never been more options for receiving the news and information they want, how they want it, when they want it and from whom they want it. In fact, with all these constantly evolving media options, it’s easy to forget that less than five years ago Facebook, YouTube, Twitter, MySpace and the whole host of other social media and micro-blogs didn’t even exist. It’s also easy to get overwhelmed and caught up in the frenzy to adapt these new mediums into a communications
How Does Your Specialty Hospital Stand Out From The Rest?

By becoming accredited by The Joint Commission

Accreditation for specialty hospitals is an accomplishment that not all hospitals can obtain – only those that meet objective national standards can become accredited and earn the Gold Seal of Approval™. What does that mean to the public? That your organization has undergone an intensive evaluation under the comprehensive accreditation process used for all hospitals.

As well as demonstrating your commitment to quality care, achieving Joint Commission accreditation is recognized by select third party payors and provides deemed status recognition for Medicare certification.

How does your specialty hospital stand out?

Accreditation from The Joint Commission provides your hospital with a competitive edge as well as risk management strategies that may help reduce organizational and health care errors. The survey process applies standards which can help your hospital achieve effective and efficient operations as you measure your hospital against national standards.

Contact us at qualityhospitals@jointcommission.org to learn how to become accredited.
strategy, while neglecting the basic media outreach and public relations that are at the core of any successful communications campaign.

How These Changes Affect Your Media Outreach Strategy

With the cutbacks of traditional newspapers and a strong push to move content online, many news organizations are simply understaffed and overworked. In some cases, entire news desks are being cut, and, in many instances, reporters are now assigned to cover multiple beats and are struggling to stay on top of the 24-hour news cycle.

Ironically, most reporters now go online to find information and leads on stories. In fact, a recent Cision and George Washington University Graduate School of Political Management survey found that among news professionals, websites are the single most important source of information for developing stories, and websites and blogs were the most useful for following stories that they had written. In addition, news stories are now commented on and shared by media consumers via Twitter and Facebook posts, and link-sharing sites such as digg.com create an ongoing conversation of engaged media consumers online.

While it’s still critically important to maintain good relationships with local and national reporters, a good earned media strategy should also include monitoring and responding to news stories in real time online, and fully engaging online networks of influencers via blogs, social networking sites and Twitter.

How to Take Advantage of These Changes

Create a page on your hospital website for press outreach

The page should be easy to get (e.g., www.hospital.com/press) and should maintain current information on whatever stories you are pitching.

Reach out to traditional news reporters and bloggers

When pitching a story, don’t forget to reach out to bloggers who cover specific topics like politics or healthcare, or local events in your area. There are a number of different blogger directories, such as technorati.com, that categorize blogs by subject matter. When sending stories to bloggers, also try to send web-friendly graphics, photos and videos to help add interest to the story.

Comment on news stories online pertinent to issues affecting your hospital

Most newspapers, and nearly all blogs, allow users to comment on stories on their sites. This is an excellent opportunity to emphasize, clarify or correct certain aspects of the story. When possible, provide hyperlinks to your press site, or to other sites that give additional information relevant to your hospital’s position.

Become part of the online conversation

Create a Twitter account for your hospital and follow reporters, bloggers, elected officials and other opinion leaders. Most reporters now link to their Twitter pages, but there are also numerous Twitter directories, like wefollow.com, that categorize Twitter users by subject and location. Also, Twitter will soon be releasing a new feature that allows users to find other users via geo-targeting, so you will be able to view, follow and message all the Twitter users in your hospital’s service area.

The Twitter community is self-organizing, and most users use hashtags (#) to categorize their tweets by subject and topic. For example, currently #healthcare and #hcr are the most commonly used hashtags for tweets related to the health care debate. By searching for hashtags at search.twitter.com, you can get a good sense of who the most active participants are in the conversation, and you can begin creating your own network of followers on Twitter. While the lingo and protocol can seem intimidating, Twitter offers explanations and “How To” sections at business.twitter.com/Twitter101.

Create an online community

Facebook.com is fast becoming its own web portal, where users are able to interact with the entire World Wide Web directly through their Facebook account, sharing their thoughts on sites and news throughout the Internet. While originally reserved for individuals, Facebook now allows businesses, organizations and politicians to create fan pages, social cause pages and business pages where your hospital can create a social media presence and communicate with Facebook users.

Take advantage of low-cost ads

Google and Facebook offer extremely cost-effective ways to get your message out to a target audience in a very measurable way. Both sites provide advertising opportunities on a cost-per-click basis, meaning you only pay when someone actually clicks on the ad. Costs vary but generally are under 50 cents per click.

On Google, you can target your ads based on geography via keyword search or content network. Keyword search advertising allows you to reach users searching for keywords you designate related to your hospital or to a story you are trying to get earned media on. Content network advertising works in a similar way, but places ads next to news stories with keywords you designate.

Facebook allows virtually unlimited ways to target your ads. Nearly anything a user has placed on his or her profile can be targeted—location, age, gender, education, marital status, political identification, interests, etc. For example, your hospital could place ads on Facebook targeting women over 40 with college degrees living within 50 miles of your hospital to call their Congressman and ask them to protect physician-owned hospitals.

Don’t Forget the Basics

We began by suggesting that you not panic simply because the entire world of communications has changed almost overnight and, most likely, it all took place while most of us were busy doing other things. We are convinced, by the way, that between the time we complete this article and it is published, there will be new Twitters, Facebooks, and web site design goodies. That is how quickly the development of new technological techniques and communication channels is moving. And while it makes perfect sense for you to remain aware of these developments and
selectively use the tools and devices that can be of help, to panic and lunge toward any of them is simply dysfunctional.

Whether you’re trying to affect public opinion via traditional media, new media or social media, your message is still the single most important element and the one to which you should most carefully attend. Your message is what you are trying to communicate to an audience by whatever channels are available or are selected. Remaining steadfastly consistent and “on message” is, in our experience, the first casualty of CPD: Communications Panic Disorder.

One of the first signs of CPD within an organization is rapid eye movement as the organization shifts quickly from one communications channel to another, seemingly without regard to whether its intended audience is available on that channel or not. In the morning, they have signed up for Twitter and began sending out messages every 2 minutes; by 3 p.m., they’ve stopped and are agitated because they only have eight friends on Facebook. In the meantime, the local reporter who covers their market segment doesn’t know who to call within the organization for a comment – or to schedule lunch.

We also see signs of CPD in organizations that express their communications panic by an almost depressive withdrawal. If they have a web site, it provides little information of use to their audience or to potential customers and clients. It may look pretty, but it has not changed since the day it was launched. They don’t collect information needed to communicate with their audience, such as email addresses, or provide an ability to receive text messages. And while one could walk down the halls of the organization and notice that nearly everyone either has or is using a cell phone PDA, their web site is not compatible for small-screen viewing.

These and other issues are not new technology problems. On the contrary, they are very, very basic and simply indicate a need for someone to calmly pay attention and point in a clear direction that makes strategic sense. Course changes and corrections will always be needed, but not at the expense of consistency. Expressing a message within a Facebook page and gathering “friends” should not lead to a new and different message, but merely an expression of the organization’s message. If, for example, your message is “quality care,” then every single aspect of your communication designs, no matter if the message is moving out over Twitter, an email message, web site or a social media page, must say “quality care,” not “lowest price in town.”

Finally, we believe all messages to the public must contain the same subtext: “We’re paying attention.” As their world becomes more and more complicated by both messages and channels that are growing at an amazing rate, those who are perceived as simply paying attention to people and listening to them will be the most successful. And that hasn’t changed at all. ♦

Bob Grossfeld is President and Josh Grossfeld is Vice President of The Media Guys. The firm assists campaigns, associations, corporations and advocacy organizations in public relations and communications strategy. The Media Guys are also the public relations firm for PHA.

Douglas Adams is generally credited as the originator of The Hitchhiker’s Guide to the Galaxy.
In 2002, a group of thirty physicians in Idaho Falls, Idaho banded together to create a hospital that was founded on the idea that partnering with physicians would result in excellent clinical results and a superior patient experience. These physicians believed so strongly in this mission and in the vision of what was possible, that they each signed on the dotted line for over $125 million of liabilities to make the dream a reality. The physicians made those commitments primarily because they wanted to have a say in the way their hospital functioned and ensure their patients received the finest care available.

At that time, the large, for-profit regional hospital in the area had become unresponsive to both the needs of the physicians, and, more importantly, to the needs of the community and its patients. The regional hospital, in monopolistic fashion, unilaterally cancelled their insurance contract with the largest insurance provider in the area, forcing many in the community to travel out of the area to receive their care. In addition, rates at the regional facility had increased to levels where it became less expensive for employers in the area to send their employees 200 miles south along I-15 to Salt Lake City to have their healthcare needs fulfilled.

In addition, this large facility had stopped listening to the needs of area doctors. Pleas from physicians imploring the administration to improve services fell on deaf ears. Turnaround times for operating rooms had ballooned to over one hour between surgeries and hospital administration’s commitment to work with the physicians continued to wane. Physicians found it increasingly difficult to manage their practices with any amount of predictability and became further removed from being able to influence their patients’ care.

Physicians, residents, and employers had had enough. The time had come for a change in the Idaho Falls healthcare market. It was this set of conditions that gave rise to the formation of Mountain View Hospital (MVH), one of Idaho’s premier physician-owned facilities.

Seven years later, the dreams of these physicians have been realized, and the path has been forged to create competitive, cost-effective results for a growing community. “Mountain View has filled a gap in the delivery of healthcare in our community,” says President of Mountain View Hospital and PHA Board Member Jeff Sayer. “Our focus, from physicians to administration, is set on providing an excellent patient experience, maintaining a strong competitive balance in the community, and always provide consumers with a choice for their health care needs.”
And that choice has become more attractive every day. In the recently released hospital rankings from a national authority, Mountain View Hospital came in as the fourth best hospital in the state while the regional, for-profit facility was ranked close to the bottom of the state list.

**Continuous Increase in Services**

In the beginning, MVH was known largely as a “bones and babies” hospital, with its strong focus on orthopedic and OB/GYN care. Over the past seven years, however, MVH has expanded its services dramatically. In addition to the world-class orthopedic and OB/GYN care that the hospital provides, MVH significantly increased the services it now offers. While leading the market in providing top of the line surgical services across a broad range of specialties, MVH has also expanded the ancillary services to respond to the needs of the medical community as well as the needs of area residents.

These ancillary services include state of the art imaging services, reference lab and blood banking, advanced wound care and hyperbaric services, a high-end physical therapy facility including a full-size pool, two urgent care facilities, sleep lab, and many other services. Each of these services has been added in response to community needs and the physician-owners’ commitment to their patients. According to Mr. Sayer, “We are a true community hospital responding to the specific needs of our community. Our physicians are long-time residents of the area and many of them are second generation physicians in the area. Because of this fact, we have a deep commitment to provide those specific services that our community needs.”

This approach has served the hospital well. Revenue has increased over 300% from the initial $20 million in 2003. Surgical volume has increased over 150% over that same period with 2010 poised to be another record-breaking year. Ancillary services continue to gain market share as the hospital maintains its focus on providing excellent patient care and an excellent patient experience. “Everything we do revolves around providing the best patient experience possible. We strive to not only provide top-notch clinical care, but also top-notch customer service as well,” says Peter Fabrick, VP of Clinical Operations. One example of the hospital’s commitment to this care is full-time personal concierge. The sole focus of the concierge is to take care of each patient and family needs while they are at the facility.

**Success Required Expansion**

Community support for the hospital has been so consistent and strong the hospital found it necessary to expand. In late 2008, MVH began a $10.5 million expansion project which was completed in August of this year. The expansion increased the number of beds from 24 to 40 beds, increased the operating room capacity by 25%, doubled the size of its nursery, and increased the capacity of its central sterile area. “With this new expansion, we hope to continue meeting the growing medical needs of the community for years to come. The community has continually supported us over the years. With this expansion, we can respond to that need,” says Sayer. (continued)
Prosperity through Partnership

Mountain View attributes its success to the concept of partnership. “Our entire model is based on partnership: Partnering with physicians to provide excellent, cost-effective care, partnering with employees to provide meaningful employment in a positive atmosphere of growth, partnering with employers with customer solutions to their health care needs, and partnering with community organizations in the area to enhance the quality of life in our community,” says Sayer.

Partnership is a word that you will hear on a regular basis if you spend much time in the facility. “One of the first things we realized when we founded our facility is that in addition to the employees and physicians, employers needed to be a part of the healthcare equation. So we simply went to them to understand what needs they had,” says Sayer. One answer to that question quickly surfaced – they needed a solution to their complex workers compensation issues.

Understanding this need, Mountain View created an occupational health program that leads the state in innovation. Employers know it as a “no cost, one stop solution” to all their workers compensation needs. The hospital knows it as a carefully designed solution that ensures that the employers/employees’ needs are met with a strategically designed team approach. The program includes trained case managers who handle all the administrative paperwork and logistics for the employer, careful coordination with insurance carriers, a non-surgical medical director, and supportive collaboration from the physicians. The program design ensures the medical costs are kept at the lowest possible levels and by partnering with the employers, the case managers can ensure employees return to work as quickly as possible, significantly reducing lost-time accidents. Both result in substantially lower costs to the employers.

The program has met with a tremendous amount of success. Nearly 400 area employers have signed up, accounting for over 37,000 employees now covered by the program. In addition, the hospital has established affiliate relationships with eight other clinics throughout the Eastern Idaho corridor to ensure employers have multiple, low-cost “portals” for their employees to access. Added to the hospital’s two urgent care locations, this has created a network of 10 clinics employers can access that span a 100 mile corridor in the state. This model of partnering with employers exemplifies the relationships that MVH creates to provide healthcare that the community needs.

This type of innovation has been noticed by the State of Idaho as well, as Governor C.L. “Butch” Otter has selected Mr. Sayer to serve on his healthcare advisory committee for the State. According to Mr. Sayer, “There is no question that there are problems in the healthcare delivery of our nation. But we believe that through innovation that is led by physician-owned facilities, we can create solutions to address these problems. We look forward to being a part of the process that will lead to new ideas, new partnerships, new innovation, and, ultimately, improved delivery of healthcare, for many years to come.”

Mountain View Hospital, with its history and its bright prospects for the future stands a model of healthcare innovation as it provides solutions to the complex problems facing the community it serves. ✪
As one of the country’s leading developers and managers of physician hospitals and ambulatory surgery centers, Nueterra Healthcare is uniquely positioned to help physicians and health care systems create strategies for successfully navigating through changing industry dynamics.

For more than a decade, Nueterra has developed and managed successful health care facilities across the country. The facilities include physician-owned specialty hospitals, physician-owned community hospitals, ASC conversions to hospitals, medical real estate and health care campuses. With 75 facilities in 28 states, Nueterra has a proven track record of success regardless of market and regulatory conditions.

The company’s comprehensive capabilities and expertise help physicians, hospitals and health systems increase market share, productivity and profitability. Nueterra specializes in:

• End-to-end development services that speed time-to-market and include a feasibility study to ensure the financial, clinical and operational soundness of the project, reducing the obstacles and risks.
• Single-source management solutions that deliver superior returns, excellent clinical outcomes and exceptional patient satisfaction.
• Value-added services such as real estate development and capital management.
• Business life-cycle management to ensure the continued growth of business and provide the visionary thinking needed to ensure success into the future.

A great example of this is in Great Bend, Kansas, where Nueterra worked with local physicians to develop a specialty hospital in 2001 and then convert it in 2009 to a community hospital. This conversion was completed despite ongoing efforts to restrict physician-owned hospitals.

"Physicians approached Nueterra about developing a specialty hospital in Great Bend because they wanted to provide additional health care options for their patients," said David Ayers, President of Nueterra’s Surgical Facilities Division. “We helped provide the vision and direction needed to successfully launch and develop the project. Then, as the specialty hospital continued to grow, we managed an expansion that added an imaging center, and began working with physicians to plan for the conversion to a community hospital.”

The expanded, full-service Great Bend Regional Hospital includes a medical surgery wing, private labor and delivery rooms, a pediatric unit, ICU, ER and full-service lab.

Moving forward, Nueterra has the infrastructure to sustain a competitive advantage throughout the lifecycle of the hospital. Nueterra is able to drive quality outcomes while controlling expenses in ways that result in increased patient satisfaction, physician satisfaction, cash flow and profitability.

Physician-Owned Hospitals Across the Country

Nueterra also developed and manages surgical hospitals in Kansas, Louisiana, Pennsylvania and Texas, hospitals that are among the best in their respective states, according to nationally known authorities. New physician-owned hospitals are being developed in partnership with health care systems in Pennsylvania and Texas. In both states, Nueterra is developing multiple facilities for each health system partner, as initial success led to discussions about long-term strategies. In Louisiana, Nueterra is leading the conversion of a very successful ASC to surgical hospital.
As of mid-2009, Nueterra had 10 facilities in development, including five physician-owned hospitals.

Nueterra’s proprietary process simplifies the complexity of facility planning, development and management. The company’s equity model means that partners control essential aspects of each facility, such as operational structure and core business practices, resulting in greater control and autonomy.

As a facility matures, Nueterra develops solutions to provide long-term rewards for years to come. The company’s expertise, scope of service and commitment to delivering results means once the facility is complete, Nueterra focuses on day-to-day management tasks so physicians and health system executives can focus on growing their business and providing the best care for their patients.

Nueterra’s disciplined approach to financial management maximizes return on investment through excellent revenue cycle management, cash flow analysis and proper cash reserve policies. Whether it is anticipating a long-term capital expense or a short-term receivables issue, Nueterra provides the oversight needed.

From the clinical to the practical, Nueterra works with partners both on-site and behind the scenes to provide the expertise needed to help them build their business successfully. Some of Nueterra’s services include:

- Access to working capital. As a successful corporate partner, Nueterra has established banking relationships that allow the company to bring financing options to a project. In the current state of the economy, many lenders require a corporate partner to access the best lending terms.

- Staffing and personnel. If required, Nueterra will help recruit and retain dedicated staff to minimize turnover and maximize contributions to a facility’s success.

- Operations management. Partners have direct access to proven policies and procedures developed for a specific facility to help control all aspects of day-to-day performance.

- Regulation and accreditation. Nueterra will facilitate a facility’s adherence to requirements and communicate with all parties to ensure long-term compliance.

- Compliance and risk management. Nueterra’s experience helps anticipate problems before they occur, and keeps owners fully advised of potential issues and solutions.

- Clinical outcomes benchmarking. To maintain quality control standards, Nueterra provides critical, ongoing feedback to partners and their medical staff on clinical outcomes.

- Long-term business planning. By identifying and quantifying future events, such as buy/sell transactions, and multi-year objectives involving financial growth markers, service quality outcomes, and patient and staff satisfaction measurements, partners can be assured they are working with an experienced and knowledgeable corporate partner.

As of mid-2009, Nueterra had 10 facilities in development, including five physician-owned hospitals.

Nueterra’s proprietary process simplifies the complexity of facility planning, development and management. The company’s equity model means that partners control essential aspects of each facility, such as operational structure and core business practices, resulting in greater control and autonomy.

As a facility matures, Nueterra develops solutions to provide long-term rewards for years to come. The company’s expertise, scope of service and commitment to delivering results means once the facility is complete, Nueterra focuses on day-to-day management tasks so physicians and health system executives can focus on growing their business and providing the best care for their patients.

Nueterra’s disciplined approach to financial management maximizes return on investment through excellent revenue cycle management, cash flow analysis and proper cash reserve policies. Whether it is anticipating a long-term capital expense or a short-term receivables issue, Nueterra provides the oversight needed.

From the clinical to the practical, Nueterra works with partners both on-site and behind the scenes to provide the expertise needed to help them build their business successfully. Some of Nueterra’s services include:

- Access to working capital. As a successful corporate partner, Nueterra has established banking relationships that allow the company to bring financing options to a project. In the current state of the economy, many lenders require a corporate partner to access the best lending terms.

- Staffing and personnel. If required, Nueterra will help recruit and retain dedicated staff to minimize turnover and maximize contributions to a facility’s success.

- Operations management. Partners have direct access to proven policies and procedures developed for a specific facility to help control all aspects of day-to-day performance.

- Regulation and accreditation. Nueterra will facilitate a facility’s adherence to requirements and communicate with all parties to ensure long-term compliance.

- Compliance and risk management. Nueterra’s experience helps anticipate problems before they occur, and keeps owners fully advised of potential issues and solutions.

- Clinical outcomes benchmarking. To maintain quality control standards, Nueterra provides critical, ongoing feedback to partners and their medical staff on clinical outcomes.

- Long-term business planning. By identifying and quantifying future events, such as buy/sell transactions, and multi-year objectives involving financial growth markers, service quality outcomes, and patient and staff satisfaction measurements, partners can be assured they are working with an experienced and knowledgeable corporate partner.
Nueterra believes in the importance of nourishing the entire individual, so beyond just helping its partners become financially prosperous, Nueterra believes in giving back to the community. Growing from the vision of Nueterra founder Dan Tasset, the One5 Foundation is working to become a leader in building successful communities.

One5 works with individuals and communities, starting with the most vulnerable-orphans. Since its inception, One5 has been working in Haiti, Uganda, Malawi and Kenya, providing medical care, building clinics and hospitals, and providing education to help decrease the risk of mother-to-child transmission of HIV. In Haiti, One5 provided 2000 Permethrin-treated mosquito nets to distribute to all ESM/C3 orphanages in efforts to prevent malaria and dengue.

One5 lifts up people living in poverty and helps them succeed in all aspects of their life so they will, in turn, become leaders and enrich their communities and countries. This strategy takes into account all basic needs essential to any successful community – food, shelter and clothing, environment and infrastructure, education, health care, business enterprise investment, and micro economic development. By providing individuals with the opportunity and means to develop their own skills and abilities, One5 strengthens the institutions and services that empower and sustain the entire community.

One5 partners with multiple organizations sharing our philosophy. To learn more about this foundation, visit www.integrallifefoundation.com.

Health Care Remains a Healthy Investment

Like any other business, health care has a distinct life cycle. Whether it is an ASC experiencing a maturing or reduction in revenue growth, or a health system facing declining reimbursement and more competition for cases and market share, health care providers today are increasingly met with challenges affecting the success of their facility. Often there is a need in a community for better care or more health care services. These ever-changing complexities can create opportunities.

One of the benefits of working with a corporate partner like Nueterra is that the company has all of the expertise needed to successfully develop and manage physician-owned hospitals and ASCs. There are many current partnership models and options available between physicians, hospitals and management companies. And Nueterra is prepared to deal with any possible changes in ownership laws so that physicians can continue to benefit from the facilities in which they have invested or are providing service.

Nueterra is alone in the industry in offering a range of services that have proven success, regardless of the healthcare environment or economic circumstances. The company is not about one-time deals or short-term success. It is focused on providing innovative solutions that ensure the long-term success of our partners. Nueterra pioneered the idea of physician majority ownership and continues to be the leader in developing business models and solutions to meet the needs of the health care community.
Health Capital Consultants:
Providing Solutions in an Era of Healthcare Reform

Health Capital Consultants (HCC) is a nationally recognized healthcare economic and financial consulting firm headquartered in St. Louis, MO, specializing in valuation consulting; financial analysis, forecasting and modeling; mergers and acquisitions; provider integration, consolidation & divestiture; certificate-of-need and other regulatory consulting; and, litigation support & expert testimony.

Founded in 1993, HCC has served a diverse range of healthcare industry & medical professional clients in over 45 states. Over the years, HCC has developed significant research resources; a staff of experienced professionals with strong credentials and certifications; a dedication to the discipline of process and planning; and, an organizational commitment to quality client service, as the core ingredients for the cost-effective delivery of professional consulting services.

At HCC, we believe that, “our product is our process” - a process that yields results which encourage the creation of measurable advantages in the marketplace for our clients. HCC’s clients benefit from field-tested methods and best practices within a project management structure that efficiently deploys our resources, and those of our clients, in an interactive, cost-effective and coordinated manner.

Producing a Collaborative Work Process and Product

HCC is known for our accessibility to our clients and our regular communication of the status and progress of each project. Our mutual success depends on HCC’s ability to collaborate with our clients to properly define our role during each phase of the project, as guided by these five elements:

• Objectivity. Our input will be based on factual observations and our prior knowledge of the specific healthcare industry market factors related to each project.
• Sound Methodology. The planning, development and implementation of a project plan is a process that requires discipline and thoroughness. HCC will customize each project plan to address each client’s particular needs as we learn and understand them.
• Balanced Involvement. Our approach is to involve all appropriate stakeholders to create an integral project team, combining our expertise with client knowledge.
• Commitment to Results. We commit to produce and communicate a credible and informative report providing our observations, findings, conclusion and opinions in a manner that achieves project objectives.
• Independence. Our role throughout the project is to maintain our independence to insure that we perform our analysis and express our views in a candid and unbiased manner while ensuring our client’s participation in the overall project process.

HCC recognizes that the healthcare industry’s environment of constant change requires the skills of an established healthcare consulting firm staffed by experienced professionals who have the technical skills and experience to competently, consistently, cost-effectively, and quickly respond to our clients’ needs. HCC understands that to succeed, we must inspire confidence that the process has been accomplished in an atmosphere of the highest integrity, mutual trust and respect. This means that the working relationship we form with each client, and the solutions we develop in concert with them for each project, are enhanced by HCC professionals who have both practical experience and a depth of knowledge of the pertinent issues to provide clients with a level of confidence unsurpassed in the consulting field.

Key Leadership

HCC and its skilled staff of certified professionals have significant experience and enjoy a national reputation in the healthcare valuation and consulting field. Our experienced staff contributes a set of unparalleled qualifications for your engagement, and sets HCC apart from otherwise qualified “generalists” in the valuation profession.

Robert James Cimasi, MHA, ASA, CBA, AVA, CM&AA, President of HCC, is a nationally recognized healthcare industry expert with over 25 years experience in serving clients in 49 states. His professional focus is on the financial and economic aspects of the healthcare industry, including: valuation consulting; healthcare industry transactions, joint ventures, mergers and divestitures; certificate-of-need and other regulatory and policy planning; and, litigation support & expert testimony. Mr. Cimasi is the author of several books and chapters, has published numerous articles in peer review journals, frequently presented research papers and case studies before national conferences, and is often quoted by healthcare industry professional publications and the general media. In 2006, Mr. Cimasi was honored with the prestigious Shannon Pratt Award in Business Valuation.

Todd A. Zigrang, MHA, MBA, FACHE, Senior Vice President at
HCC, has over twelve years experience in providing valuation, financial analysis, and provider integration services to HCC’s clients nationwide. He has developed and implemented hospital and physician driven MSOs and networks involving a wide range of specialties; developed physician-owned hospitals and ambulatory surgery centers and outpatient centers; participated in the evaluation and negotiation of managed care contracts; performed valuations of a wide array of healthcare entities; developed project financing; created pro-forma financials and feasibility analyses; and, completed due diligence analyses. Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia and is a fellow of the American College of Healthcare Executives.

Anne P. Sharamitaro, Esq., Vice President of Research at HCC, focuses on the areas of regulatory compliance, Certificate of Need; managed care, and antitrust consulting. She has written numerous peer-reviewed articles and has presented healthcare industry related research papers before several healthcare industry associations. Ms. Sharamitaro holds a J.D. with Health Law Certificate from Saint Louis University School of Law, and has been admitted to the Missouri Bar.

Providing Comprehensive Healthcare Economic and Financial Valuation Services

There are many events that may set the stage for the valuation (appraisal) of a healthcare enterprise. Whatever the reason for the valuation, consulting with the HCC team of qualified, experienced and certified healthcare valuation professionals will ensure a thorough analysis of the subject entity, or property interest to be appraised, within the context of the marketplace in which it exists. The scope of HCC valuation services ranges from comprehensive, formal written reports with certified opinions to limited, restricted use analyses and valuation consultations.

Healthcare Enterprise Valuations

HCC provides opinions of value, in both the for-profit and tax exempt arenas, for the sale or transfer, merger & acquisition, lending & capital formation, and liquidation or dissolution of healthcare enterprises. HCC’s healthcare enterprise valuation services are also provided for management planning, insurance claims, gift & estate tax planning, and for other related purposes.

Healthcare Asset Valuation

In addition to healthcare enterprise valuation, HCC provides opinions of value related to the valuation of tangible assets, such as accounts receivable; cash and investments; furniture, fixtures, and equipment; and, leasehold improvements. HCC also provides valuation services regarding certain intangible assets related to intellectual property; human capital; regulatory, financial, and technology intangible assets; and, goodwill. HCC’s staff of experienced professionals will provide a valid opinion as to the classification of a subject entity’s tangible and intangible assets, and the value of those assets within the context of industry trends, the subject entity’s historical development, and changes in an that entity’s organizational structure and operation.

Healthcare Services Valuation

Within the heightened and ever-changing regulatory environment in which healthcare entities and providers operate, transactions involving the employment of physicians require a certified opinion of value to support the compensation arrangements developed between physician providers, and enterprises who employ these providers, (often exempt organizations), in order to withstand scrutiny from both state and federal agencies, as well as to meet the stringent statutory requirements under federal Fraud and Abuse laws.

HCC has performed valuation engagements related to Fair Market Value and commercial reasonableness of physician compensation transactional arrangements for provider enterprises (and their legal counsel) nationwide. HCC conducts each valuation engagement in accordance with the standards of the valuation profession, as well those requirements of the IRS and OIG.

Litigation Support & Expert Witness Services

HCC also provides technical assistance to legal counsel through litigation support services, focused solely on the healthcare industry, in such areas as: commercial damages; lost or enhanced earnings capacity; healthcare valuation; merger, acquisition or divestiture transactions; provider relationships; managed care issues; healthcare industry research; shareholders disputes; economic and utilization demand forecasting; bankruptcy; anti-trust; discrimination; certificate of need feasibility analyses; and, fraud and abuse issues.

HCC has assisted in cases in the Federal District Courts, State Courts, Tax Court, Bankruptcy Court, and arbitrations, on engagements entailing complex economic, legal, financial, valuation and other related issues across a broad spectrum of provider entities in the healthcare industry by providing reliable and cost-effective services.

Examples of Recent HCC Client Projects

| Client: | 35+ bed, physician-owned surgical hospital |
| Location: | Midwestern U.S. |
| Engagement: | Valuation of an acute care, surgical spine hospital |

| Client: | Shareholders of a physician medical practice |
| Location: | Northwestern U.S. |
| Engagement: | Valuation of a multi-location 20+ physician cardiology group practice and related cardiac diagnostic and catheterization lab enterprise |

To learn more about HCC, visit www.healthcapital.com.
As a child growing up in small town Oklahoma, I watched my father manage patients as a family physician. He took care of patients in the morning, all day long and into the night. He was the very image of a hometown doctor who made house calls and put his patients first. As a kid watching I thought, “I don’t want to do that!”

But dad’s commitment to his patients was woven into my DNA in those early years and despite my best efforts to go into fields of science, math or finance – medicine pulled me like a magnet. I knew I couldn’t take a job at a desk and wanted to work with my hands.

My “doctor rebellion” was short lived. By my second year in college, I was thinking medical school. I entered the University of Oklahoma College of Medicine in 1977, did my post graduate work in Internal Medicine at the University of Oklahoma Health Sciences Center and completed my Fellowship in Interventional Cardiology at Beth Israel Hospital in Boston.

As I got into medicine in the late 70’s, I was seeing “physicians” losing control of the very patient care that was calling me into the profession. DRG’s and corporately owned hospitals were taking patient decisions away from the physician and putting those decisions in the hands of non-physicians. It was becoming a world turned up-side-down, far from the world my father served so selflessly. Though still a fledgling physician myself, the seed of a dream was germinating. We must take back our profession, and make patient care the top priority. A lofty dream – but how could it become a reality?

From 1987 to 1991, I was an assistant professor of medicine at the University of Oklahoma School of Medicine and the Director of Interventional Cardiology at University Hospital. I saw first hand the bureaucracy of medicine and became intrigued by the business side of developing the practice of medicine.

I moved into private practice in 1991 as an interventional cardiologist. The
work required in this specialty is no desk job… I got to combine clinic work with surgery and most of all I got to enjoy direct patient care with sometimes very sick patients. This was my father’s world.

I partnered with another cardiologist and our business goal was to grow! We soon became “The Heart Group” with 8 cardiologists and had the patient mass to begin bringing services directly under the umbrella of the physicians group. On-site echocardiograms and nuclear services better served our patients and taught us we could manage those services more efficiently and cost-effectively than traditional hospitals.

The concept of a new way to deliver cardiovascular services was taking shape in our practice. We were bringing on more services internally by-passing the traditional hospital systems and bureaucracies. My old dream of taking back the profession and making patient care top priority was taking root in a new hospital model. In fact, I had no idea at that time that my professional life was going on or be so directly and distinctly tied to this new physician-controlled, patient-centered model…

Then in 1995, our group became aware of a hospital in McAllen, Texas that specialized in cardiovascular care. We rushed to see it ourselves and the pieces of the puzzle we were trying to put together began to form the picture of an Oklahoma hospital totally dedicated to the care of hearts under the ownership of cardiologists.

Our vision was a hospital with the ability and agility to grow without the constraints of small ideas and large bureaucracies. We knew this system had to be flexible to incorporate new ideas and technologies and nimble to seize opportunities while never losing sight that patients are the top priority.

Our team began shopping the notion of a heart hospital to major hospitals and investors in the Oklahoma City area. We then learned an early hard lesson – we didn’t have the physician mass to make it happen – so we went back to work on the basics.

We expanded our existing cardiology group and brought them up to speed with the concepts of a physician-owned heart hospital. In 1998, we merged with another physician group to create Oklahoma Cardiovascular Associates, the largest group of cardiovascular specialists in Oklahoma. We took the time to fine tune the principals that would guide the project.

Physicians would drive the major decisions with a micro-thin administration to streamline the process from idea to action.

We knew nursing was key. We committed to no more than a 1:4 nurse-to-patient ratio on the general floors and a 1:1 ratio in critical care. The number crunchers said that commitment would lose money. There was no compromise – nursing care was critical. We believed a strong nursing culture would pay off in high retention rates, low staff turnover, and would reduce the need for many ancillary non-nursing positions. We designed nursing stations in 8 bed pods, putting the nurses very close to patients.

All services would revolve around the patient. The facility was designed with optimal patient flow in mind. Patient transport had to be limited and services brought to the room instead of forcing the patient to be constantly on the move. Our concept for patient rooms was to make them more family friendly as well. We wanted a design that not only allowed family in the room, but actually encouraged family to stay in the room. The rooms would have a variety of seating options that converted into beds.

Patients and their families would get valet and concierge treatment when they entered the doors at no added cost. Our food service would be tailored to each patient, bringing specially ordered food when the patient was hungry instead of when it was convenient for the hospital.

Technology was also a huge element of the design that would become the Oklahoma Heart Hospital. Architects conceived fiber optic wiring from the
foundation up. There would be very little paper in this facility. This would be an all-digital hospital with an electronic medical record following the patient through every step of their stay in the hospital and in our rural clinics from diagnosis to discharge.

Physician offices were moved into the hospital design to keep doctors just steps away from their patients. ER → close to cath lab → close to OR, etc. Radiology, pharmacy and labs would be in the core of the facility.

My long held dream of a care model that puts patients as the top priority and physicians in control was a reality – on paper.

Two years later we were ready to take the idea of the Oklahoma Heart Hospital to a willing hospital partner. Mercy Health Center was that ideal partner. They were already an established major hospital in the Oklahoma City area, with land to expand and the need for a strong heart program. We broke ground that year.

In August of 2002, the Oklahoma Heart Hospital opened its doors as the first all-digital hospital totally dedicated to hearts in the nation. Oklahoma Cardiovascular Associates owned 49% of the venture and Mercy Health Center owned the remaining portion of the hospital.

Patients quickly came to the hospital. Not necessarily the urban, wealthy patients you might expect but patients from underserved rural Oklahoma in desperate need of cardiovascular services. OCA has 40 clinics in rural Oklahoma that rapidly evolved into a patient referral system to the hospital.

One of the first lessons learned was that we dramatically underestimated the role of the emergency department in this hospital model. We built the facility with two ER rooms and almost immediately set to expand the ER by another 10 beds to meet the demand.

Our primary dream of putting the patients first paid off within the first three years when the hospital was ranked in the top one percent of hospitals in the nation for patient satisfaction.

Within 5 years, patient demand grew so fast and furiously we had to obtain new land and grow the facility by 70,000 square-feet and begin plans for a second mirror facility in south Oklahoma City. Oklahoma Heart Hospital South Campus is on track to open in January of 2010. But, political forces threaten the dream…

National lawmakers seem relentless in their efforts to stop the growth with laws that would limit the percentage of ownership doctors can have in hospitals. Wave after wave of attacks began in the early 2000’s and continue to this day.

These political forces have again stirred the patient care DNA within me left by my father. I’m committed to standing on the precept that physicians cannot fully meet our patients’ needs if we aren’t also protecting those needs all the way to the boardroom and beyond.

I don’t have all the answers about how physicians can regain and retain control in a new medical reform environment, but I do know we must retake our role as the number one advocate for our patients. We are the best trained to make the most difficult decisions regarding injury, disease and death and we must not abdicate that role again. ☞

Dr. John Harvey is a board certified cardiologist who received his training at the University of Oklahoma followed by sub-specialty training in interventional cardiology at Beth Israel Hospital in Boston. He is a founding member of Oklahoma Cardiovascular Associates, a 40 member cardiovascular group in central Oklahoma and has served on its board since inception. In addition to his private practice, he serves as Chief Executive Officer and President of the Oklahoma Heart Hospital, a specialty cardiovascular hospital group with two full service hospitals in Oklahoma City.

Why Partner with Cirrus Health?

They Come Doctor Recommended.

Why? Because Cirrus Health understands physicians are the decision-makers in providing the highest quality of care to patients. As a health services organization, it is our responsibility to provide the right solution to meet the unique needs of physicians in today’s healthcare industry. Let us know how we can best serve you, so you can better serve your patients. Email us at information@cirrushealth.com or call 1-888-744-4443.

www.cirrushealth.com

CIRRUS HEALTH

Partners In Health
The Surgical Specialty Center at Coordinated Health – Allentown

The Surgical Specialty Center @ Coordinated Health – Allentown which opened on July 14, 2009 is the new model for clinical integration between the physician practice and the community hospital.

Coordinated Health, a 50-physician multi-specialty musculoskeletal medical group, consolidated two established practice locations into a new 35,000 sq. ft. medical office with 30 private examination rooms, a 10,000 sq ft outpatient physical therapy center, and a full service diagnostic imaging center. The group practice developed the new space in association with a new physician-owned 22-bed hospital. The Surgical Specialty Center, which occupies the remaining 45,000 sq. ft. of the building, has 4 operating rooms, 2 procedure rooms, and 22 large private patient rooms.

The Surgical Specialty Center at Coordinated Health – Allentown is the second hospital developed by Coordinated Health. The prior facility is a 20-bed physician-owned hospital with 6 operating rooms and 2 procedure rooms that opened in 2006 in nearby Bethlehem, Pennsylvania. The Surgical Specialty Center at Coordinated Health – Bethlehem is located on a campus that includes a 37,000 sq. ft. medical office building housing a similar location of the group practice.

Recognizing the need to integrate physician medical practices with a surgical hospital to provide a better patient experience, Coordinated Health founder Emil DiIorio, MD brought together over 30 local physicians and business people to create the new hospital. In addition to the orthopedic and spine surgeons at Coordinated Health, surgeons specializing in podiatry, plastics, retina, vascular, and general surgery all worked together on the development. As was done in the Bethlehem facility, the integration of community medical services was completed by the regional tertiary care center, also a partner in the venture. The result is a new delivery model designed to provide more efficient, more affordable, higher quality health care for the people of the Lehigh Valley.

Experience the difference of a physician driven philosophy and patient-centric approach to healthcare management. Our team provides proven results, partnering with physicians to lead their facilities and achieve success. As a physician owned company, we share your vision of excellent healthcare in an improved business environment.

Corazon Ramirez, MD
President & CEO
cmr@physiciansynergy.com
Phone: 214-693-2220

Greg Weiss
President, Business Development
gweiss@physiciansynergy.com
Phone: 214-693-2220

Manuel Ramirez, MD
Vice President, Business Development
mramirez@physiciansynergy.com
Phone: 214-649-2813

Michael Conroy
Vice President, Finance
mconroy@physiciansynergy.com
Phone: 817-822-9970

Katherine Lower
Vice President, Operations
klower@physiciansynergy.com
Phone: 214-683-5915

www.physiciansynergygroup.com
On September 24-26, 2009, Physician Hospitals of America, PHA, hosted its 9th Annual Conference and Exhibits at the Hilton New Orleans Riverside in New Orleans, Louisiana. At the conference were over 60 exhibitors representing a broad range of medical equipment and services, as well as business sectors key to the construction, development, and management of physician hospitals. Also present were many corporate members, sponsors, and industry leaders, with a new all-time conference high of more than 415 attendees.

The conference featured thirty break-out sessions covering topics that ranged from hospital operational issues to implications of various federal regulations, review of statistical studies and a range of clinical presentations. The keynote address was delivered by Jason Hwang, MD, MBA, of the Innosight Institute. Dr. Hwang is the co-author of the recently released book, “The Innovator's Prescription: A Disruptive Solution for Health Care.” Dr. Hwang co-authored this book with Clayton M. Christiansen a Harvard Business School Professor and Jerome H. Grossman, MD who is the Director of the Harvard Kennedy School Health Care Deliver Policy Program. Other keynote speakers included a political panel presentation by PHA leaders; a legal presentation by Bill McMurrey, S. Craig Holden, Michael Joseph, and panel moderator Scott Becker; and Astrid Levelt of Cogentis Health Group, Vancouver, BC, and Dr. Nigel Murray of Fraser Health, Surrey, BC, who provided a panel presentation on Comparative International Health Systems.

If you are interested in purchasing the audio files, with sequenced presentation files, for the 2009 conference, please go to: http://www.allstartapes.com/conferences/conference_1320.shtml.

Physician Hospitals of America’s 10th Annual Conference & Exhibits is scheduled for September 23-25, 2010, at the Hyatt Regency San Francisco in San Francisco, California. Make plans to attend today! For more information on the conference please go to: www.physicianhospitals.org or call PHA at (605) 275-5349.

You Want To Focus On Quality.
We Have The Technology Solutions to Measure Your Hospital’s Success.

EdgeSurvey™ sets the bar for hospital patient satisfaction measurement and benchmarking. By leveraging innovative web-based technology, EdgeSurvey effortlessly automates and streamlines your entire patient satisfaction surveying process.

Call CTQ Today To Learn About Our No-Obligation Trial!

The Clinical Benchmarking Partner For PHA
**PHA News in Brief**

**Congresswoman Dahl kemper Visits Edgewood Surgical Hospital**

Representative Kathy Dahl kemper (D-3rd PA) visited Edgewood Surgical Hospital in Transfer, Pennsylvania on Thursday, August 13th. The Congresswoman had a chance to visit with patients, staff, as well as physicians.

**Amkai and Mavicor Announce Partnership**

Amkai, a business management and electronic medical records provider, and corporate member of PHA, announced at the close of the summer a new market services partnership with Mavicor. Amkai and Mavicor have agreed to jointly represent IT solutions to the marketplace. Mavicor provides a variety of basic technology support service solutions, including backup and restoration services that are critical for the success operations of any facility.

**Congressman Johnson Visit to Forest Park Medical Center**

Physician hospital advocate Representative Sam Johnson (R-3rd TX) visited Forest Park Medical Center in Dallas, Texas on Thursday, September 3rd. Congressman Johnson has been a huge advocate of physician-owned hospitals and we greatly thank him for taking the time to visit with Forest Park Medical Center.

**PHA Benchmarking Update**

We have drawn to a close our fifth quarter of data collection for the PHA Benchmarking Program. The first five quarters of data collection went smoothly and the information is being used for internal benchmarking and to garner national political support. For PHA member hospitals, benchmarking is a member benefit and is free of charge. For non-member hospitals, it is a charge of $2500 for four quarters of data capture and full reporting. If you would like more information on the benchmarking program, or have any questions, please contact Keri Bolte, PHA Member Services Manager, at keri@physicianhospitals.org or at (605) 275-5350.

**Buyer’s Guide**

<table>
<thead>
<tr>
<th>Anesthesia Management</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia Healthcare Partners</td>
<td>Institute for Orthopaedic Surgery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Architectural Consultants</th>
<th>Mgmt/Development/Capital Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marasco &amp; Associates</td>
<td>Cirrus Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accreditation</th>
<th>Medical Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Joint Commission</td>
<td>Soma Technology, Inc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial/Insurance Services</th>
<th>Medical Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IMA Financial Group, Inc.</td>
<td>ProScan Reading Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Patient Satisfaction/HCAHPS Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CTQ Solutions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symbion Healthcare</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receivables Mgmt/Debt Collection</td>
<td></td>
</tr>
<tr>
<td>Mnet Collection Agency</td>
<td>23</td>
</tr>
<tr>
<td>Professional Finance Company</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Software/EMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthland</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Valuation Consulting/Financial Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Capital Consultants</td>
</tr>
<tr>
<td>VMG Health</td>
</tr>
</tbody>
</table>
At our Speciality Surgical Hospitals and ASCs ...

... we strive to facilitate **physician efficiency and productivity** in order to provide exceptional patient care.

**Specialty Surgical Hospitals**

**South Dakota**
- Black Hills Surgery Center
ten: (605) 721-4700
- Dakota Plains Surgical Center
ten: (605) 225-3300
- Sioux Falls Surgical Center
ten: (605) 334-6730

**Oklahoma**
- Oklahoma Spine Hospital
ten: (405) 749-2700

**Ambulatory Surgery Centers**

**California**
- Barranca Surgery Center
ten: (949) 552-6266
- Surgery Center of Newport Coast
ten: (949) 706-6300

www.medicalfacilitiescorp.ca

**Head Office**
250 Yonge Street, Suite 2400
Toronto, ON
MSB 2M6 Canada
ten: (416) 848-7380
Toll Free: 1-877-402-7162
HCC’s mission is to bring our diverse knowledge, experience base and innovative ideas to our clients’ planning and decision-making process. HCC’s objective is to provide our clients with skilled, experienced professionals who are genuinely committed to helping them succeed. HCC’s commitment is to maintain the highest level of integrity, thoroughness, reliability and technical expertise in providing our services and professional judgment to our clients.