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Change Brings Progress,
Member Involvement Remains Key

I am honored and humbled to take over the presidency of PHA from the capable hands of Doug Johnson. For the past 2 years Doug has led PHA through turbulent legislative waters with great skill and wisdom. We are grateful for his exemplary service to physician hospitals and look forward to his continuing contributions as immediate past-president.

When I joined the board of PHA in 2002 (then the American Surgical Hospital Association) I was new to the physician hospital industry. Immediately, I was impressed by the quality of the people on the board. While many individuals have served on the board in the last 6 years, all have demonstrated intelligence, integrity and commitment to the cause of physician ownership of hospitals. The last PHA membership election expanded the number of board members from 14 to 16 and increased the number of physicians on the board from 4 to 6. Please join me in welcoming our new board members: Thomas Bertucini, MD, Jeff Sayer and Hooman Sedighi, MD. It will be my distinct pleasure to lead the PHA board and membership for the next 2 years.

As part of my new president orientation I visited the PHA “world headquarters” in Sioux Falls, SD last month. Our executive director Molly Sandvig, member services manager Keri Bolte and administrative coordinator Kim Gevik were gracious hosts. The PHA offices are efficient, customer service oriented and a place where a lot of good work gets done – much like PHA hospitals. Since joining PHA in 2006, Molly’s leadership has transformed our organization. Membership has grown by 275 percent, the annual budget has increased by more than 200 percent and the PHA PAC had increased by 440 percent. Alongside Randy Fenninger, our invaluable Washington representative of 5 years, Molly has made PHA a recognized, influential (and persistent) voice on Capitol Hill.

Since 2002, PHA has repelled the perennial efforts of the opponents of physician hospitals. Our industry has survived an 18-month moratorium on new facilities, a CMS “freeze” on new Medicare numbers, 5 congressionally mandated studies and countless legislative threats. 2008 was certainly no exception. No less than 5 bills brought language against physician hospitals including a farm bill, Iraq war funding bill, mental health parity bill, rural hospital bill and the SCHIP bill. Despite the enormous lobbying war chests of our opponents, PHA prevailed on every bill. A good idea is hard to kill. Grassroots initiatives, state organizations, PAC contributions, an enhanced public relations campaign, and hundreds of member visits on Capitol Hill contributed to the cause.

The elections of 2008 have presented many questions, challenges and opportunities to the future of American healthcare. There is no question that physician hospitals will be part of a great healthcare debate in 2009. We look forward to providing a unique and constructive voice to the process that Mr. Obama and Mr. Daschle are designing at this very moment. Unfortunately, our legislative opponents see an enhanced opportunity to pass a bill that would be disastrous to our concept of superior, accessible and affordable hospital care. PHA must prepare for what will likely be our greatest threat to date. To do so, it is imperative that every PHA member:

• Contribute to the PHA PAC fund.
• Renew your PHA membership.
• Attend Washington, DC fly-ins.
• Bring legislators to your facility.
• Join in grassroots initiatives including activating your patients and community to call or write their legislators.
• Join your state physician hospital organization.

Against all odds, physician hospitals have survived 6 years of misguided legislative initiatives and the attacks of an entrenched, dysfunctional hospital industry. We have survived because it is a great model, because we provide superior healthcare and because of the passion and commitment of PHA members. We must re-double our efforts in 2009.

Brett Gosney
President, Physician Hospitals of America
CEO, Animas Surgical Hospital
Executive View

PHA and Healthcare Reform:
The Courage to Change the Things We Can…

Molly Sandvig, J.D.

A famous social activist once said, “Never doubt that a small group of thoughtful, committed citizens can change the world…”

Over the last few years as Executive Director of PHA, I have become convinced the entrepreneurial, courageous physicians represented by PHA are exactly the type of thoughtful and committed group to which this statement applies. For years, physicians, not hospital administrators and not government bureaucrats, have been leading the way toward the highest quality care and new and better technologies.

Historically, physicians opened and owned the first hospitals in their communities. Some of these evolved into important medical centers that set new standards of excellence, such as the Mayo and Cleveland Clinics. With the advent of the current physician hospital industry, physicians are once again opening hospitals focused on the basic objectives of achieving patient-centered care and maintaining the ability of physicians to practice responsible, personalized medicine. By implementing these basic standards, physician hospitals are already reforming healthcare, one hospital at a time.

Back to the Basics

It is well established that the cost and quality of care are directly affected by the basic relationships that exist between providers and patients. Therefore, substantive changes benefiting patient care can be achieved by simply getting back to the basics of medicine and allowing physicians and nurses to do their jobs in a setting that promotes individual responsibility, personalized care, and incentive for best patient outcomes. Physician hospitals are a working demonstration of the higher quality care that can be achieved when physicians are allowed to make decisions regarding hospital business and when staff is given the ability to provide the personalized attention patients need. All too often, in the current system that regularly promotes bureaucracy rather than valuing the decisions of medical providers, those basics are overlooked.

As we discuss healthcare reform and the need for improved quality, the formula used to produce better quality care at physician hospitals across the country may very well offer a helpful solution to healthcare at large. Here are three key healthcare basics currently employed at physician hospitals that have proven to increase the quality of patient care provided:

Nurse to patient ratios are significantly better at physician hospitals than general hospitals. At physician hospitals, nurse to patient ratios average 1 nurse to 4 patients; however, nurse to patient ratios at general hospitals are typically 1 to 8 or higher. With lower nurse to patient ratios, nurses are able to provide the personalized care that patients truly need. And, nurses enjoy the ability to provide the type of care they feel their patients deserve.

In its federally mandated report to Congress, MedPAC stated that the most common reason for physicians to establish and own hospitals was governance. “Physicians wanted to control decisions made about the patient care areas of hospitals so they could improve the quality of care provided, improve their productivity, and make the hospital more convenient to them and their patients.” Report to Congress, Physician-Owned Specialty Hospitals, March 2005, Medicare Payment Advisory Commission (MedPAC), pgs. 7-8. Physician ownership of hospitals puts control and responsibility where it belongs – with doctors and their patients. Physicians take an oath to do everything in their power to care for their patients. When physicians are directly involved in every aspect of the delivery of healthcare, patients distinctly benefit.

Another positive choice for patients is to provide care in the most efficient place possible, consistent with patient safety and good medical outcomes. Often times, where hospitals are concerned, one size does not fit all. Physician hospital facilities are frequently built with the concept of efficiency and patient satisfaction in mind. This heightened efficiency in turn impacts cost effectiveness, quality and patient satisfaction.

Simple, back to the basics healthcare that is focused on the provider/patient relationship can truly reform the quality, efficiency and cost of care. Here are a couple of other areas in which physician hospitals are at the forefront of reform.

Transparency and Patient Involvement

In order to keep healthcare costs under control, there must exist a degree of individual patient responsibility balanced in conjunction with a level of social responsibility. Patients must have a stake in the game, so to speak. At Physician Hospitals of America, we believe the patient can be the best regulator or watchdog of quality care, but only if given the appropriate tools to make informed choices. Therefore, transparency, both
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of quality and cost, are an absolute necessity. Patient-centered care requires informed choice. It is completely unacceptable that patients do not currently have the tools they need to research the care options available. Physicians can play an important role at the local, state and national levels working collectively with hospitals by assisting in the creation of a system of transparency and reporting that is logical and useful to patients. In addition, as smaller hospitals that are not burdened to as great a degree by the morass of cost-shifting, physician hospitals may volunteer as “beta-sites” or model facilities for purposes of testing transparency/reporting systems.

Physician/Hospital Partnerships

Finally, in order to accomplish the goal of achieving patient centered reform, it will be very necessary that all segments of the industry work together. Public/private partnerships, federal/state partnerships, and certainly hospital/physician partnerships are all in the best interest of the patient. Physician hospitals currently in partnership with larger hospitals or systems provide a valuable example of how healthy relationships can form between doctors and hospitals.

In summary, at Physician Hospitals of America we believe that in any discussion regarding healthcare reform, patients’ needs must be considered first and foremost. We believe that physicians and their opinions must be truly valued as those in charge of and responsible for care in America. We believe that as patients and physicians we must demand efficient, high quality care, and the ability to make an informed choice.

There are a variety of ways to become directly engaged in national Administrative and Congressional efforts to enact healthcare reform. We need your help to influence the new Administration and Congress as they consider various methods of achieving reform. If you would like more information on how get involved, please contact me at PHA.

Molly Sandvig, J.D.
Executive Director
Physician Hospitals of America
Barack Obama’s campaign theme was “change” and while it is still too soon to determine just what will change in the United States and how much, there is no question that his election brought change to the White House and Congress.

For members of Physician Hospitals of America (PHA), and any other hospital with physician ownership, the shifts in the political firmament create apprehension about the future. We know our enemies have not given up their battle to end physician ownership of hospitals. It is certain that the increase in the Democratic majorities in Congress will make them even bolder. It is also clear that there are several legislative vehicles that will be considered in 2009 that could carry language contrary to the interests of PHA members.

However, it is just as certain that Congress and the new Administration face difficult economic challenges that demand immediate attention. It is also true that there is a genuine interest in pushing for a major overhaul of the entire healthcare system and that quality and cost effectiveness will be important issues in any debate over system-wide change.

Everyone knows that the Democrats increased their majorities in the House and the Senate. While they fell short of their goal to get 60 seats in the Senate and create a “filibuster proof” majority, they are much closer, with the Republicans controlling only 40 seats (Final count will depend upon the eventual outcome of the Coleman/Franken race in Minnesota.) It will only take a few Republicans to cross over on a given bill to allow the Senate Democratic leadership control on the floor. This new political dynamic could have an important impact on how the physician ownership issue plays out, since for the past two years, it was the
Office Score against physician hospitals remains an active “pay-for.” This is still a concern as the Congressional Budget Jurisdiction over Medicare and the physician ownership issue. All of these bills will pass through House and Senate Committees with the year, driven again by the need to fix the physician fee schedule’s problems. The $64,000 question is which legislative package might become the vehicle. As was done in 2007 and 2008. The $64,000 question is which legislative package might become the vehicle. Going into the new Congress, several possibilities exist. The first will be the economic stimulus package. Following shortly thereafter will be the reauthorization for the State Children’s Health Insurance Program (SCHIP) which needs to pass by the end of March. A Medicare package is likely later in the year, driven again by the need to fix the physician fee schedule’s problems. All of these bills will pass through House and Senate Committees with jurisdiction over Medicare and the physician ownership issue. Of course, this doesn’t prevent opponents of physician ownership from trying to add something to another unrelated piece of legislation, like a farm bill or an appropriations bill. This is still a concern as the Congressional Budget Office Score against physician hospitals remains an active “pay-for.”

The new Administration has yet to weigh in on this issue. Then-Senator Barack Obama did not play a visible role in the debate over ownership, probably because it is not a real issue in Illinois and his time was occupied by other matters, like winning delegates. Health and Human Services Secretary designate Tom Daschle is familiar with physician-owned hospitals because of their presence in his home state of South Dakota. He helped moderate the Breaux amendment in 2003, but he has yet to address the issue from his perch at HHS or as the new President’s health reform czar. There has not been time for any regulatory action so the Administration is still something of a blank slate. It is probably unrealistic to expect the same support that the Bush Administration provided, but we should give Obama and the Administration a chance to show their cards before we assume that they are against us.

Of course, this doesn’t prevent opponents of physician ownership from trying to add something to another unrelated piece of legislation, like a farm bill or an appropriations bill. This is still a concern as the Congressional Budget Office Score against physician hospitals remains an active “pay-for.”

As always, it will be very important to maintain existing political relationships and develop new ones. Now is not the time to roll over and play dead. This is the time for aggressive political and legislative efforts. PHA is already working with the membership to help in this area, with state specific programs. A third tool is the fact that independent reviewers continue to recognize the high quality of care that physician-owned hospitals provide. Very few community hospitals can match the record established by PHA members, and this success proves the main thesis of physician ownership. Putting doctors in charge of medical care really does mean better outcomes for patients. Every medical error or post operative infection in a community hospital costs Medicare more. Every time a patient in a physician-owned hospital dodges those problems, it is money in the bank for Medicare or another health plan.

Every hospital has these and other tools at its disposal. While the political climate may appear difficult, nothing is final and aggressive political action can do a lot to create a better situation and a better outcome. PHA will do all it can to support you while you are doing all you can on behalf of your patients and your hospital.
AGENDA

Tuesday, March 17, 2009
8:00 am  Continental Breakfast
8:15 am  PHA Announcements
8:30 am  Norman Ornstein, Ph.D., Political Analyst & Resident Scholar at the American Enterprise Institute, Inc.
10:00 am  Break
10:15 am  Republican Congressional Member
11:00 am  Michael R. Manthei, JD, Partner/Healthcare Attorney, Holland & Knight LLP
11:45 am  Legislative Luncheons/Fundraisers
1:30 pm  Democratic Congressional Member
2:15 pm  AMA Representative
3:00 pm  Break
3:30 pm  Greg Scandlen, Consumers for Healthcare Choices/Heartland Institute
4:30 pm  Molly Sandvig, JD, Executive Director, PHA and Randy Fenninger, JD, President, MARC Associates
6:00 pm  Dinner on your own/Fundraisers

Wednesday, March 18, 2009
8:00 am  to 5:00 pm  Congressional Visits

*Topics are subject to change

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Helping Health Care Organizations Help Patients
In ways similar to other hospitals in the healthcare marketplace, physician-owned hospitals are experiencing a variety of financial, regulatory, and reimbursement-related challenges that, coupled with credit market issues, are putting increased pressures on their operations. Significant concerns about the ever-decreasing access to capital and the increased costs of available capital, higher administration costs, significant increases in uncompensated care and declining reimbursements from payers have placed significant strain on the healthcare market as a whole. With funding reserves and investment values decreasing, hospitals across the country are searching for creative ways to cut costs and restructure their businesses, including delaying expansion projects and facility renovations, foregoing technological and software updates or even cutting staffing levels.

Placing expansion or renovation plans on hold or cutting staffing levels can address these challenges only to a point, beyond which patient care issues arise. Similarly, improving reimbursement rates and reducing the number and amount of uncompensated claims have limited impact on immediate financial challenges. Accordingly, other options should be reviewed, which options, if properly employed, may help shore up the hospital to continue operating its business in an ordinary fashion, which, in turn, can impact its ability to continue meeting its obligations. For example, the sudden shutdown of a critical supplier could leave the hospital without critical supplies and unable, as a result, to operate in the ordinary course. Keeping up-to-date on the condition of those third-parties is crucial for the smooth operation of the hospital and allows the hospital to anticipate problems and, if necessary, work to resolve difficulties or issues in early stages, rather than once the problem becomes critical.

First, be aware of your surroundings. It is critical that physician-owned hospitals understand the current business environment. The challenges hospitals are facing—operational and/or financial—are likely not unique to them and may be worse for the lenders, equipment lessors, software licensors, suppliers and service providers with which they do business. Financial difficulties experienced by any of these entities have the potential to jeopardize the ability of a hospital to continue operating its business in an ordinary fashion, which, in turn, can impact its ability to continue meeting its obligations. For example, the sudden shutdown of a critical supplier could leave the hospital without critical supplies and unable, as a result, to operate in the ordinary course. Keeping up-to-date on the condition of those third-parties is crucial for the smooth operation of the hospital and allows the hospital to anticipate problems and, if necessary, work to resolve difficulties or issues in early stages, rather than once the problem becomes critical.

Even in situations where negotiations are not possible or are unlikely to resolve the difficulties experienced by these third-parties, advance warning of the party’s deteriorating financial position provides the savvy hospital operator time to prepare and develop a strategy to protect the hospital’s unique interests in or with the troubled third-party.

Second, understand your lease agreement. Many physician-owned hospitals lease the land on which they operate from private third-party lessors. The lease agreement between the hospital and its landlord defines the relationship between these parties, including the terms and conditions of possession and payment. In many cases, such leases also contain clauses specifically drafted to protect possession of the property in the event of a foreclosure proceeding or a bankruptcy proceeding. It is critical to understand these clauses, to the extent that they exist, and to understand how state and federal foreclosure and bankruptcy laws impact the hospital’s continued rights as a tenant while the landlord experiences financial difficulties or legal actions.

While the Federal Bankruptcy Code, in most circumstances, prevents a landlord from using a bankruptcy filing as the means to evict the tenant, state foreclosure actions typically do not afford this protection. A tenant of a landlord in bankruptcy cannot be forced to vacate the premises, even if the landlord...
"rejects" (i.e., terminates) the lease. Rather, it can choose whether or not to continue to occupy the premises through the term of the lease and may offset its rent payments against damages resulting from the landlord's actions.

State law foreclosure proceedings against leased property afford no similar protections for the tenants. Particularly for those hospitals leasing from a REIT, where the land itself and rents received therefrom typically constitute the only assets available to satisfy creditors of the troubled landlord, it is crucial to understand the hospital/tenant's rights. In these instances, subordination agreements—often executed as part of the original financing and with limited analysis—assume a new, critical role in the hospital's future.

Third, understand your loan documents. Almost every physician-owned hospital has some amount of secured debt, and many have debt levels high enough to render them “highly leveraged.” Moreover, loan agreements for physician-owned hospitals typically are not “covenant-lite.” Rather, most such agreements have a series of financial and operational covenants that are tested at least quarterly, and often more frequently. As a result, as hospitals face current operating and market challenges, management should review the relevant loan documents and insure that they fully understand the covenants contained in those agreements. Physician-owned hospitals should consider instituting a formal monthly or quarterly covenant review process to assess the financial condition of the hospital and determine whether it is in compliance with the obligations set forth in the loan documents.

If the hospital is currently in default, a review of the loan documents should pinpoint the specific default and allow the hospital to develop a plan to address the deficiency. Early default detection better positions the hospital to enter into discussions with lenders regarding a possible waiver of default or renegotiation of loan covenants at a time where the borrower has some negotiating leverage and bargaining power. Waiting too long to recognize a default and begin discussions with lenders results in the balance of negotiating power being tipped in favor of the lender. If the hospital is not in default, a regular review process may nevertheless help the hospital avoid default by identifying problem areas early, in time to put in place protective measures and before the situation is beyond the hospital's control.

Fourth, be willing to negotiate with lenders. A default under a loan agreement, even one not easily or quickly cured, does not (and should not) mean the immediate demise of the hospital. Rather, a default needs to be addressed through a quick and creative, but realistic, proposal to the lender or lenders, coupled with a request for a reasonable forbearance or standstill period. It is imperative that the hospital's management take the lead in crafting the solution. An individual lender has neither the specific knowledge (about the hospital) nor the time (owing to other problem loans) to solve the hospital's problems. Rather, management must provide the solution, which must include specific operating changes, projections reflecting the impact on the business of such changes and a timeline for implementation.

Fifth, consider filing for protection under chapter 11 of the United States Bankruptcy Code. If faced with an uncooperative lender or an "unfixable" problem, a physician-owned hospital may need to consider a chapter 11 filing. While a full review of the pros and cons of chapter 11 are beyond the scope of this article, a bankruptcy filing can be used to accomplish two results. First, it may be used as a defensive step. A hospital experiencing a temporary (and fixable) challenge that has caused a default under its loan agreement could face a lender unwilling to waive the default or forbear from exercising its remedies. In such event, a bankruptcy filing may be the best way to continue to operate while remedying the underlying issue. The filing of bankruptcy holds the lender at bay, relieves the hospital of many immediate cash demands and provides breathing space for the turnaround. Alternatively, for the hospital with insurmountable challenges and/or the need for a major balance sheet fix, a bankruptcy filing may serve as the means to effect an ownership change and a resulting "clean slate." The so-called section 363 sale process in bankruptcy has been used in a number of bankruptcies by a variety of industries to allow for an ownership change and a clean break with the business's past problems. A similar approach may be appropriate for physician-owned hospitals.

In order to survive these turbulent times, physician-owned hospitals should be constantly reviewing their financial statements and key financial ratios to develop a continuous sense of the well-being of their operations. Hospitals should also conduct regular loan document compliance reviews. By casting a wary eye towards business operations and the operations of critical suppliers, vendors and third-party relationships, hospitals that have properly prepared for difficult eventualities and have not been caught unaware can find creative and appropriate solutions.
Dо you feel like healthcare is becoming increasingly about paperwork and insurance reimbursement instead of patient care? Most offices leave from 5 to 42 percent of their potential reimbursement on the table because they lack proper processes, are understaffed, their staff is not adequately trained or appropriately incented, or the office has not invested in appropriate technologies. This is money that you have already worked for and have earned but that you may not be taking every possible step to collect.

There are 10 primary “leaks” where you could be leaving money on the table. Here are these leaks and the common mistakes made that keep you from getting every cent you have earned.

**Mistakes in patient registration.** Revenues are lost from not collecting or verifying insurance eligibility prior to seeing patients as well as forgetting to collect co-pays. The early registration process is also where a practice should address outstanding patient balances.

**Missed reimbursable services.** Around 3 to 5 percent of the services and supplies provided are typically missed and not billed out even though these services and supplies are reimbursable by the insurance carriers.

**Inappropriate chargemasters and fee schedules.** Depending upon your hospital market and specialty, your chargemaster (CDM) should be set to appropriate rates to make sure you are in line with your cost and regional pricing guidelines and that you are billing for maximum reimbursement for both in- and out-of-network facilities.

**Down Coding.** Not billing and documenting appropriately is very common. If you are regularly down coding, you will receive less money than you deserve for the work performed. A coding audit can help you to understand if you are being too conservative or not documenting correctly.

**Passive claim follow-up.** If you are not optimally providing proactive claim follow-up every 14 to 21 days until the claim is resolved, you should be. This allows you to reduce your cash conversion cycle. It also catches the 2 to 3 percent of claims that insurance payers typically “lose” since you are proactively following-up versus waiting for returned explanation of benefits (EOB) that will never come back.

**Poor secondary filing processes.** This can be a time consuming process that many offices or billing companies decline to do as the return on investment (ROI) on the cost to staff needed to perform this function does not always pay off. However, you could be leaving 2 to 4 percent of your reimbursement on the table. So, consider the value of adding a staff member or adding the responsibility to a current staff member.

**Line-item EOB posting.** Each line of the EOB must be separately reviewed, posted and followed up by a member of your staff. Don’t fall in the trap of simply identifying that an EOB had a single payment attached to it and accepting the entire EOB and all procedures as paid.

**Poor or non-existent reporting.** The billing manager should review key performance metrics on a daily basis and prepare a comprehensive monthly review or set of reports for each surgeon, cost center and any ancillary services. These monthly reporting packages need to be reviewed by all key stakeholders in the hospital to understand how their activities are affecting the revenue and profitability of the facility. If you cannot measure it, you cannot manage it. Understanding these details and how they affect your business are the building blocks for effective financial management.

**Not tracking denial and rejection trends.** Each area of the office needs to understand how their mistakes can affect reimbursement so that the same mistakes are not made twice. Optimally, you should create approximately 12 denial codes that identify why a payment was not made and track these codes on a weekly basis to help identify problem areas to focus on until they are all reduced to an acceptable level.

**Outdated technology.** Are your computers updated? Do you use a Web-based practice management system? Have you invested in a coding/claim scrubber? Do you submit claims electronically? Do you have a document imaging system? Do you use ERA (electronic remittance) for posting? Have you reviewed electronic medical record options? The use of outdated technology may prevent your hospital from running its operations to maximum efficiency. The long-term benefits and savings of investing in new technology can often easily surpass the amount invested in the technology.

To collect all of the money you have already earned requires that you fully optimize each of these billing functions or “plug” the leaks described above. Each area might be responsible for between .5 percent up to 10 percent of your potential revenue. However, if you leave many areas poorly
functioning, you can quickly find your hospital leaving up to 42 percent of your revenue uncollected. We recommend a thorough review of each area to assess your exposure and an ROI analysis to determine how much money you are leaving uncollected. Compare this figure to the cost of fully optimizing each function.

Benchmark to track your success

You should also be benchmarking your results and tracking these trends. Some common goals are:

- 97 percent collection rate
- Days in A/R less than 40 days
- Receiving 100 percent of your contracted allowables
- Less than 8 percent of A/R aged over 120 days
- 100 percent collection rate at the front desk
- In the top 90 percent in your region for customary reimbursement from your carriers

The first 85 percent of your payments should be considered the “low hanging fruit” which should come in within 21 days if you have a strong billing team. The next 12 to 15 percent is harder to obtain and more expensive for an office or a billing company to properly staff the functions that are required to retrieve your money. This is why it is important to ensure that you can profitably manage each of these billing functions so as to not leave any money uncollected.

Making a decision on a billing company based upon price. You should understand the benchmarks and ranges for what billing companies charge in your area, particularly for your area of specialty, and understand that not all operations are equal. Oftentimes, a low price option is able to undercut the competition because the services offered may neglect some of the labor intensive actions that are required to chase down every penny you have earned. Check to see if there are hidden costs for items like billing secondary payors and patient statements that you need to factor in. Do a point-by-point operational comparison between your options to gain a complete understanding between the differences in service delivery. Optimally, you will find or build a service that provides the level of service detailed above. Saving a little money on the rate charged by the billing company is not a win if they do not collect everything they should.

You have earned your money so make sure that you have a team or a partner that is willing to go out and fight for every cent.

Hunter Howard is President of MediGain, a company dedicated to helping healthcare providers to preserve profitability with improved and low cost back-office processes. Contact Mr. Howard at hunter@medigain.com. Learn more about MediGain by visiting www.medigain.com.

Reimbursement Changes to Expect

With the deepening economic downturn rippling throughout the economy, hospitals, insurance companies and physician groups are bracing themselves for a downward marketplace spiral.

Individuals that are strapped financially will often put off necessary medical treatments until their situation becomes serious and they land in the already clogged emergency rooms. Many are delaying elective care and physician visits are already down as are the number of prescriptions being filled. These times often push people into a healthcare avoidance mode, particularly the uninsured. Waiting to seek care until conditions require it is costly and ultimately drives up healthcare costs.

Financially constrained employers will look to reduce premiums by shifting more of their costs to plan members. Therefore, you can expect an increase in HSA programs and patient responsibilities. High Deductible Plans are replacing the strict EPO and HMO options that used to allow for cheaper premiums in companies annual plan offerings to their employees. With the increase in these patient-driven plans, we will see an increase in payments coming from the patient through sources such as Care Credit, Medical Expense accounts and consumer-driven price shopping of their medical services to find the best deal. With rising unemployment, you will also see more physicians faced with decisions to take on charity cases at a time when they are under pressure to lower costs.

Everyone is watching to see what a Universal healthcare plan might look like under the Obama presidency. Former South Dakota Senator Tom Daschle has been chosen to lead the Department of Health and Human Services to be the lead architect of the new plan. Many question whether the country can afford to initiate the changes Obama campaigned on in our current economic environment including Universal healthcare coverage.

Some other things to look for:

Recent changes in workers compensation have caused many providers to cease working with these patients all together. States have adopted mandatory interviews with the physicians on individual workers compensation cases taking up to 1 to 2 hours a day causing disruption in patient scheduling, and affecting patient care and their practices revenue. Many workers compensation claims now are going straight to litigation and states are introducing IPA style workers compensation pay scales.

Disproportionate share reimbursement funding may come under further jeopardy. These funds are allocated to hospitals, or physicians in underserved areas, to receive additional funding for treating high percentages of underprivileged patients (charity, bad debt, or excessive government plans). These funds are in jeopardy of being cut each year and are now more likely to be reduced with the current budget constraints.

Many banks, groups and businesses have been either purchasing medical practices or purchasing their forward A/R at a discounted rate and then taking over reimbursement responsibilities. The tightening of the credit markets is not going to allow these companies to borrow as they have been making their business model unworkable in the current economic environment.
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Tired of apologizing to patients for care that didn't meet their expectations, Doctors Hooman Sedighi, Cecil Bailey, Anthony Doti, Wafer Gamil, Archana Thota, and Scott Wood decided to do something about it. More than two years later, their dream of building a hospital where patients, staff and physicians partnered to provide excellence in inpatient rehabilitation care was realized. On November 14, 2008, the first patient was admitted to GLOBALREHAB’s first hospital in Dallas, Texas. A second hospital followed in Fort Worth only a month later. The physician owners feel that they have learned over the years as to what pitfalls to avoid in order to provide excellent quality care to their patients in a rehabilitation setting. Confirming that we learn from our mistakes and the mistakes of others, Dr. Sedighi frequently recites a classical proverb about a Persian philosopher. When the man was asked about his perfect etiquette, he responded, “I learned my etiquette from those who had none. Whatever they did, I avoided.” This has been part of the GLOBAL approach: evaluate all possible problems and have multiple options for overcoming them.

GLOBALREHAB’S physician ownership assures that there is physician involvement in every aspect of patient care. Beyond their medical expertise, physician owners also collaborate on everything from equipment selection, best practices and techniques, to food and menu selections.

The Road To Success

Understanding that starting a new hospital required a broad spectrum of knowledge and skill, GLOBALREHAB’S leadership recruited experienced consultants and a strong corporate team to establish policies, manage the construction project and move GLOBAL toward successful opening and survey. The hard work and planning paid off as GLOBAL completed deemed status Medicare survey within the first week of operation!

The GLOBALREHAB Model

Each 42-bed hospital houses thirty-eight (38) private and four (4) semi-private beds. The facility is designed to provide a hotel like atmosphere with open spaces and modern décor while providing state of the art equipment and optimal space for therapeutic interventions.

Patients walk or wheel to the dining area where they select foods prepared by our in-house chef. Tanya Williams, Food Services Director, states, “I don’t want people to say that this is good food for a hospital. I want them to say that this is really good food.” Nursing and therapy staff members accompany patients to the dining room in order to supervise functional skills for negotiating architectural barriers, communication and problem solving, and activities of daily living.

Adjacent to the dining area, patients have access to a rehab courtyard that has been designed with a variety of surfaces to practice safe walking or wheelchair skills. The courtyard includes concrete, sand, grass, crushed gravel, inclines, stairs and arches – typical challenges for patients after discharge.

Interdisciplinary Care Delivery

The GLOBAL culture is one that focuses on a true interdisciplinary team model. The primary rehabilitation nurse attends each team meeting along with the physician, therapy staff, the nutritionist, pharmacist and other ancillary staff members who are working on the patient’s team. Using the UDSmr system, patients’ functional goals are set at the 90th percentile as compared to national data for patients with similar diagnoses and functional status. By setting the standard high, the team is challenged to overcome any barriers to patient success and works together to assure that goals are met. The entire team meets weekly to discuss patient progress, barriers to goal achievement and care planning requirements. A daily “huddle” on the unit assists the team working with the patient to address any issues identified in the prior 24 hours and to establish key goals for the day that are consistent with the team plan and goals.

Focus on Quality

Consistent with the commitment to exceptional quality, an extensive
Quality Assurance and Performance Improvement Plan was developed to assure data analysis related to eight key areas: Regulatory Compliance, Human Resources, Ethics Compliance, Customer Satisfaction, Utilization Management, Safety Management, Quality Controls and Outcomes. Sally Parnell, Corporate Chief Clinical Officer, explains “GLOBALEXCELLENCE was developed to translate the rhetoric of quality into practice. Our objective is to have everyone associated with GLOBAL focus on the key areas of the program in order to assure that we are always looking for opportunities for improvement. “

Achieving Positive Outcomes

In order to achieve the exceptional outcomes desired, GLOBAL made an early commitment to providing the right staffing levels, skill mix and intensity of service so that patients could make significant progress and return home in a reasonable time frame. Beyond the expected “three hours of therapy a minimum of five times per week”, GLOBAL provides weekend therapies to assure that patients continue to gain function each day. Patient therapy programs are patient specific and include very little group therapy – another way of assuring that patients receive optimal care.

GLOBAL’s focus on “patient first” provides patients with an exceptional level of care while allowing caregivers time to teach, coach and reinforce the skill sets that have been acquired in rehab.

That commitment has already improved outcomes. While GLOBAL has had only a small number of discharges to date, the length of stay for patients at GLOBAL is 27 percent less than the expected length of stay for patients with the same diagnoses and functional losses. This decrease in utilization of hospital days will result in significant cost savings for payers. And, in spite of the significantly lower length of stay, discharges to the community are currently at 83 percent which is much better than the rates currently reported by most Inpatient Rehabilitation Hospitals (IRFs) nationally.

Financial outcomes are directly related to clinical success. Rob Tyler, Corporate CFO is responsible for assuring that GLOBAL is on target for revenues and consistently controls expenses. His perspective is one that supports GLOBAL’S mission and vision: “Controlling costs is certainly important, but must be balanced with assuring the right level of staffing and resources to provide excellent patient care. Resources used to train staff in documentation, clinical skills and efficient delivery of services provide a significant return on our investment. Quality and cost effectiveness are not mutually exclusive but go hand in hand. Doing what’s right for patients leads to financial as well as clinical success.”

Providing Access

Many Inpatient Rehabilitation Facilities have made a decision not to accept patients who require dialysis either due to cost issues or due to patient fatigue levels that limit participation in therapy. GLOBALREHAB Hospitals have the capacity to care for a limited number of patients with dialysis needs. For these patients, the dialysis treatments will be scheduled late in the day to allow as much participation in therapy as possible. The treatment team will adjust treatment to deliver care in more frequent, shorter periods of therapy in order to accommodate for patient fatigue that results from dialysis and the underlying pathology that it requires.

Uncompensated Care

Consistent with the values of Partnership, Integrity, Compassion, Individualized Care, Stewardship and Improvement, GLOBALREHAB has chosen to provide a budgeted level of charity care. Dr. Hooman Sedighi, GLOBAL'S Corporate CEO and Founding Partner states, “We have all seen patients in our practices that are excellent rehabilitation candidates but have been denied access due to funding. We wanted to create an opportunity for those patients to be considered for admission to GLOBAL. We have been truly blessed in this project and have a strong desire to give back to our communities by providing this service.” In support of this desire to benefit individuals and communities, each GLOBAL hospital has a budgeted capacity dedicated specifically to uncompensated/charity care patients.

Lessons Learned

While the success to date has been noteworthy, GLOBAL is already working on improving the model. A third hospital, located in San Antonio, Texas, has been started and will benefit from the lessons learned in Dallas and Fort Worth. “Doing rehab right, means admitting that there is always an opportunity for improvement” says Angie Phillips, GLOBAL’S Corporate COO. “It means really listening to our patient partners, our employee and vendor partners, and our physician investor partners in order to find potential improvements.”
At Regent Surgical Health, we specialize in turning around surgery centers and small struggling hospitals. In addition, we develop “de novo” facilities in areas contiguous to our existing markets and in locations possessing unique characteristics that allow for quick and successful results.

The Expertise:
In northwest Indiana, we took on the challenges of turning around an existing surgery center as well as developing a surgical hospital. In 2008, Regent and its physician partners converted Calumet Surgery Center to a surgical hospital, Surgical Hospital of Munster, three years after turning the ASC from a break-even venture to a profitable one.

The renovated nine-bed hospital serves the northwest Indiana community with advanced, compassionate care including general surgery, orthopedic, spine, GI, ENT, ophthalmology, gynecology, urology, pain management, family practice and internal medicine. Thirty physicians and the adjacent Hammond Clinic own the majority of the hospital, with minority ownership from Regent. Nearly 75 physicians have privileges and serve the community with high quality healthcare in a brand new environment.

“Regent helped turn around the center by attracting new physicians, bringing in new procedures, reducing costs and creating greater efficiencies,” says Dr. Sanders, Surgical Hospital of Munster board member and president of Hammond Clinic.

Surgical Hospital of Munster is just one example of how Regent’s expertise is used to develop as well as manage centers and produce almost immediate improvements in the facility’s financial health. With 13 ASCs and physician-owned hospitals in eight states across the country, the Chicago-based company has developed a winning philosophy of partnership.

Physicians should have the time and resources to offer high quality care to each patient. In order to do so, doctors need to own the majority interest in their facilities and control their destiny. As a result, Regent typically owns about 20 percent of the ambulatory surgery centers and 10 percent of the physician-owned hospitals in which it is a partner.

Taking a hands-on approach, Regent’s experienced principals spend substantial time on-site at the facility while the business is turned around. They work with the current administrator or provide one of their knowledgeable principals as an interim administrator until one can be recruited who reports to both Regent and the facility's board of directors. They use their management expertise to oversee the business and clinical operations of the facility in partnership with the on-site administrator to make certain that the appropriate steps are being taken to achieve the collective goals of the partners.

The Aim:
• Increase revenue by bringing in new partners, new specialties and maximizing reimbursement. New partners bring energy, patients and high quality care. Additional specialties enable the hospital to serve more patients and develop additional expertise. And by negotiating contracts with insurers,
Physician Hospitals of America

Regent ensures the hospital is appropriately reimbursed for all procedures.

• Reduce costs. By maximizing staffing efficiencies, and lowering supply costs and equipment through group purchasing, Regent helps run healthcare facilities efficiently.

The Results:
By increasing revenue and reducing costs, Regent makes sure the facility is financially viable, enabling physicians to focus on providing high quality care.

While there are commonalities, each facility, turnaround or new, is a different situation and requires the expertise of a management team that can create a high quality facility that is also financially healthy.

In Dayton, Ohio, Regent worked with 60 area physicians to open Medical Center at Elizabeth Place, a four-OR, 26-bed physician-owned hospital. Housed inside the former St. Elizabeth’s Hospital, a community hospital that closed in 2000, MCEP is part of a “medical mall” with 75 healthcare-related tenants on the 226-acre campus. Regent owns a minority interest and runs the hospital for the physicians, whose specialties include general surgery, orthopedics, ophthalmology, diagnostic imaging, urology, neurology and more. The City of Dayton even supported its tenants on the 226-acre campus. Regent makes sure the facility is financially healthy.

Three years ago Mike McKevitt, Regent Senior Vice President showed up at my office unannounced. It was a busy clinic day, and I almost turned him away. Glad I didn’t,” says Dr. John Fleishman, MCEP board member and practicing surgeon. “Over the next year he and Regent CEO Tom Mallon were able to bring together a diverse group of previously unaffiliated physicians into a cohesive unit with a specific purpose. Within a year we had opened a physician-owned and operated community hospital with over 60 physician owners.”

For Dayton, MCEP represents a return to high quality, compassionate, competitively priced healthcare. While the hospital’s opening was challenged by one of the area’s not-for-tax hospital systems, MCEP has helped promote competition and returned a hospital setting to one of Dayton’s most impoverished neighborhoods. MCEP also employs 80 people in a market that is economically depressed. “The not-for-tax hospital system threatened doctors and argued that MCEP would force it to close one of its hospitals,” says Tom Mallon, Regent CEO. “It was a false cry then, and it is today.” A strong partnership, leadership from Regent and an active public relations campaign helped the effort to open Medical Center at Elizabeth Place.

“Regent is fantastic at organizing and empowering physicians. They have always been there when we needed them and provided the leadership that has made us a success,” continues Fleishman.

The Philosophy:
Regent believes that healthcare should be primarily patient and physician centered. The pressures on physicians - from reduced reimbursements, higher malpractice rates and increased competition - are causing them to consider different ways of conducting their business. Patients are becoming more demanding, sophisticated and educated.

Physician-owned hospitals provide answers to some of the pressures confronting the healthcare system today. These facilities are able to deliver services efficiently for both physicians and patients with higher on-time percentage than community hospitals and lower the general cost of care. Patients wait less and physicians can perform more cases in the same amount of time.

With the ability to focus on surgery and provide higher quality of care, physician-owned hospitals report infection rates of less than 1 percent. Also offering high touch care, patients regularly give 98 percent approval ratings for surgery centers and surgical hospitals. “We can take care of our patients the way we would want to be cared for – with the finest physicians, a friendly, knowledgeable and experienced staff in a patient-focused setting,” says Denise Cheek, Surgical Hospital of Munster chief operating officer.

While the political climate regarding physician ownership is still uncertain, Regent continues to pursue new surgical hospital development opportunities as well as turnaround situations.

“Surgical hospitals operate more efficiently, resulting in higher quality care and a more cost effective way to deliver healthcare,” says Mallon. “With a flatter management structure, it’s easier to be nimble and to focus on creating a strong, customer-focused operation.”

At Regent Surgical Health, we work to not only provide financial success, but to also optimize our partners’ strengths so we can offer high quality care to every patient. Patient-focused care results in better outcomes clinically and financially. Working with physician partners, success can be achieved by working together toward common goals. Our commitment is evident each day through the actions of the entire Regent family, from the surgeons and physicians to our nurses, support staff and management team.

For more information on Regent, contact Tom Mallon, Regent CEO and Founder at 708.492.0531 or visit www.regentsurgicalhealth.com.
n business since 2004 and already making a big impression in the industry, Amkai LLC established its roots in the 1980’s. Dr. Peter Sereny and much of the current team founded and grew HealthIS throughout the 1990’s. That company is best known for its lead product AdvantX™, the industry-standard administrative management system with over 1,000 installations today in surgical hospitals and surgery centers.

Started a few years after the sale of HealthIS, Amkai is leveraging its deep experience in outpatient surgery to realize a dual mission, both for outpatient and inpatient care providers. First, the company aims to provide a true next-generation solution to replace the large base of AdvantX and other aging legacy management systems in use today. The second goal is to lead the charge to wide adoption of electronic medical records (EMR).

Amkai’s strategy to achieve these goals is to offer a comprehensive solution – called AmkaiEnterprise™ – that manages information across the spectrum of administrative and clinical functions in a facility. Craig Veach, Senior Vice President, summarizes the company’s unique strengths, “Amkai’s product suite is built specifically for outpatient and specialty hospital surgery rather than for a wide range of specialties so we can optimize for that environment. We’ve developed the entire solution ourselves rather than trying to piece together components through acquisition and partnership. And while most vendors have moved away from an integrated approach, we embrace the idea of supplying software for surgical hospitals, surgery centers, and the affiliated physician practices.”

Amkai is a strong proponent of the EMR. With over fifty installations of its AmkaiCharts™ solution, it is one of the leaders in this arena. AmkaiCharts is a full-featured EMR with clinical documentation through each stage of the surgical case, real-time alerts (e.g., risk-to-fall, timeouts) that promote patient safety, internal messaging, and even a CPOE module.

**Surgical hospitals contemplating an EMR usually face the following options:**

Clinical systems provided by traditional hospital vendors that are frequently very costly and complex to implement in the surgical hospital setting.

“Generic” outpatient EMR’s designed primarily for a broad range of medical specialties and claiming to apply to the surgical hospital as part of their scope.

Document management systems. Often billed as an EMR, these systems usually consist of a scanning solution to convert paper records to electronic format for storage and retrieval. The files are images but not discrete data.

Amkai’s EMR represents a true alternative to these choices. Surgical hospitals can turn to AmkaiCharts for a solution with rich functionality that is tuned for the outpatient surgery environment rather than that of the community or academic hospital. At the same time, they can further their electronic health record objectives with software that produces structured data capable of meeting multiple short and long-term needs.

The company believes that growing adoption of EMR is being fueled by realization of compelling bottom line benefits. These benefits can be grouped into three major categories, notes Craig Veach. “Our hospital
and ASC users are seeing direct operating cost reductions through automation of many manual processes, operational efficiencies driven by better analytics as a result of access to more and better data from the EMR, and benefits coming from enhanced patient safety.” Examples of EMR functions with particularly high impact for the surgical hospital include electronic tracking to give a real-time view of the patient’s location and status in the facility, and documentation of specific data throughout the surgery and overnight stay that eases the growing burden of quality reporting to various sources.

During 2008, Amkai has been rounding out its comprehensive vision with the launch of AmkaiOffice™. This management system can be acquired independently of the EMR, but gains added power when fully implemented with AmkaiCharts to permit data sharing and elimination of repeated data entry. The management software was designed by improving on many of the best features of legacy software while taking it to a whole new level with a host of functions requested by the industry for many years. In taking this approach, Amkai benefits from its intimate knowledge of AdvantX as well as the company’s ability to take a fresh start approach rather than trying to adapt older software in its portfolio. Amkai is currently expanding its version of AmkaiOffice to meet several specific requirements of surgical hospitals.

Those wishing to learn more about Amkai’s approach to comprehensive information management are invited to visit www.amkai.com and register for Amkai’s overview webinar.
Physician Profile: Corazon M. Ramirez, MD

Back in 1996, when Plano Surgery Center welcomed its first patient through the glass enclosure that formed its entryway, a small group of physicians marked the occasion by performing a procedure they had done many times before. There was little celebration and hardly any applause—a far cry from the way one expects to remember the beginning of a new chapter, but any sort of festivity would have been premature. For Dr. Corazon M. Ramirez, this was simply the first step on what would end up being more than a decade-long journey towards accomplishing her dream—developing healthcare delivery systems that are focused on patients and driven by physicians.

Big dreams are nothing new for the short-statured physician. While still a surgical resident in the Philippines, Dr. Ramirez envisioned herself with a career practicing medicine in the United States. In 1981, she ventured across the Pacific to the “Land of Opportunity” when she was offered a chance to realize that vision with a Plastic Surgery Fellowship in Detroit, Michigan. After a few months up North, Dr. Ramirez found her way to warmer climates in Dallas, Texas, this time as a Cardiac, Vascular and Thoracic Surgery Fellow. Due to the requirement to redo her surgical training which was done abroad, Dr. Ramirez elected to start over as an Anesthesiology Resident at the University of Texas Southwestern Medical Center in Dallas. Fulfilling her dream wasn’t going to be easy, but she was determined to accomplish her goal.

Dr. Ramirez got her start running healthcare facilities as the Medical Director of Forest Park Surgery Pavilion in the early 1990s. When this facility was sold by Columbia Hospital Corporation, the partners of Forest Park Surgery Pavilion sought to acquire a facility they could completely call their own. The result was Plano Surgery Center with Dr. Ramirez as its Founder and CEO. Through Dr. Ramirez’s dedication and leadership, Plano Surgery Center was syndicated as a 100% physician-owned center and continues to operate as such to this day.

Motivated by the success of that first venture, Dr. Ramirez again spearheaded the development of a second fully physician-owned facility. In 1999, Medical Arts Surgery Center opened in the heart of the University Medical Center Complex. Its own success prompted talk of expanding the facility into a General Hospital. Unfortunately, the building in which the Surgery Center was located was owned by the Medical School, and its future was uncertain.

Fast-forward to 2004 and the opening of Pine Creek Medical Center—the only 100% physician-owned acute care general hospital in the Dallas-Fort Worth Metroplex. Through the tireless efforts of Dr. Ramirez, Kathie Lower, and the rest of the management team, it was Medicare and JCHAO certified in a very short period of time. On this opening day, speeches are given and pictures are taken. There is applause and congratulations, and the ceremonial cutting of the ribbon. Today, there is cause for celebration, but the vision that Dr. Ramirez once had is not yet complete.

Currently, Dr. Corazon Ramirez serves as the President and CEO of Physician Synergy Group (PSG), a management and development company which she founded in 2007. PSG assisted in the reopening of the Arizona Regional Medical Center in Mesa, Arizona, in September 2008 and is involved in the development of a Neurosurgical Medical Center in Fort Worth and Presidio Medical Center near the city’s Alliance Airport. PSG has been asked to facilitate development and manage several other projects which are currently in the works.

Dr. Corazon Ramirez approaches her work with an energy and passion much larger than her five foot frame would suggest. Her confidence in the ability of physician-owned facilities to provide excellent healthcare in an improved business environment is infectious, and her partners and colleagues appreciate the work that she has done. As Dr. Mark Hoyle commented when he first met Dr. Ramirez, “I thought that surely she was an eight-foot giant the way the doctors talk about her.”

Dr. Ramirez continues to practice anesthesiology, and the same energy that she dedicates to her work has found its way into her home where she is both a loving wife and a doting mother. She is married to Dr. Manuel R. Ramirez, an Anesthesiologist and Pain Management Specialist who is also a partner at Pine Creek Medical Center. Stephanie Kaye, her daughter, graduated from Southern Methodist University in 2006 with a BS in Spanish as well as a BBA in Marketing and serves as the Director of Marketing for Pine Creek. Justin, her son, will graduate from Southern Methodist University this May and plans to attend medical school in the fall. Clearly, her family shares her same passion.

With the founding of PSG, Dr. Corazon Ramirez’s dream of providing patients with the highest-quality care through the development of facilities driven by passionate physicians has finally come into existence. The ability to dream big has always been among this country’s greatest resources. In this world where change is the rule rather than the exception, even if we find success, we must not forget to dream even bigger. Although Dr. Ramirez has found success, she continues to expand her vision to new horizons, always dreaming big.
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Ask any practicing physician why they chose a career in medicine and chances are you’ll hear, “to help patients get and stay healthy.” Ask any of the dedicated professionals on hospital boards the same question and you’ll likely hear a similar answer. Which is why the sometimes strained relationship between the hospital medical staff and governing boards is so disconcerting. Physicians and hospital boards agree that this struggle can negatively affect patient care, and that is an outcome neither can tolerate.

To preserve and strengthen the important relationship between physicians and hospital governing boards, the American Medical Association (AMA) developed a set of 12 principles, and in November 2007 the AMA House of Delegates unanimously voted to adopt these principles as AMA policy.

First among the principles is for the medical staff and hospital boards to share the responsibility for quality of care, but allow the medical staff to have the final say in what is best for the patient. Make no mistake, physicians know hospital governing boards serve a noble purpose. The hospital board serves as a checks and balances system for the medical staff – ensuring an appropriate balance between patient care interests and corporate sustainability and growth. While hospital boards have the right and obligation to make certain decisions, they must make those decisions with the guidance of the hospital medical staff’s expertise.

The full set of 12 principles can be viewed on the AMA Web site. Some of the key principles include:

• Give a medical staff elected representative a voting seat at hospital governing board meetings to ensure medical staff input into hospital governance.

• Allow individual members of the medical staff, if they meet the established criteria, to be eligible for full membership on the hospital’s governing board.

• Ensure that areas of dispute and concern between medical staff and hospital governing bodies are addressed by a well-defined process in which each side is equally represented. The well-defined process should be determined by agreement between the medical staff and the hospital.

• Preserve the medical staff’s right to self governance. Outlined within the principle are what this should include, such as how medical staff bylaws are created and adopted, and guaranteeing a fair hearing and appeals process for the medical staff.

In any good relationship, it takes hard work and open communication to make it mutually beneficial. The creation of these principles are an important step toward that goal, and the ultimate objective of working together to provide our patients with high quality care. As hospital medical staffs and governing boards face these issues, implementing these principles can help improve the relationship. Rowing together, we can reach the shore.

Cecil B. Wilson, M.D., Board Member, American Medical Association
On October 2-4, 2008, Physician Hospitals of America, PHA, hosted its 8th Annual Conference and Exhibits at the La Quinta Resort & Club in Palm Springs, California. At the conference were approximately 74 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 400 attendees.

The conference featured over thirty breakout 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 Regina E. Herzlinger, PhD, of the Harvard Business School, and was incredibly well received. Dr. Herzlinger is widely considered one of the nation’s foremost experts on the economics of healthcare and hospital utilization, and is
one of the first advocates for consumer-driven reform, physician ownership, and specialization. Other key speakers included healthcare financial consultant Robert J. Cimasi, MHA, ASA, CBA, AVA, CM&AA, CMP, from Health Capital Consultants and healthcare economist John E. Schneider, PhD, from HECG, LLC. Both Mr. Cimasi and Dr. Schneider are known for having conducted groundbreaking research and analysis regarding physician ownership of hospitals.

The conference also featured several track sessions that allowed attendees to choose their own path of attendance tailored to their interests. Day one covered track sessions that related to development and conversion, sustaining performance and growth, and law politics and the press, with a special presentation from Mr. Bob Grossfeld, of The Media Guys & iFilms, PHA’s public relations firm. Day two consisted of a series of general sessions with content aimed at grabbing the interest of all attendees. Day three allowed attendees to receive in-depth education information on clinical operations, administration and finance, and a newly added track of physician topics.

“The success of the conference certainly indicates the growing interest in and strong support of physician owned and operated hospitals,” said Molly Sandvig, PHA’s Executive Director. “In eight short years our organization has grown from a few physicians and administrators who believe in the concept of ownership, to a national voice for healthcare reform that has demonstrated how putting physicians back in control of hospitals leads to better, safer care for patients.”

Physician Hospitals of America’s 9th Annual Conference and Exhibits is scheduled for September 24-26, 2009, at the Hilton New Orleans Riverside in historical New Orleans, Louisiana. Make plans to attend today! For more information on the conference please go to: www.physicianhospitals.org or call PHA at (605) 275-5349. For hotel reservations, call the Hilton New Orleans Riverside at (504) 561-0500.

Michael Weaver, Symbion and Wendy Bitner, Animas Surgical Hospital, dressed and ready for the Friday Fiesta.

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Physician-Owned Hospital Awards & Honors

With many awards and honors released in 2008, physician-owned hospitals were at the forefront. Because of the high quality care that physician hospitals provide to patients and the positive working environment they provide to employees, many PHA member hospitals have been recognized as contributing to the overall success of the healthcare industry.

Arkansas Surgical Hospital for the second year in a row has been rated as one of the top hospitals in the state, according to a report released by HealthGrades annual study of hospital quality. ASH was also in the top five percent in the country for spine surgery and for joint replacement and was ranked a Five-Star Hospital for total knee replacement, total hip replacement, spine surgery, back and neck surgery with and without spinal fusion. ASH was ranked second in Arkansas for spine surgery. For more information on ASH, visit: www.arksurgicalhospital.com.

Galichia Heart Hospital is the only hospital in Wichita, Kansas to be accredited as a chest pain center. Kansas’ other accredited chest pain centers are located in Topeka, Lawrence and the Kansas City area. The accreditation is for three years and earning the designation takes more than a year. The designation has assisted the medical staff in reducing the amount of time it takes to get the arriving patient having a heart attack to the cath lab, and has improved their ability to care for those patients. For more information on Galichia Heart Hospital, visit: www.ghhospital.com.

Harris Methodist Southlake Hospital was recognized in the Modern Healthcare 100 Best Places to Work in Healthcare honors program. The program recognizes workplaces in healthcare that enable employees to perform at their optimum level to provide patients and customers with the best possible care and services. Organizations and companies from all segments of the healthcare industry with a minimum of 25 full-time employees were eligible. For more information on Harris Methodist Southlake, visit: www.hmsouthlake.com.

Lafayette Surgical Specialty Hospital for the second year in a row, Lafayette Surgical Specialty Hospital received “The Nightingale Award”, a Hospital of the Year award presented by the PHA.
Louisiana Nurses Foundation. The Nightingale Awards are presented annually in a number of categories which recognize outstanding nurses, administrators and hospitals. Lafayette Surgical Speciality Hospital won the category of Hospital of the Year for hospitals with 100 beds or less. For more information on Lafayette Surgical Speciality Hospital, visit www.lafayettesurgical.com.

Thomas Reuters recently released their study of 100 Top Hospitals for Cardiovascular Care. The study examined the performance of 970 hospitals by analyzing clinical outcomes for patients diagnosed with heart failure and heart attacks and for those who received coronary bypass surgery and angioplasties. Among the 100 listed were the following Physician-Owned Hospitals: Arizona Heart Hospital, Indiana Heart Hospital, Louisiana Medical Center & Heart Hospital, Heart Hospital of Lafayette, Nebraska Heart Institute Heart Hospital, Avera Heart Hospital of South Dakota, Heart Hospital of Austin, and Doctors Hospital at Renaissance.

*If your hospital has received any awards or honors, please contact PHA for inclusion in future issues of the PHA Pulse.

PHA Benchmarking Update

We have drawn to a close our second quarter of data collection for the new PHA Benchmarking Program. Both the first and second 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 $2,500 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.

2009 PHA Annual Meeting Goes Green!

In an effort to be environmentally responsible, PHA will not be providing session handouts to annual meeting attendees in the form of a conference syllabus. Attendees will be able to access session handouts from speakers at the event, as well as a digital media mechanism once they have arrived at the conference. At the conference, each attendee will be in receipt of a CD which will include all information in regards to speakers, sponsors, session handouts, and other information that has been included in the syllabus in past years.

Website Reminder: Physician Hospital Career Opportunities

Did you know that PHA has a Career Opportunities job posting site on their website, specifically for physician-owned hospitals? The site allows members and non-members the opportunity to post a job title, description, and other information for a small fee. Job seekers have the ability to post their resumes to the available resume database. Some of the advantages of posting a job through PHA Career Opportunities are: better return on investment as companies may get higher quality applicants, cheaper than posting on a Monster or CareerBuilder site, anyone who posts a job and pays the fee automatically has access to the resume database at no additional cost, and through the resume database employers can set up search words to be alerted of certain applicants. Go to www.physicianhospitals.org and click on Career Opportunities.

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Meet the New PHA Board Members

**Thomas V. Bertuccini, MD, FACS** – A native of New Haven, Connecticut, Dr. Bertuccini graduated from St. Vincent College, Latrobe, PA and was awarded his MD from Creighton University School of Medicine in Omaha, NE. He completed his residency in neurological surgery at the Barrow Neurological Institute, Phoenix, AZ, with additional studies at the University of Western Ontario and the University of Pittsburgh, School of Medicine. He is a Diplomate of the American Board of Neurological Surgery, Fellow of the American College of Surgeons, Fellow of the Stroke Council of the American Heart Association, member of the Congress of Neurological Surgeons, North American Skull Base Society, New York Academy of Sciences, Southern Neurosurgical Society, Louisiana Neurosurgical Society, Louisiana State Medical Society and the Lafayette Parish Medical Society. He currently serves as Medical Director and Chairman of the Board of Managers of Lafayette Surgical Specialty Hospital, in Lafayette, Louisiana.

**John W. Dietz, Jr., MD** – Dr. John Dietz is an orthopaedic spine surgeon and Chairman of the Board of Managers at Indiana Orthopaedic Hospital. He is a part of Ortholndy, a large orthopaedic practice group in Indianapolis, Indiana. A graduate of West Point and Duke Medical School, he joined Ortholndy in 1995 after serving as an Army orthopaedist. The Indiana Orthopaedic Hospital is a 42 bed/10 OR physician owned hospital which opened in 2005.

**John R. Harvey, MD** – 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 the board since its inception. In addition to his private practice, he serves as Chief Executive Officer of the Oklahoma Heart Hospital, a 94 bed heart specialty hospital in Oklahoma City.

**Jeffery L. Sayer, CPA** – Mr. Sayer is currently serving as President of Mountain View Hospital in Idaho Falls, ID. He also serves as a member of the Governor’s Select Committee on Health Care Reform for the state of Idaho and as a board member of two venture capital funds focused on healthcare investments. He began his 20 year career with Ernst & Young in Silicon Valley where he specialized in advising venture capital-backed companies through all stages of growth. Since then he has provided financial and executive-level leadership for companies ranging from start-up ventures to companies with over $500 million in sales. Mr. Sayer’s expertise is helping troubled companies restore profitability and has had the opportunity to work in multiple industries including healthcare, construction, and technology. Mr. Sayer is a CPA and graduated from Brigham Young University.

**Hooman Sedighi, MD** – Dr. Hooman Sedighi is President and CEO of Global Rehab, a physician-owned in-patient rehabilitation hospital system with locations in Dallas, Fort Worth and San Antonio, Texas. Dr. Sedighi is board certified in Physical Medicine and Rehab and Pain Medicine. He is also one of the physician partners of Pine Creek Medical as well as Gulf States LTAC of Dallas. Dr. Sedighi was also the former Medical Director of Healthsouth Medical Center in Dallas. Dr. Sedighi earned his BA in biology and chemistry at Indiana University in 1984, his medical degree at Indiana University School of Medicine in 1988.
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