

There is no leadership crisis in hospitals or health care, p. 2

Hospital boards need to look in-house for CEOs who know their organizations and are good operators, writes Donald E. L. Johnson.

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Press Ganey: Patients see room for hospital quality improvement, p. 6

Patients generally give hospitals high scores for the skill and friendliness of their caregivers but see room for improvement in areas related to food and rooms, the satisfaction measurement firm says.

Time for health care reform is ripe, Jackson Hole Group says, p. 10

Greater integration of technology into the practice of medicine, combined with a human touch, offers the cure to a deteriorating American health system, according to the leader of The Jackson Hole Group.

Pediatric hospitalist programs can improve quality, costs, p. 12

The economics of private practice medicine, the trend toward increasing specialization and the demand for higher standards of health care are prompting rapid change within the health care sector.

Fitch Ratings sees looming problems for not-for-profits, p. 8

Fitch said it believes that ongoing concerns in the sector will lead to instability over the medium to long term. Specific concerns include increased competition from niche players, inability to access capital markets for necessary improvements and rising supply costs.

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Market Memo:

Children's hospitals the right decision for some systems

By Bradley Worrell

For not-for-profit hospitals faced with increased demand for services at a time when they are already bursting at the seams, it may make sense for hospital administrators to respond by thinking both big and small: Big in terms of recognizing the need for new facilities and small in terms of the target market those new facilities should serve—children.

Children's hospitals represent a "semi-hot market" currently, according to Keith Moore, chairman and CEO of McManis Consulting of Greenwood Village, Colo. "I think there's a new interest in children's hospitals," he said. "The new interest comes from several factors, but we're having several clients quite interested in children's hospital activities and we understand why and we agree with them."

For hospitals struggling to meet demand on their existing campus, children's hospitals represent a service that can be operated effectively on a second campus. Children's hospitals also can re-engage philanthropic efforts because they tend to be popular with communities, and they tap into the increased role consumers are playing in health care in terms of seeking out specialized care.

Moore notes in particular the increased role consumers are having in health care and its impact on children's hospitals. "I think the

bar is being raised in terms of how care is being provided," he said. "I think that more and more parents are becoming aware that there is a difference in the care that a child receives depending on whether a child, for example, is anesthetized by an anesthetist or by a pediatric anesthetist. Or similarly, if a child is being operated on by a surgeon or by a pediatric surgeon. I think there's a much greater awareness that there's a difference."

As a result, children's hospitals often have more negotiating clout with payers as they are often perceived as a "must-have" hospital in an insurer's provider network. Additionally, they benefit from their ability to corner the market for complex tertiary care despite being located in large population

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See related story on pediatric hospitalist programs, p. 12

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centers with multiple hospitals and they tend to have a broad geographic draw in comparison to competing community hospitals, according to New York-based Standard & Poor's (S&P), one of the two main agencies that rate the bonds of health care facilities. S&P also notes children's hospitals' strong philanthropic appeal and success in major fund raising efforts.

Primarily because of those reasons, Standard & Poor's notes that its ratings on children's hospitals have been very stable, with no downgrades within the past two years. That contrasts with the health care sector at large, where downgrades have outpaced upgrades by a factor of more than five to one. Roughly 82% of children's hospitals have an S&P credit rating of 'A' or above, compared to 54% for the wider health care sector (see Figure 1 below).

Changes at federal level benefit children's hospitals

Children's hospitals have benefited in recent years from changes in governmental policy that have resulted in additional revenues. In 1999, Congress approved additional funding through the Health Care Research and Quality Act. As a result, funding for general medical education (GME) at children's hospitals rose to nearly \$221 million in 2001, up from \$38 million in 2000.

Another milestone in funding for children's health care was the creation of the State Children's Health

Insurance Program (SCHIP) in 1997 as part of the Balanced Budget Act of 1997. SCHIP allocated more than \$40 billion in federal funds over a 10-year period to extend health insurance coverage to low-income children of working families who were ineligible for Medicaid but unable to afford private health insurance. The legislation proved to be a substantial boon to children's hospitals, as it provided a source of reimbursement for children who in the past had typically been treated on an uninsured basis.

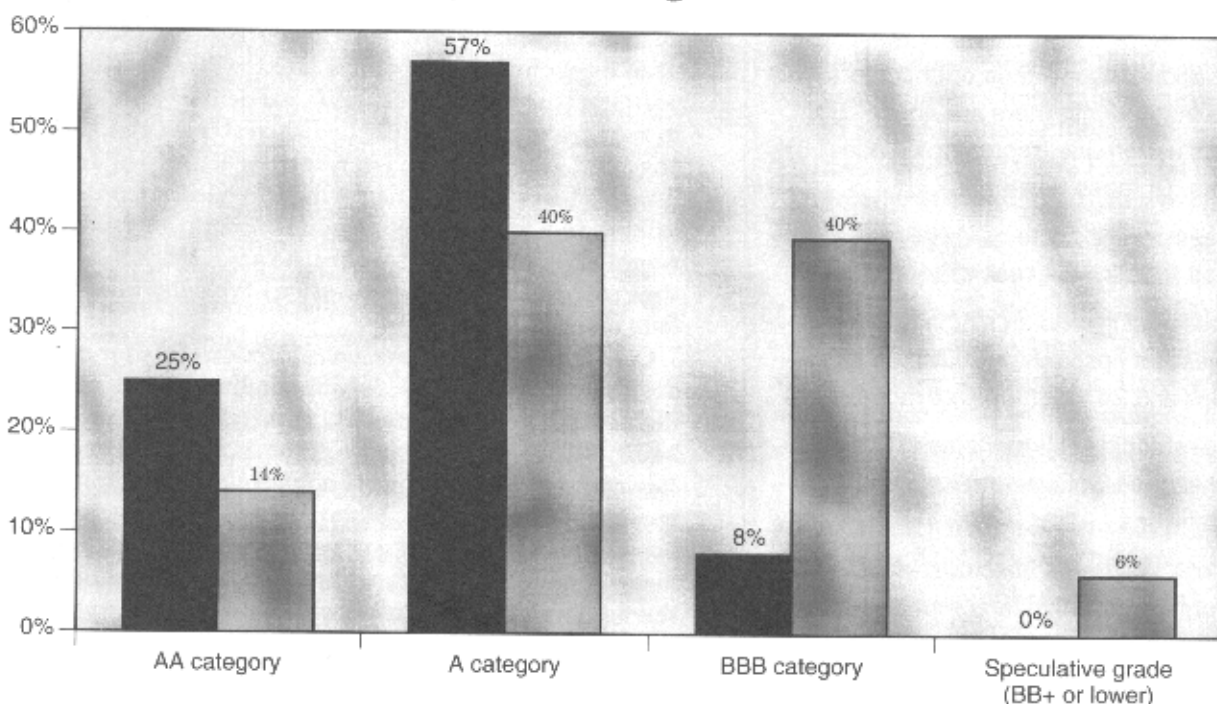
U.S. Reps. Billy Tauzin (R-La.) and John Dingell (D-Mich.) recently introduced a bill that would extend the availability of \$1.2 billion allocated for 1998 and 1999 and \$1.5 billion allocated for 2000 and 2001. The bill provides that states that have not spent their 2000-2001 funds would retain half of the money, while the other half would be distributed to states that have spent their allotment.

Meanwhile, the Centers for Medicare and Medicaid Services reported in February that SCHIP enrollment climbed to 5.3 million children in fiscal year 2002, up from 4.6 million in 2001 and 3.3 million in 2000.

Moore credits state CHIPs programs with being one of the most positive developments for children's hospitals in recent years and with spurring growth of children's hospitals, which now number about 250

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Figure 1: Distribution of U.S. hospital credit ratings



The chart at left shows the distribution of credit ratings for children's hospitals (in black) compared to those of all hospitals (in grey). Children's hospitals tend to be rated 'A' or above.

Source: Standard & Poor's

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nationwide (see Figure 2 for a listing of types of children's hospitals). "They moved what used to be a marginally not-profitable part of your business into a marginally for-profitable part of your business," he said.

Sour economy risks hurting children's hospitals

Children's hospitals' reliance on state and federal funding represents something of a double-edge sword, however, particularly in times of economic and political uncertainty. (Medicaid accounts for more than 45% of inpatient days at most children's hospitals, and is as high as 70% at some urban children's hospitals). Many states—in the midst of their worst budget crisis in decades—are looking at making deep cuts in Medicaid, which could impact children's hospitals.

"That is a concern for a children's hospital—how far will those cutbacks happen and what will they do?" Moore said. "... I think the economy, where it is now and the state budgets where they are now, we're about to see some problems. And in fact, we are already seeing some problems."

Martin Arrick, director of the not-for-profit health care group at Standard & Poor's, said it's too early to know to what extent Medicaid funding will impact children's hospitals. It is possible some states will respond by reducing eligibility or reducing benefits.

"It's a risk at this point. It's something we're keeping our eye on," he said. But Arrick added that he believes legislators will want to hold children harmless and will

work to make the cuts as painless as possible.

As children's hospitals anxiously await possible reduction in Medicaid funding, many are already hurting because the down economy has adversely affected their endowments and the amount they're receiving in charitable giving. Still, Arrick said that, in their favor, children's hospitals tend to have strong balance sheets. For example, 'A' rated children's hospitals have a median days' cash of 193 versus 164 in all hospitals, with unrestricted cash-to-debt ratios of 124% versus 107% in the broader sample. The differential in the 'AA' category of children's hospitals is even more pronounced.

Additionally, Arrick noted that even in difficult times hospitals remain favorites in terms of giving. And like other charities, children's hospitals are increasingly searching for "the big donor" who is less susceptible to market swings. Of wealthy contributors, Arrick said: "At some point, you have enough money that a 5% or 10% market correction doesn't change your basic impulse on who and what ... you want to support in your community. I think children's hospitals still have a very strong edge in the ability to fund raise. I think we (at S&P) see that as a continuing strength."

Questions to ask before you build

Moore said that a number of questions need to be answered for any hospital or health system considering building a children's hospital. Key among these is: Is there sufficient market to reach a threshold where it makes sense to build one?

It's also important to determine whether there is agreement among key referral sources that there is a need for a children's hospital and that they would refer patients there. The question is particularly important in regions where multiple health systems exist. "How easy is it going to be to get referrals across system lines?" Moore asked. Answering the question requires talking to a lot of people to gauge how strongly they would support such a venture, he said. Market surveys that could answer those questions typically take about four months, Moore said.

Construction times and construction costs for children's hospitals vary widely depending on factors including how big the facility is, what amenities are being offered, where it is being built, any land acquisition costs (it's not uncommon for children's hospitals to receive land donations, Moore notes), and whether the hospital will occupy new or renovated facilities. Also a factor in any timeline is where the equity funding for the new children's hospital will come from—whether the hospital must raise the money itself or get from a health system.

Figure 2: Types of Children's Hospitals

According to the National Association of Children's Hospitals and Related Institutions, there are about 250 children's hospitals nationwide, representing about 5% of all U.S. hospitals. Of those hospitals:

- About 45 are freestanding acute care children's hospitals, virtually all of which are teaching hospitals.
- About 40 are freestanding children's rehabilitation, specialty and convalescent hospitals, including 16 short-term care facilities and 24 long-term care facilities.
- About 50 are freestanding children's psychiatric hospitals, including about 10 short-term care and 40 long-term care facilities.
- About 100 are joint children's hospitals—large pediatric programs organized within larger medical centers that generally (but not always) call themselves children's hospitals.

A survey by *Health Care Strategic Management* of nearly a dozen providers with children's hospitals under construction or recently completed found varying levels of philanthropic support. On the low end, St. Vincent Children's Hospital in Indianapolis is currently halfway through a \$6 million campaign for its new facility, which opened in January. On the high end, The Children's Hospital (Denver) has already received \$45 million thus far for its planned \$400 million campus, which remains on the drawing board and is not expected to open until 2007. Meanwhile, the University of Chicago's Comer Children's Hospital has received a \$21 million contribution from one donor alone, Gary C. Comer, founder of the Land's End clothing-catalogue company.

HCSM found that the quickest hospital construction completion time, including planning, was two years, while the longest was a little more than five years.

Once built and in operation, it generally takes about two years for a children's hospital to generate a return on investment, Moore said. He noted that certain services, such as neonatal care, tend to be more profitable than others.

It's important to note that children's hospitals are generally less profitable on an operational basis than the medians for the larger hospital sector, as a result of a payer mix that is more reliant on Medicaid and other forms of government funding. The median is 0.5% for 'AA' rated and 0.0% for 'A' rated children's hospitals (percentages does not include funds generated through endowments and fund raising), in contrast to 1.3% and 1.6% margins, respectively, for the general acute-care universe, according to Standard & Poor's.

A number of operation questions must also be answered before a new facility is built, such as its governance. "Freestanding" hospitals typically have their own board of governors and operate as separate business units, while "hospitals-within-hospitals" remain integrated units within the larger "adult" hospital. "Freeleaning" hospitals tend to combine elements of both forms of governance. Individual circumstances will dictate which model is appropriate for a hospital or health system.

Kid's hospitals: Bigger is better

HCSM's survey of new children's hospital projects across the country found a number of common denominators among the facilities. Chief among these was the move to single-bed units and physically larger facilities.

Such was the case with the University of Chicago's Comer Children's Hospital, where the new 155-bed facility will add about 50 more beds than the existing 40-year-old facility but will be roughly two-and-a-half

times the size. New rooms will be single bed and will include dedicated "family zones" that will include a bed where parents can sleep.

"What we've really focused on is designing patient care areas, appropriately sized to meet the needs of the children and, very importantly, their families. We believe that the families are part of the care-giving teams," said Ken Kates, the hospital system's chief operating officer.

At St. Vincent's, the new children's hospital means the health system was able to move the general pediatrics unit out of a portion of the "adult" hospital known by staff members somewhat less than affectionately as "The Cave."

"It was not designed for pediatrics originally and it never really—the décor was not friendly to pediatrics, although the staff very much did their best and was very creative. It just wasn't adequate," said Mary Ann Scott, executive director of the children's hospital.

In many cases, hospital administrators said moving into a new children's hospital allowed them to consolidate their services, particularly in cases where offerings were once scattered throughout an "adult" hospital. ■

For more information on children's hospitals, contact Keith Moore, chairman and CEO of McManis Consulting, 720-529-2110.

Projects at a glance

A number of not-for-profit health systems are building new children's hospitals, or have recently completed projects. Among them are:

- Maria Fareri Children's Hospital in Valhalla, N.Y., 125 beds, \$147 million. Opens in spring 2004.
- Phoenix Children's Hospital, 307-beds, \$106.5 million. Opened in May 2002.
- St. Vincent's Children's Hospital in Indianapolis, 72 beds, \$24 million. Opened in January.
- The Children's Hospital in Denver. Bed number unspecified, \$400 million campus. Opens in 2007.
- University of Chicago Comer Children's Hospital, 155 beds, \$130 million. Opens in early 2004.
- Vanderbilt Children's Hospital in Memphis, Tenn., 206 beds, \$191 million. Opens in December.

Additionally, a number of children's hospitals are in the process of making improvements and renovations to their facilities. ■