Inside: 18 Hospitals With Great Neurosurgery Programs (p. 15)

October 2009
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BECKER'S
Hospital Review
BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

Current Trends in Hospital and Health System CEO Compensation

By Lindsey Dunn

The compensation of hospital and health system top executives varies greatly and is dependent, largely, on the size and type of the institution the executive is leading as well as the experience of the executive. However, there are several recent trends in healthcare executive compensation that seem to affect the majority of the executives, regardless of the institution they oversee.

1. Declines in base salary increases

Most hospital executives can still expect salary increases, although they will likely not see in-

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58 Hospital and Health Industry Leaders

Joel Allison — Mr. Allison is president and CEO of Baylor Health Care System in Dallas. He joined Baylor in 1993 and served as Baylor's senior executive vice president and COO before being promoted to president and CEO in 2000.

Michael Blaszyk — Mr. Blaszyk is executive vice president and CFO for Catholic Healthcare West. Mr. Blaszyk, who has 30 years of healthcare experience, provides financial oversight for more than $10.6 billion in annual spending. Prior to joining the system, he was senior vice president and CFO at University Hospitals Health System in Cleveland.

Jack Bovender, Jr. — Mr. Bovender currently serves as chairman of Hospital Corporation of America and previously served as HCA's CEO, president and COO. Before being named president and COO in 1992, Mr. Bovender held several senior level positions with HCA.

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12 Best Practices for a Successful Hospital Neurosurgery Program

By Dan Rafter

At the neurosurgery department at Northwestern Memorial Hospital in Chicago, surgeons don't try to compete with the physicians in their surrounding communities. Instead, they offer services that complement what these doctors already offer.

At the University of California, San Francisco Medical Center, the surgeons in the hospital's neurosurgery department rely on the latest in new technology, even using surgical instruments that they themselves have designed.

And at Massachusetts General Hospital's Neurosurgical Service, doctors are encouraged to exercise their creativity and entrepreneurial spirit to

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Publisher's Letter

Re: Becker's Hospital Review; Free Hospital E-Weekly; www.BeckersHospitalReview.com

We hope that you enjoy and find this issue of *Becker's Hospital Review* useful. If you are interested in signing up for the free *E-Weekly*, filled with informative hospital and health system business and legal news and analysis, and statistics and lists, please either e-mail myself at sbecker@mcguirewoods.com or Rob Kurtz at rob@beckersasc.com.

For ongoing information related to hospitals and health system leadership and management, please go to www.BeckersHospitalReview.com.

This issue contains coverage of executive compensation trends, information to help ensure hospitals remain vibrant in a challenging economy, interviews with leading CEOs and lists of 58 industry leaders and 18 hospitals with great neurosurgery programs.

We are interested in feedback on these articles and lists. Should you have any comments or questions, please e-mail Rob Kurtz (rob@beckersasc.com) or call him at (781) 605-1837.

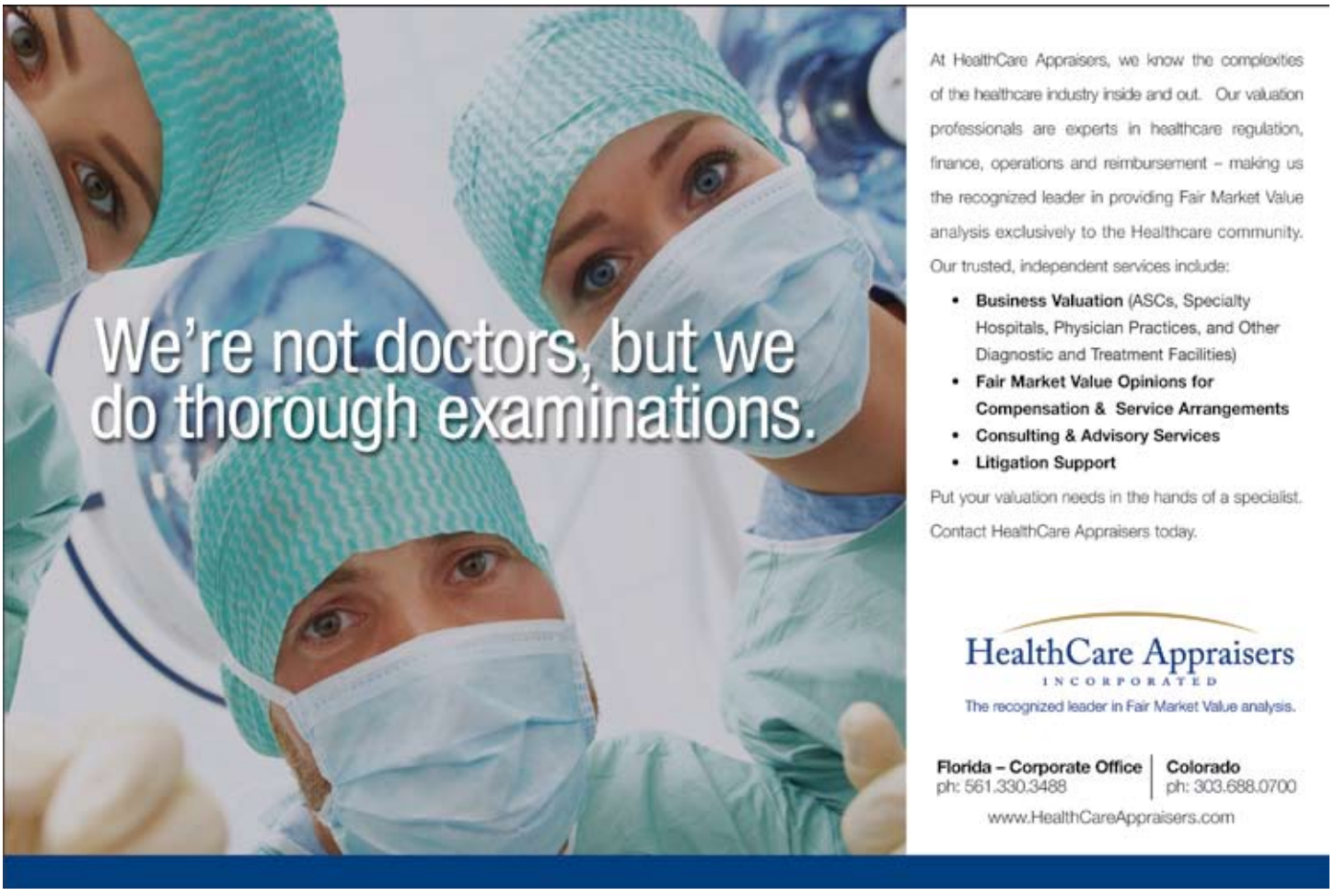
2009 was a tremendously interesting year for hospitals and health systems. Notwithstanding the talk of doom and gloom, many hospitals have thrived and survived in 2009. Moreover, hospitals that have managed their debt loads well and found ways to improve efficiencies, have thrived. There is much greater focus on the management of staff size. It is critical that hospitals continue to focus on building exceptional service lines.

Again, if you desire to sign up for *Becker's Hospital Review E-Weekly*, go to www.BeckersHospitalReview.com or e-mail Scott Becker or Rob Kurtz. Moreover, if you have questions on any of the issues raised in this issue, please contact Scott Becker or Rob Kurtz.

Very truly yours,

Scott Becker

P.S. We have increased the frequency of *Becker's Hospital Review* for 2010 to six times per year and circulation to 15,000 per issue.



Current Trends in Hospital and Health System CEO Compensation (continued from page 1)

creases as high as in the past. The average salary increase for health system and hospital executives was 3.5 percent in 2009, down from 4.0 percent in 2008, according to Integrated Healthcare Strategies, a healthcare human resources consulting firm.

The 2009 median base salary for a health system CEO is $657,000, according to Integrated Healthcare Strategies. The median salary for an independent hospital CEO is $434,500, and the median salary for a subsidiary hospital CEO is $300,000. It is important to note, though, that salaries vary greatly, beginning at around the low six-figure range and increasing upwards to $1 million.

Although most executives will experience slight increases, some hospitals and health systems are freezing or cutting salaries as a result of financial strain. According to Integrated Healthcare Strategies, one-third of organizations froze executive salaries for 2009. Another 6 percent of organizations reduced base salaries for executives, according to David Bjork, senior vice president & senior advisor for Integrated Healthcare Strategies.

2. Sensitivity to internal parity

Hospital boards seeking internal parity in the compensation of all C-level executives is another trend affecting CEO compensation.

"This is probably one of the the biggest trends we've noticed in terms of compensation," says Greg Zoch, partner, Kaye/Bassman International, an executive recruiting and search firm. "In the past, if a system wanted to bring in a CEO at $300,000 and the CEOs in their system were making considerably less, say around $250,000, it wasn't an issue. Now, that same system might be more sensitive to finding a CEO that would fit into $250,000 or $275,000 to be more in line with the other salaries."

3. Performance-based bonuses

In addition to base salary, most hospitals offer bonuses to their top executives based on organizational performance.

"About 80 percent of the industry uses an annual performance incentive and about 25 percent also have long-term incentives," says Mr. Bjork. "Long-term incentives, such as a bonus tied to the performance of the organization over maybe three years, are much more common in bigger organizations, such a multi-hospital health systems."

These long-term bonuses could be as high as 30 percent of salary and are sometimes paid out over a multi-year period, according to Mr. Bjork.

Kathy Noland, PhD, senior vice president for B.E. Smith and a former healthcare CEO, says that these pay-for-performance bonuses are a win-win for healthcare organizations, local communities and patients. In these pay-for-performance arrangements, CEOs should be compensated for meeting a number of objective, measurable goals that are determined by the organization's strategic plan. These goals may include improving measures such as national quality or customer satisfaction ratings by a certain percent and meeting specific growth and service line goals, she says. "Tying compensation to performance gives the board the assurance that executive performance is driven by a strategic plan and is fairly rewarded," says Dr. Noland.

James Brophy, vice president of B.E. Smith and a former member of several hospital boards, recommends that organizations make these perfor-

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**Data as of January 31, 2009.*

mance metrics transparent to organization members so that employees and medical staff can track the performance of the organization and its leadership team. "The key is that the board aligns executive compensation with achievement of the hospital's strategic plan and goals. Compensation should be based on performance, and performance must be measured in quantifiable terms, not subject to someone's personal opinion," he says.

Mr. Bjork expects that bonuses, like salary increases, will also generally be smaller this year than in years past due to the effect of the recession on the financial performance of hospitals and health systems. In fact, a survey of hospitals found that roughly 20 percent reported plans to reduce 2009 incentive opportunity levels, and another 10 percent planned to eliminate their executive incentives for 2009, according to Integrated Healthcare Strategies.

4. Disappearing perquisites

Perquisites or "perks" that were once commonplace, such as car allowances, country club memberships, financial planning allowances and other expense accounts, are disappearing as line items in many CEO compensation packages.

Some hospitals and health systems are instead giving a single allowance to encompass all the perquisites that used to be single line items. "Instead of giving [the CEOs] a dollar amount for every perquisite, the board may give them $10,000 and say 'do what you want,'" says Mr. Bjork.

Many organizations have stopped providing these perquisites and instead try to roll an additional allowance into the CEO's base pay if need or perhaps add a signing bonus to bridge the gap. This method seems to be more common for CEOs with less experience. "The next generation CEOs are often coming in at a higher salary with lower benefits and perquisites than the last generation CEOs," says Mr. Zoch. "Most newer CEOs never had a car allowance."

The recession is causing boards and compensation committees to reconsider the traditional CEO compensation package, says Mr. Bjork. "They are looking to cut costs everywhere. They start to think, 'Are we paying executives too much?'" he says.

Mr. Brophy says that hospital and health system boards need to be sensitive to the current economic climate and public scrutiny of executive compensation. "The board needs to undergo a very thorough process to determine a competitive salary and benefit package," he says. "A number of factors go into determining what a competitive package is, but in today's environment, boards must be sensitive to the scrutiny of its employees, medical staff and community."

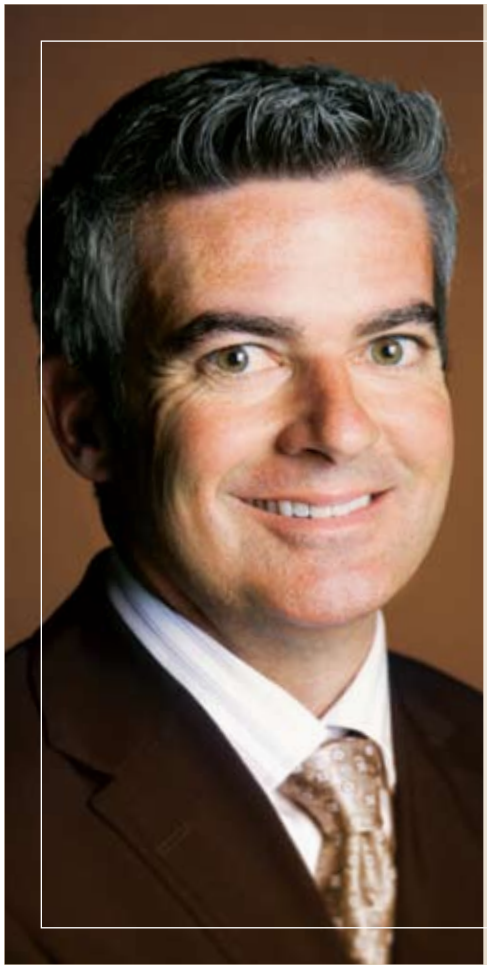
5. Improved relocation benefits

Recent changes in the housing market have also changed the type of relocation benefits offered to CEOs. Traditionally, employers would pay for relocation costs, but now additional benefits, such as housing allowances, are more commonly being offered.

"One of the biggest challenges facilities face in getting top talent at the C-level is in dealing with relocation issues. The CEOs are thinking, 'Can I sell my house in this market?'" says Mr. Zoch. "The smart employers are taking the housing issue off the candidate's back. They are offering company-paid condos or housing allowances for anywhere from 6-12 months or longer if needed. This allows the CEO to maintain two homes if necessary."

6. Move to defined-benefit supplemental benefits

Because of government regulations regarding maximum contributions to retirement plans, such as 401(k)s, many hospital and health system CEOs have



long been afforded supplemental retirement benefits. In the past, these supplemental retirement benefits would have been defined-benefit plans, meaning the CEO could expect the benefit to have a certain value upon retirement. Now, many CEOs are receiving supplemental retirement benefits, and often their qualified retirement benefits as well, in the form of defined-contribution plans, meaning that the ultimate value of the benefit is dependent on the performance financial markets and how the benefit is invested. This is a trend in compensation that is affecting all levels of healthcare employees and employees in many other industries as well, says Mr. Bjork.

"New regulations are changing the way supplemental retirement benefits are being delivered. It used to be much easier to figure out how to design deferred-benefit plans. Now, some boards are throwing up their hands and just giving the CEO cash now to invest for their own retirement," says Mr. Bjork.

Determining CEO compensation

How much compensation a hospital or health system board should offer a CEO is determined by a number of factors, including the size, profitability and payor structure of the organization as well as the experience of the CEO.

"Asking what CEOs are being paid is kind of like asking how much a car costs," says Mr. Zoch. "A hospital district that is struggling to make budget is not going to be as competitive as a facility with tremendous cash flow."

The compensation that a hospital or health system should offer to a CEO will be dictated by the market, says Mr. Zoch. "What you paid to the last person in the position may be a starting point, but it's usually best for a third party to do a salary survey for the hospital's specific marketplace that takes into account the range of CEO experience in that market," he says. "Ultimately, though, it really doesn't matter if the CEO you really want has an 'above market' compensation package now. If you want that individual, the market rate just changed. And if you want or need them enough, you will have to acquiesce to the market and pay it. Or keep looking."

Mr. Brophy recommends that hospital boards seek peer group comparisons of compensation and a third-party opinion from a person or firm with expertise in healthcare executive compensation. However, he warns that this type of data and expertise is not all that is needed. "[Survey data and third-party opinions] can guide the board but they cannot be the only factors considered. Ultimately, the board is accountable for the decision," he says.

Any survey data or benchmarks should be put in context of the unique community environment of the hospital or health system, the challenges that face the organization and the expertise needed by the executive to successfully meet these challenges, says Dr. Noland. "The level of experience does impact compensation, so planning for that upfront will be beneficial," she says.

Hospitals and health systems currently recruiting CEOs should be prepared to meet the demands of the market if they want to be successful in their efforts.

"It doesn't do [hospitals] any good to pay just enough to get the best candidate but not enough to keep them. If you think you've gotten a really good deal on a candidate, you probably aren't paying them enough to keep them from accepting a counteroffer or from being recruited later by another organization," says Mr. Zoch. "You will spend effort, time, money and emotion searching for this person. If you find the one you want, pay them well, even if it's slightly above market value. Good people will make you money." ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

58 Hospital and Health Industry Leaders
(continued from page 1)

Richard Bracken — Mr. Bracken currently serves as president and CEO of Hospital Corporation of America. He began his career with HCA in 1981 and has held various executive positions with the company, including CEO of the Green Hospital of Scripps Clinic and Research Foundation in San Diego, Calif., and CEO of Centennial Medical Center in Nashville, Tenn.

Larry Cash — Mr. Cash is CFO and executive vice president for Brentwood, Tenn.-based Community Health Systems. He has more than 30 years of healthcare financial experience and joined CHS in 1997.

Dexanne Clohan, MD — Dr. Clohan is senior vice president and chief medical officer for HealthSouth Corp. She is a board-certified physical medicine and rehabilitation physician and has served as HealthSouth's CMO since 2006.

Delos "Toby" Cosgrove, MD — Dr. Cosgrove is president and CEO of the Cleveland Clinic Foundation, which is comprised of the Cleveland Clinic, nine community hospitals, 14 family health centers and ASCs, Cleveland Clinic Florida, Cleveland Clinic Toronto and the developing Cleveland Clinic Abu Dhabi. Dr. Cosgrove previously served as chairman of the Cleveland Clinic's Department of Thoracic and Cardiovascular Surgery.

Lloyd Dean — Mr. Dean is president and CEO of Catholic Healthcare West, one of the leading non-profit healthcare systems in the United States. In this role, Mr. Dean is responsible for $11 billion in assets and the overall management, strategy and direction of CHW's integrated healthcare system comprising 41 acute-care hospitals, as well as medical clinics, home health organizations, two health plans, five medical practice groups and an estimated 53,000 employees and 10,000 physicians in California, Arizona and Nevada.

John Dietz, MD — Dr. Dietz is chairman of the board at Indiana Orthopaedic Hospital in Indianapolis and an orthopedic and spine surgeon with OrthoIndy. He is a member of the American Academy of Orthopaedic Surgeons and the North American Spine Society and is a fellow of the Scoliosis Research Society.

Michael Dowling — Mr. Dowling is president and CEO of North Shore-Long Island Jewish Health System in New York, the largest healthcare network in New York State. Mr. Dowling previously served as the health system's executive vice president and COO. Prior to that, he was a senior vice president at Empire Blue Cross/Blue Shield.

Trevor Fetter — Mr. Fetter has served as president and CEO of Tenet Healthcare Corp. since Sept. 2003 and also serves as a member of the company's board of directors. He also currently serves as the chair of the board for the Federation of American Hospitals.

Georgia Fojtasek — Ms. Fojtasek is president and CEO of Allegiance Health in Jackson, Mich., a regional healthcare provider that operates 40 facilities — including hospitals, diagnostic centers and rehabilitation centers — across six counties in Michigan. Prior to accepting her current position, she was senior vice president and COO of Allegiance.

Lawrence Foust — Mr. Foust serves as senior vice president and general counsel at the Childrens Hospital of Los Angeles. He has provided legal services for the healthcare industry for more than 29 years, including service with the Kaiser Foundation Health Plan, Jenkens & Gilchrist and Sisters of Charity of the Incarnate Word of Houston, now known as CHRISTUS Health.

David Fox — Mr. Fox is president of Advocate Good Samaritan Hospital in Downers Grove, Ill., and has been a healthcare executive his entire career. He joined Advocate Good Samaritan in 2003 and was recently named as *Becker's Hospital Review*'s hospital CEO of the year.

Joe Freudenberger — Mr. Freudenberger is CEO of OakBend Medical Center in Richmond, Texas. He has held several positions in hospital administration, serving as COO for OakBend and as CFO for Memorial Health System of East Texas in Lufkin, Texas.

Alyson Pitman Giles — Ms. Giles is president and CEO of CMC Healthcare System and Catholic Medical Center in Manchester, N.H. She has been president and CEO of CMC Healthcare System since 2002 and president and CEO of Catholic Medical Center since 1999.

Edward Goldberg — Mr. Goldberg is president and CEO of St. Alexius Medical Center in Hoffman Estates, Ill., and has been a hospital administrator for more than 32 years. Mr. Goldberg previously served as a vice president for Columbia/HCA, administrator at Hartgrove Hospital in Chicago, administrator at Charter Barclay Hospital in Chicago, regional director with Charter Medical Corporation and administrator at Coral Gables (Fla.) Hospital.

Gary Gottlieb, MD — Dr. Gottlieb is president of Brigham and Women's Hospital in Boston. In 2010, he will succeed James Mongan as president and CEO of Partners Health System in Boston. He also serves a professor of psychiatry at Harvard Medical School.

Jay Grinney — Mr. Grinney has served as president and CEO of HealthSouth Corp. since 2004. Prior to joining HealthSouth, Mr. Grinney served as president of Hospital Corporation of America's Eastern group, which employs more than 65,000 people and consists of 91 hospitals located in 10 states. He also served as president and CEO of HCA's greater Houston division and as COO of the Houston region.

John Harvey, MD — Dr. Harvey serves as medical director and CEO at Oklahoma Heart Hospital and Oklahoma Cardiovascular Associates. He is a board-certified physician specializing in cardiac electrophysiology and pacing and has been with Oklahoma Cardiovascular Associates since 1998.

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3. CMS Announces Final IPPS Rule for FY 2010; Includes 1.6% Increase for Inpatient Payments
4. Hospital Average Length of Stay, Charges and Costs by Payor
5. Hospital CFO Whistle-Blower Leads to $2.4M Medicare Antikickback Settlement
6. North Shore University Hospital Gets Highest Pay-for-Performance Reward in Nation
7. 3 Best Practices for Successful Hospitalist Programs From Dr. Stephen Houff
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Debbie Hay — Ms. Hay is the president of the Texas Institute for Surgery in Dallas. She previously served as administrator for a surgery center and as an emergency room nurse and manager.

Cathryn Hibbs — Ms. Hibbs is CEO of Deaconess Hospital in Oklahoma City. Prior to her appointment at Deaconess, she was a division vice president of operations for Community Health Systems.

Jeffrey Hillebrand — Mr. Hillebrand is COO of NorthShore University HealthSystem in Evanston, Ill., and has been with the organization since 1979. He previously served as executive vice president and president of NorthShore University HealthSystem Medical Group as well as senior vice president and president of Glenbrook (Ill.) Hospital.

Rebecca Hurley — Ms. Hurley serves as executive vice president, general counsel and secretary for Legacy Hospital Partners. Ms. Hurley previously served as senior vice president, general counsel and secretary for Triad Hospitals.

Deborah Carey Johnson — Ms. Johnson is president and CEO of Eastern Maine Medical Center in Bangor. She started at EMMC as a staff nurse in the critical care unit, then moved on to department head nurse in critical care, assistant administrator of nursing, administrator for specialty centers and finally the executive vice president and COO before assuming her current role as president and CEO.

Charles "Chip" Kahn — Mr. Kahn is president of the Federation of American Hospitals and one of the most notable experts on health policy and financing. He was appointed to the governing board of the National Quality Forum in 2007 and serves as a principal in the Hospital Quality Alliance.

Gary Kaplan, MD — Dr. Kaplan is chairman and CEO of Virginia Mason Medical Center in Seattle. He joined Virginia Mason in 1981 and has served the hospital in numerous roles including deputy chief of medicine and medical director.

Chris Karam — Mr. Karam is a regional leader in CHRISTUS Health, one of the top 10 Catholic health systems in the United States, where he serves as president and CEO of the CHRISTUS St. Michael Health System in Texarkana, Texas, one of the most dynamic regions in the CHRISTUS Health system.

Donna Katen-Bahensky — Ms. Katen-Bahensky is president and CEO of the University of Wisconsin Hospital and Clinics in Madison. Before coming to the University of Wisconsin, she held numerous executive positions at health systems across the country including the University of Iowa Hospitals and Clinics and Iowa Health Care, Virginia Commonwealth University and the Medical College of Virginia and the University of Nebraska Medical Center in Omaha, Neb.

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Bill Keaton — Mr. Keaton was appointed as CEO of Baylor Medical Center in Frisco, Texas, in 2001. Prior to his appointment at Baylor, Mr. Keaton served as COO of River Region HealthCare System in Vicksburg, Miss., and as CEO of Columbia Panhandle Surgical Hospital in Amarillo, Texas.

Jane Keller — Ms. Keller is the CEO and chief nursing officer for the Indiana Orthopedic Hospital in Indianapolis. She started at OrthoIndy, the group that owns IOH, as the executive director/nursing director of surgery centers.

John Koster, MD — Dr. Koster is president and CEO of Providence Health & Services and has been with the health system since 1997. Prior to that, Dr. Koster served as vice president for targeted member services at VHA in Irving, Texas.

Paul Levy — Mr. Levy has served as the president and CEO of Beth Israel Deaconess Medical Center, a Harvard Medical School teaching hospital, since 2002. He is the executive dean of administration at Harvard Medical School and previously was an adjunct professor of environmental policy at MIT.

Kevin Lofton — Mr. Lofton has served as president and CEO of Catholic Health Initiatives since 2003. Prior to his current role, he served as executive vice president and COO of the health system as well as president of the southeast region.

Pamala Maher — Ms. Maher is CEO of Arizona Regional Medical Center, which opened in Oct. 2008. Prior to serving as CEO at ARMC, Ms. Maher served as CEO for a number of hospitals in Wyoming, Texas and Arizona and as senior administrator at Advanced Cardiac Specialists, an internal medicine and cardiology practice in Arizona.

Tom Mallon — Mr. Mallon is a co-founder and CEO of Regent Surgical Health, which specializes in working with physician and hospital partners in the development, management and turnaround of specialty hospitals and surgery centers. Before founding Regent, he served as a founding member and remains a general partner with Gryffindor Capital Partners, a Chicago-based venture-capital fund.

Thomas A. Michaud, CPA — Mr. Michaud is the CEO and chairman of the board of Foundation Surgery *Affiliates*. Before founding FSA, he held the positions of COO and CFO of a regional surgery center management company.

Thomas Miller — Mr. Miller is president of Division V operations for Community Health Systems. Before joining CHS in 2007, he was regional president of the Lutheran Health Network and CEO of Lutheran Hospital in Fort Wayne, Ind.

Daniel Moen — Mr. Moen is CEO of Plano, Texas-based Legacy Hospital Partners. He previously served as executive vice president for development at Triad Hospitals. Mr. Moen began his healthcare career with Humana in 1977 and worked there in positions of increasing responsibility for 14 years.

Mark Neaman — Mr. Neaman has served as president and CEO of NorthShore University HealthSystem since 1992. Mr. Neaman has spent his entire career with NorthShore, joining the hospital in 1974.

Gary Newsome — Mr. Newsome is president and CEO of Health Management Associates. Mr. Newsome previously served as division president of hospital operations and president of group operations for Community Health Systems.

Herbert Pardes, MD — Dr. Pardes is president and CEO of the New York Presbyterian Health Care System in New York City. He previously served as U.S. Assistant Surgeon General and was director of the National Institutes of Mental Health during the Carter and Reagan administrations.

Thomas Priselac — Mr. Priselac is president and CEO of Cedars-Sinai Health System and currently serves as chairman of the American Hospital Association. Mr. Priselac has been with Cedars-Sinai since 1979, serving as CEO since 1994.

John Rex-Waller — Mr. Rex-Waller is the chairman, president and CEO of National Surgical Hospitals. He has also served as the CFO of Hawk Medical Supply and previously was the CFO and a co-founder of National Surgery Centers, which was one the largest independent owners and operators of ASCs in the country.

Britt Reynolds — Mr. Reynolds is a senior vice president and a division president for Health Management Associates. Previously, he served as vice president of operations for Community Health Systems, managing hospitals in Illinois, New Jersey, Pennsylvania and West Virginia

Thomas Royer, MD — Dr. Royer is president and CEO of CHRISTUS Health system, leading the day-to-day operations for CHRISTUS Health. In his nearly seven years with the organization, Dr. Royer has led CHRISTUS Health through a remarkable period of growth, making it one of the 10 largest Catholic health systems in the country.

Sister Mary Jean Ryan — Sister Ryan is the president and CEO of SSM Health Care in St. Louis, Mo., a healthcare system sponsored by the Franciscan Sisters of Mary which owns, manages and is affiliated with 20 acute care hospitals and two nursing homes in Wisconsin, Illinois, Missouri and Oklahoma.

Molly Sandvig, JD — Ms. Sandvig is the executive director for the Physician Hospitals of America. In this role she leads the organization's day-to-day business and operational functions and directs PHA's membership recruitment, public relations and political advocacy efforts.

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4. Decentralization of surgery: Anesthesia department friend or foe?

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Nancy Schlichting — Ms. Schlichting is president and CEO of the Henry Ford Health System in Detroit, where she previously served as executive vice president and COO. Prior to joining Henry Ford in 1998, Ms. Schlichting was executive vice president and COO of Summa Health System in Akron, Ohio.

Ron Shafer — Mr. Shafer is vice president of Division V operations for Community Health Systems. In this position, he manages hospitals in Indiana, Kentucky and Ohio.

David Shulkin, MD — Dr. Shulkin is president and CEO of Beth Israel Medical Center in New York City. He previously served in numerous physician leadership roles including the chief medical officer of the University of Pennsylvania Health System, the Hospital of the University of Pennsylvania, Temple University Hospital and the Medical College of Pennsylvania Hospital and was the chairman of medicine and vice dean at Drexel University School of Medicine.

Wayne Smith — Mr. Smith serves as chairman of the board, president and CEO of Franklin, Tenn.-based Community Health Systems. Prior to joining CHS, Mr. Smith was with Humana for 23 years where he held a variety of senior management positions including president and COO.

Paul Summerside, MD — Dr. Summerside is the chief medical officer and president of the board at BayCare Clinic in Green Bay, Wis. He also serves as president of Aurora BayCare Medical Center, director of wellness for Aurora BayCare Sports Medicine and chairman of medical education for the University of Wisconsin-affiliated medical school program in Green Bay.

Nick Turkal, MD — Dr. Turkal serves as president and CEO of Milwaukee, Wis.-based Aurora Health Care. Dr. Turkal previously served as a senior vice president and president of Aurora's metro region, where he oversaw the operations of Aurora's facilities and services in the Milwaukee area, including Aurora St. Luke's Medical Center, Aurora Sinai Medical Center, St. Luke's South Shore and West Allis Memorial Hospital

Richard Umbdenstock — Mr. Umbdenstock is president and CEO of the American Hospital Association and past chair of the AHA board of trustees. He previously served as executive vice president of Providence Health & Services, an integrated healthcare system formed through the merger of Providence Services and Providence Health System.

Chris Van Gorder — Mr. Van Gorder has served as the president and CEO of Scripps Health since 2000. Scripps operates five acute care hospital campuses, 13 outpatient clinics and regional home healthcare services with more than 2,600 affiliated physicians and 11,000 employees.

Harold Varmus, MD — Dr. Varmus is president and CEO of Memorial Sloan-Kettering Cancer Center in New York. He was the former director of the National Institutes of Health and co-recipient (along with Dr. J. Michael Bishop) of a Nobel Prize for studies of the genetic basis of cancer.

Andrew Ziskind, MD — Dr. Ziskind has served as president of Barnes-Jewish Hospital in St. Louis since 2005. Dr. Ziskind previously served as associate vice president for clinical programs and vice dean for clinical affairs for the University of Washington in Seattle. ■

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12 Best Practices for a Successful Hospital Neurosurgery Program
(continued from page 1)

both deliver better patient care and to improve the department's overall performance.

These are just three examples of how the country's top neurosurgery programs provide the best patient care possible.

Building a top neurosurgery programs isn't easy. But for those hospitals that do it, the rewards, both in service to the community and financially, are immense.

But how is a top neurosurgery department built? Here are 12 suggestions from doctors and administrators at some of the top departments in the country on how to create a top-ranked neurosurgery department.

1. Make patients' needs the top priority. The best neurosurgery programs place the needs of their patients above all other concerns. Providing top patient care, though, isn't as simple as it sounds. It means relying on the latest equipment and technology so that a neurosurgery department provides the best medical care, employing the top surgeons and specialists, and doing the little things that make a patient's stay as pleasant as possible.

At the University of California, San Francisco Medical Center, surgeons in the neurosurgery department not only spend time explaining procedures and recovery times to their patients, they also do the same with these patients' family members.

"We talk to them not only about the disease that they are dealing with, but how they are going to be taken care of from the beginning of the process to the end of their hospitalization," says Mitchel Berger, MD, professor and chair of the hospital's department of neurosurgery. "We are not only talking to the patient, but to the caregiver, too. That is something that we all think is important."

2. Work with all of your hospital's resources. At the Cleveland Clinic, specialists in the neurosurgery department are split into six centers: pediatrics, epilepsy, functional neurosurgery, cerebrovascular, spine and brain tumor.

But that doesn't mean that the surgeons working in these specialties operate as an island. When a neurosurgeon specializing in pediatrics develops a treatment plan for a patient, the physician might meet with a fellow specialist who works in the functional neurosurgery division. That same physician might also meet with hospital physicians outside the neurosurgery department who deal with orthopedics or spinal injuries, depending on the patient's needs.

It's all part of the department's goal to tap into all of its resources to provide the best possible treatment for patients, says Molly Allen, a hospital administrator and manager of the clinic's neurosurgery department.

"When we look at the neurosurgery department as a whole, we acknowledge the differences between each of the specialties," Ms. Allen says. "But we also acknowledge that neurosurgeons are a pretty cohesive group. They work together consistently and cross subspecialty centers when it benefits patient care."

3. Offer a broad range of services. The neurosurgery faculty at Boston's Massachusetts General Hospital boasts a broad range of expertise. The large staff of physicians here treat a wide range of neurological disorders, ranging from those that impact the youngest of infants to those that strike the elderly.

"That is something that you can't find in most other places," says Ron Ash, administrative director of neurosurgery at Massachusetts General. "It allows our faculty to focus in on those areas that they feel they are experts in."

Massachusetts General can do this because it boasts such a sizeable staff. By running a large department, the department can feature physicians that specialize in just about any neurological disorders patients might have, thus broadening the appeal of the facility to its target patient base.

4. Employ the top technology. The field of neurosurgery is constantly evolving. So is the technology that neurosurgeons use to treat their patients. That's why the country's top neurosurgery departments are constantly upgrading their medical technology.

The neurosurgeons at the University of California, San Francisco Medical Center rely on intraoperative MRI scanners and image-guided systems to provide for the most precise surgical navigation. Many of the surgeons even use specialized microsurgical instruments that department faculty members themselves have designed.

Department faculty member Michael Lawton, MD, for example, worked with microsurgery tool maker Mizuho to design microsurgical in-

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struments that can be used to perform bypass procedures on patients who have had strokes. This instrument set is known as the Lawton Neurovascular Bypass set, and will soon by released by Mizuho.

"We ask for the absolute best and latest equipment to use in the operating room," Dr. Berger says. "We want every bell and whistle that there is."

5. Encourage creativity. The top neurosurgery departments give their skilled practitioners the opportunity to be creative and develop new ideas and theories. Neurosurgeons at Massachusetts General Hospital are encouraged to apply an entrepreneurial spirit, Mr. Ash says. Part of their mission is to tap into their own talents to develop new procedures, treatment methods and theories.

One of the physicians at the hospital's neurosurgery department took a one-year endovascular fellowship. This allows him to now work alongside other neurosurgeons and neuroradiologists in the department who also practice endovascular surgery. Taking the fellowship required a serious commitment from the physician, Mr. Ash says. The physician spent a full year traveling to Buffalo, N.Y., three days a week for the fellowship and then returning to Massachusetts General Hospital for his regular duties.

We encourage our physicians to develop their own skills and techniques and capabilities," Mr. Ash says. "When our surgeons develop their own skills and techniques, it helps us in terms of increasing the breadth and depth of services that we can offer."

6. Encourage specialization. Edward Benzel, MD, chair of neurosurgery at the Cleveland Clinic, seeks the top specialists for his program. Specialists, he says, offer the best possible care for patients.

"Our type of program, with so many people specializing in so many divisions of neurosurgery, makes it more complicated for administrators. But it is much better for the patients," Dr. Benzel says. "The bottom line is that patients are much better served by specialists, by physicians who do what they do arguably better than any other. The bottom line is we do what is best for the patient, and having true specialists as decision-makers and providers is what is truly best for the patient."

The same holds true at the University of California, San Francisco Medical Center, where specialists only concentrate on their own areas of expertise.

"When you are hired into this department, you have to stay in your own domain," Dr. Berger says. "You become an expert. You are not diluted with other things that you have to do."

7. Top care equals more business. A neurosurgery department can't concentrate only on patient care. It must also be strong financially. Fortunately, the top neurosurgery programs have found that the two — patient care and financial success — are related.

Dr. Berger says that because his department has earned a reputation as one of the top centers for neurosurgical treatment, it is never lacking for patients.

"We have established ourselves in this region as the center where patients with complex neurosurgical disorders go," Dr. Berger says. "They know that if they come here they will get the best care they can get."

8. Create a strong residency program. A neurosurgery program is only as good as its talent. That's why administrators at Massachusetts General Hospital work hard at fostering a strong residency program. Such a program attracts the brightest minds to the hospital.

And when Massachusetts General graduates the top doctors from its residency program, this just inspires a further funneling of talent into the program.

"We have a stellar residency program that attracts great candidates," Mr. Ash says. "It's a great starting point for these doctors' careers. And they're here with us for at least seven years. They become well-integrated into the institution. And many of them stay with us."

9. Communication is critical. The administration and medical faculty at Massachusetts General are free to share concerns and ideas with each other at any time, Mr. Ash says. But the communication isn't limited to inside the department. Staffers with the neurosurgery department also discuss patient care and administrative matters with physicians and officials in other hospital departments outside neurosurgery.

As an example, Mr. Ash points to the department's "Grand Rounds." These are weekly meetings that are formal conferences between the neurosurgery department and other hospital departments.

"The communication goes both ways," Mr. Ash says. "It's important to maintain the strong working relationships with other specialists with whom we work. We need those good working relationships to make things work well here."

10. Don't forget about the importance of research. While the focus on most neurosurgery departments is deservedly on the daily care and treatment of patients, the top programs also concentrate on research and education.

Dr. Benzel says he is proud of the research that his physicians do on new techniques and treatments.

"Our goal is to form a tight, cohesive clinical care program," Dr. Benzel says. "Such a program transcends into the research and education arenas, as well, by addressing both research and education in a multidisciplinary and yet focused manner."

11. Work with doctors in your community. When Hunt Batjer, MD first arrived at Northwestern Memorial Hospital in 1995, the Chicago hospital's neurosurgery program was considered weak, Dr. Batjer says. Dr. Batjer, who is now the chairman of the department of neurological surgery at Northwestern Memorial, had one goal: change this view.

The department now ranks as one of the top in the country. As part of the process of rebuilding the hospital's neurosurgery department, Dr. Batjer reached out to the private physicians in the Chicago neighborhoods surrounding Northwestern Memorial. He wanted to find out exactly what these physicians wanted to see from a top-notch neurological department.

The answers weren't surprising, but they were telling. The physicians Dr. Batjer spoke with wanted quick responses. If they called from the emergency room with a critically ill patient, they wanted to get a physician on the phone from Northwestern's neurology department immediately. And they wanted to arrange a patient transfer immediately, too.

"They didn't want to have to worry about whether that patient had insurance or not … any of that financial nonsense," Dr. Batjer says. "I made sure to tell my faculty to say 'Yes, right away' when these outside physicians called. We still do that."

The physicians also wanted follow-up after they sent patients to Northwestern's neurology department.

"They didn't expect 100 percent success," Dr. Batjer says. "But they did expect 100 percent follow-up."

12. Don't compete with your referring doctors. Dr. Batjer has a theory regarding neurosurgery departments: The bread-and-butter services don't build a department's reputation. It's the highly technical niche services that bolster that reputation, he says, and it's these services that bring in the referral business from outside physicians.

"We are going to have the best people and the best infrastructures to treat the most complex of problems," Dr. Batjer says. "We are not going to go out in the community and try to compete with our referring doctors. We want to be a resource for those practices, not an opponent. We want to offer the services that complement their practices." ■

Contact Rob Kurtz at rob@beckersasc.com.

18 Hospitals With Great Neurosurgery Programs

Barnes Jewish Hospital/Washington University (St. Louis). Barnes-Jewish is the largest hospital in Missouri, with more than 1,250 beds, more than 1,800 employed physicians and nearly 18,300 surgeries performed in 2008. The hospital has four dedicated neurosurgery ORs, and its 20-bed neuro-intensive care unit has computerized radiograph viewing and an in-unit positron emission tomography (PET) scanner. Its neurosurgeons also use a Gamma Knife to treat brain tumors and other abnormalities and the Cavitron, a surgical device that disintegrates and aspirates brain tumors. They perform stereotactic neurosurgery, a computer-assisted guidance in brain surgery that allows placement of biopsy tools or electrodes deep in the brain, and surgical navigation, which uses computers to plan precise approaches to areas of the brain during surgery. Other services include intraoperative angiography, which uses x-rays of blood vessels in surgery for aneurysms or arteriovenous malformations; movement disorder surgery, which is the surgical implantation of stimulators to treat Parkinson's isease and certain types of tremor; and cortical mapping EE, which helps surgeons stay away from essential brain functions.

Cedars-Sinai Medical Center (Los Angeles). Cedars-Sinai Medical Center, with 977 beds, near Beverly Hills, has had a long roster of movie stars as patients. The Cedars-Sinai Institute for Spinal Disorders, featuring eight neurosurgeons and two neuro-oncologists, performed more than 1,000 major neurosurgical procedures in 2008, ranging from craniotomies for tumor resections to surgical resection of vascular malformations. The Comprehensive Brain Tumor Program is involved in several innovative protocols for brain tumors, including the use of a dendritic cell vaccine for malignant glioma. Cedars-Sinai Medical Center has dedicated neurosurgical operating rooms equipped with intraoperative MRI, image-guided surgery, operating microscopes, lasers and intraoperative angiography. The institute also has the capability to perform stereotactic biopsy and radiotherapy of tumors.

Cleveland Clinic. Structured as a group practice, the Cleveland Clinic employs 1,800 staff physicians who work in multidisciplinary teams and use several hospitals totaling more than 1,000 beds. Neurosurgeons in the Cleveland Clinic Neurological Institute work with other physicians and providers. The center for brain tumors and neuro-oncology, for example, is a partnership with the clinic's cancer institute. Other centers in the Neurological Institute are involved in brain health, strokes and cerebrovascular health, brain aneurysms and related disorders, epilepsy, Multiple Sclerosis, pain, neuromuscular and neurological restoration. The institute benefits from extensive inter-specialty collaborations. Its fully integrated model allows the institute to measure quality and outcomes on a continual basis.

Duke University Medical Center (Durham, N.C.). The 924-bed Duke University Medical Center, commonly known as Duke University Hospital, is the flagship of Duke University Health System. Duke neurosurgery is one of the largest and busiest academic programs in the country. Neurosurgeons at Duke perform a wide array of disciplines, including primary and secondary brain and spinal tumors, one of the largest high-grade glioma patient populations in the world. More than two-thirds of adult brain tumor patients at Duke take part in clinical trials, compared to only 8 percent nationally. Duke neurosurgeons also remove skull base tumors, perform complex spinal resections and fusions, pain and functional neurosurgical procedures, peripheral nerve procedures and open vascular and endovascular procedures.

Emory University Hospital (Atlanta). Emory University Hospital, with 587 beds, is staffed exclusively by faculty at Emory University School of Medicine, treating 80,000 outpatients a year. The neurosurgery department includes Sanjay Gupta, MD, CNN's chief medical correspondent, and department chairman Daniel L. Barrow, who has authored *The Practice of Neurosurgery*, a major textbook of neurosurgery. The hospital's 20-room neuro-intensive care unit, which opened in 2007, includes a high-resolution CT machine and has a dedicated staff of neurointensivists. Neurosurgeons at Emory University are now removing benign tumors from deep within the brain though tiny incisions and openings in the skull no larger than a pea, which eliminates the need to fully open the skull to remove tumors.

Johns Hopkins Hospital (Baltimore). The 982-bed Johns Hopkins Hospital was an early teaching institution where the terms "rounds" and "residents" were coined. However, the hospital is by no means stuck in the past. For example, Johns Hopkins neurosurgeons are taking new therapies for treating brain and spinal tumors from the laboratory to the bedside. They have developed and refined many new techniques, including endoscopic, radiosurgical and other minimally invasive procedures that are saving lives or improving quality of life. Hopkins investigators are also using stem cells to answer fundamental questions about the brain's ability to regenerate or produce abnormal pathologies. Neurosurgery specialties include diagnosis and treatment of brain tumors, cerebral aneurysms and arteriovenous and cavernous malformations, carotid artery stenosis and spinal disorders. The hospital's neurological critical care unit provides the highest quality, most up-to-date, specialized care for neurosurgical patients after surgery and for patients with head and neck injuries, seizures and stroke.

Massachusetts General Hospital (Boston). The 905-bed Massachusetts General Hospital, teaching hospital of Harvard Medical School, conducts the largest hospital-based research program in the country, with an annual budget of more than $400 million. Neurosurgery at the Massachusetts General uses almost 10 percent of the hospital's beds and has an average daily census of 70-90 patients. The program has two interventional neuroradiologists and 32 neurosurgeons, of whom 15 are residents, performing about 2,600 neurosurgical operations annually. Four ORs are dedicated to neurosurgery and a 17-bed neuro-intensive care unit is staffed continuously. Neurosurgery researchers at Mass General are studying mutations that occur in glioblastomas, a form of brain tumor; neural growth and regeneration of damaged brain functions; intraoperative monitoring and imaging; cerebral blood vessels; and cellular neurobiology.

Mayo Clinic (Rochester, Minn.). Mayo Clinic, Rochester, has 1,700 physicians in more than 60 specialty and subspecialty areas, admitting patients to 1,265-bed Saint Mary's Hospital and 794-bed Rochester Methodist Hospital. Mayo's Department of Neurosurgery consists of 10 neurosurgeons working closely with colleagues throughout Mayo Clinic and performing more than 3,000 neurosurgical procedures each annually, among the highest procedural volumes for this specialty in the world. This year, neurosurgeons at Mayo found that posterior fossa exploration surgery provided significantly better pain relief than stereotactic radiosurgery for patients with trigeminal neuralgia. The Mayo Clinic's Brain Injury Program was recently named the State Lead Center of Excellence by the Sarah Jane Brain Foundation, which is developing a seamless, evidence-based brain-injury plan for children and young adults.

Methodist Hospital (Houston). The 899-bed Methodist Hospital is in the heart of the storied Texas Medical Center, but it also has small satellite hospitals throughout the Houston area. The Methodist Neurological Institute

is built around four principles: physician-scientists, advanced technology, comprehensive patient services and innovative facilities. Specialists from multiple disciplines analyze a patient's condition from all perspectives to develop an all-encompassing treatment plan. More than 50 neurologists, neurosurgeons, neuroradiologists and neuro-rehabilitation physicians collaborate to make the institute a center for diagnosis, treatment, clinical trials and research. Clinicians and researchers at the institute provide comprehensive care for patients with neurological disorders including stroke, Parkinson's, Alzheimer's, multiple sclerosis, ALS, brain tumors, epilepsy, pituitary tumors and spinal disorders.

Mount Sinai Hospital (New York). The 1,171-bed Mount Sinai Hospital is located just east of Central Park and is affiliated with many hospitals throughout the city. Mount Sinai is a leader in functional neurosurgery, having pioneered the use of low frequency stimulation for the treatment of dystonia. Neurosurgeons at the hospital have performed the most deep brain stimulator (DBS) implants for Parkinson's disease, essential tremor, and dystonia in the New York region. Ongoing research includes clinical trials of gene therapy for Parkinson's and Alzheimer's disease and the use of DBS for the treatment of depression. Having pioneered stereotactic techniques since 1993, Mount Sinai has extended the scope of operable brain tumors by using frame-based or frameless stereotaxy, awake-and-asleep brain mapping, micro-neurosurgery and endoscopic surgery. The hospital now hosts an advanced multidisciplinary program for stereotactic neurosurgery, using computer-assisted image-guided neurosurgery to accomplish minimally invasive brain and spine procedures.

Neurologic and Orthopedic Institute of Chicago. The Neurologic and Orthopedic Institute of Chicago is dedicated exclusively to neuroscience and Orthopedic surgery. It has 10 operating rooms, 52 medical/surgical beds, 15 rehabilitation beds and 18 intensive care beds, a stereotactic radiosurgery suite, a neuroangiography suite and a comprehensive diagnostic imaging suite with a 1.5-tesla MRI and CT. The neurological practice is lead by the Chicago Institute of Neurosurgery and Neuroresearch. Physician expertise includes brain tumors, neck and back pain and neurovascular and stroke care.

Northwestern Memorial Hospital (Chicago). The 873-bed Northwestern Memorial Hospital claims to be the tallest hospital in the country, with one tower that is 22 stories high. The hospital boasts a cerebrovascular program for the surgical and endovascular treatment of stroke, brain aneurysms, brain or spinal vascular malformations, and other blood vessel-related problems. Its Acute Spinal Cord Injury Center, a partnership with the Rehabilitation Institute of Chicago, is one of 14 model systems of care for spinal cord injury in the nation. Northwestern has a state-of-the-art neuro-oncology program, minimally invasive surgical and non-invasive radiosurgical treatment for tumors and blood vessel malformations, treatment of functional disorders and a comprehensive program for the treatment of intractable and chronic pain.

Ronald Reagan UCLA Medical Center (Los Angeles). The 600-bed Ronald Reagan UCLA Medical Center opened in 2008 at a cost of $1 billion and is one of the first structures in the state that can withstand an 8.0-magnitude earthquake. UCLA Neurosurgery includes innovative clinical programs in epilepsy, neuroendoscopy, minimally invasive brain and spinal surgery, neuro-oncology for brain tumors, cerebrovascular surgery, stereotactic radiosurgery for brain and spinal disorders and surgery for movement disorders such as Parkinson's disease. The programs collaborate closely with other departments, including neurology, pharmacology, ortho-

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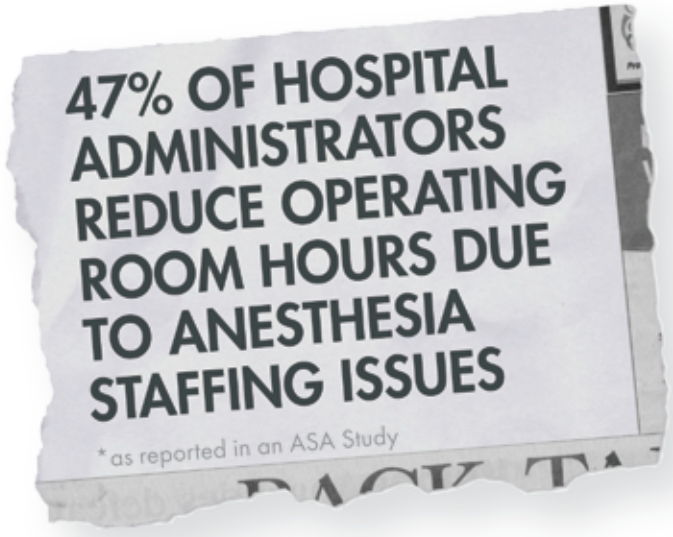

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pedics and bioengineering. UCLA Neurosurgery has been using the RP-6 mobile robot system in its neurosurgery intensive care unit. The robot allows doctors to virtually consult with patients, family members and healthcare staff at a moment's notice, even if miles away from the hospital.

Rush University Medical Center (Chicago). Rush University Medical Center, with 613 beds, is undertaking a $900 million redevelopment that will include a new 14-level hospital and an orthopedic ambulatory building. Neurosurgeons at Rush collaborate with neurologists, neuroradiologists, critical care nurses and other specialists to address the full scope of problems affecting the brain, spine and nervous system. They use deep brain stimulation to eliminate tremors of Parkinson's disease and perform innovative surgeries to treat epilepsy. In a recent study, Rush researchers found that quantitative magnetic resonance angiography is a promising screening tool to detect instent stenosis with high sensitivity and specificity. Also, Rush has been testing the Penumbra Stroke System, a minimally-invasive investigational technique to remove blood clots in large brain vessels that cause acute ischemic stroke by using suction and catheterization techniques to rapidly restore blood flow in the brain and limit damage caused by stroke.

St. Joseph's Hospital and Medical Center (Phoenix, Ariz.). Located in the heart of Phoenix, 743-bed St. Joseph's Hospital and Medical Center has a medical staff of close to 1,500 physicians and 180 residents in 12 specialties. The Barrow Neurological Institute at St. Joseph's treats patients with conditions such as brain and spinal tumors, cerebrovascular conditions, and neuromuscular disorders. It is equipped with state of-the-art technology, including four biplane neuro-angio suites, three 3-tesla MRIs, five 1.5-tesla MRIs, one 3-tesla intra-operative MRI, one 7-tesla research scanner and multiple CTs. Researchers at Barrow have identified a novel receptor in the brain that is extremely sensitive to beta-amyloid peptide and may play a key role in early stages of Alzheimer's disease. Barrow researchers are also working with magicians to discover the brain's mechanisms involving attention and awareness, which are leading to new insights on treating ADHD, Alzheimer's disease and brain trauma.

University of California, San Francisco Medical Center. The 560-bed UCSF Medical Center is affiliated with the University of California, San Francisco. The Department of Neurological Surgery at UCSF has services at all major hospitals in the area, providing a full range of neurosurgical subspecialty care. UCSF neurosurgeons use intraoperative MRI scanners and image-guided systems for precise surgical navigation. The hospital's research program is founded on a tradition of bench-to-bedside translational research, with the goal of bringing promising new treatments from the laboratory to our patients. One novel therapy at UCSF Medical Center involves using a miniature nerve stimulator instead of medication for the treatment of profoundly disabling headache disorders.

University of Chicago Medical Center. The 520-bed University of Chicago Medical Center recently began construction of a new 10-story building that will have 240 beds and 24 ORs when it opens in 2013. Research laboratories in the Section of Neurosurgery are well-equipped for channel studies, microfluorometry, blood flow measurement, cellular neurophysiology, molecular biology, pharmacology, microscopy, biochemistry, tissue culture, histology and animal pathology. The Section includes ancillary services in neurology, neuropathology, neurophysiology and a sleep laboratory. Three full-time neuroradiologists, trained and experienced in interventional neuroradiology, work closely with the neurosurgical service

University of Pittsburgh Medical Center. UPMC, encompassing 20 hospitals, also has operations in Italy, Ireland, the United Kingdom and Qatar and has heavily invested in information technology. UPMC neurosurgeons work closely with colleagues at the organization's Cancer Institute on brain, pituitary, spinal and peripheral nerve tumors. Advanced techniques allow for the removal of tumors that are of sizes and in locations of the brain that once would have been considered inoperable. UPMC neurosurgeons have performed more than 1,000 innovative surgeries in the past decade, removing brain tumors through the sinuses and nostrils. They have begun to perform brain surgery through a straw-like device to remove tumors deep in the brain. In addition to being one of the nation's premier users of Gamma Knife surgery, UPMC employs magnetoencephalography equipment for registration and localization of neural activity in brain research and in clinical practice. ■

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Total U.S. Costs for the Top 10 Most Frequent Principal Diagnoses

$329.2 billion was spent on community hospital stays in 2006, according to the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project (HCUP). Overall, the inflation-adjusted cost of hospitalization in the U.S. grew 52 percent from 1997, when it was $216.3 billion.

Here are the top 10 inpatient hospital principal diagnoses with the highest aggregate costs, along with their total inflation-adjusted hospital costs in 2006 and percentage of total costs, according to HCUP.

1. Coronary atherosclerosis (coronary artery disease) — $17.5 billion (5 percent)
2. Acute myocardial infarction (heart attack) — $11.8 billion (4 percent)
3. Congestive heart failure — $11.2 billion (3 percent)
4. Liveborn (newborn infant) — $10.8 billion (3 percent)
5. Osteoarthritis (degenerative joint disease) — $10.3 billion (3 percent)
6. Septicemia (blood infection) — $10.2 billion (3 percent)
7. Pneumonia — $9.9 billion (3 percent)
8. Complication of medical device, implant or graft — $9.4 billion (3 percent)
9. Adult respiratory failure, insufficiency, or arrest — $8.1 billion (2 percent)
10. Disorders of intervertebral discs and bones in spinal column — $7.6 billion (2 percent) ■

Source: Levit K (Thomson Reuters), Stranges E (Thomson Reuters), Ryan K (Thomson Reuters), Elixhauser A (AHRQ). *HCUP Facts and Figures, 2006: Statistics on Hospital-based Care in the United States.* Rockville, MD: Agency for Healthcare Research and Quality, 2008. http://www.hcup-us.ahrq.gov/reports.jsp

Hospital CEO Spotlight: Q&A With Jane Keller of Indiana Orthopaedic Hospital

By Lindsey Dunn

Jane Keller, RN, CEO of the Indiana Orthopaedic Hospital in Indianapolis, has been in the healthcare field for more than 20 years, working first as a trained RN in the operating room and later specializing in orthopedics. Here, she discusses some of the decisions, challenges and accomplishments that have shaped her career.

What is the best decision you've made in your current position?

The best decision I made as CEO was to surround myself with a knowledgeable management team. They are smart, talented people who share the same values and vision of our organization. They are willing to challenge the conventional wisdom and think creatively and innovatively, and they make me better at my job.

What is the most difficult decision you've had to make in your career?

Without a doubt, the most difficult decision for me was to move into administration full time. As a nurse, caring for patients is my passion as well as my profession. I'm thrilled that I accepted the challenge of leading IOH because now I care for my patients in a strategic sense, working with our physicians and our entire staff to create a patient-focused, healing environment.

What is your proudest accomplishment at your organization?

Our proudest accomplishment is achieving our HealthGrades rating each year for total joint replacement, placing us among the top hospitals in the country in this specialty. This complements our hospital's HCAHPS results for patient satisfaction, which continues to recognize the overall patient experience at IOH as one of the best in our area. These measurements show that our physicians and staff are committed to providing high quality, patient-focused orthopaedic care to our patients.

What is the best part of your job?

The best part of my job is hearing from our patients that they and their families had a wonderful experience and received wonderful treatment from the staff. These are folks who were in the hospital — and they enjoyed the stay. I read their e-mails and comments, and I'm especially grateful when they recognize the nurses and other caregivers by name. This allows us to recognize those individuals for the great job they do.

What is the most significant obstacle your organization has faced and how did you overcome it?

The ongoing legislative battle with those who want to close physician-owned hospitals. As the CEO of a hospital owned by physicians, I continually struggle to understand why opponents of physician ownership — which has a century-long tradition in this country — want to deny patients greater and more convenient access to high-quality care in a patient-focused setting and threaten the economic contribution we make to our communities.

What do you anticipate as the biggest challenge you will face in the future?

Our biggest challenges in the next few years will be surviving the challenge to physician ownership; continuing to provide the level of care we committed to when we opened IOH, while facing the unknown of healthcare reform; and the issue decreasing reimbursements for that care. In addition, patients are becoming sophisticated healthcare consumers who will be "shopping" for their healthcare needs in the next several years. We will have to be creative in gaining our share of that market.

What is one thing that you wished you would have known before taking on this position?

That my life would be consumed with meetings!

What is your biggest goal for your organization in the upcoming year?

Our biggest goal is delivery of safe, high quality care to our patients. We also continue to maximize operational efficiencies at IOH, making sure we are prepared for the healthcare reform that is coming. We continue to look at supplies, implants and contracts to make sure we are getting the best value for our dollar — which helps lower the cost of healthcare overall. ■

Learn more about Indiana Orthopaedic Hospital at www.indianaorthopedichospital.com.

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Finding Dollars in Unexpected Places: 4 Best Practices for Hospitals From Studer Group's Stephanie Baker

By Lindsey Dunn

Hospital leaders seeking to improve the financial success of their facilities have two options: to increase revenue through higher volumes and more services or to decrease expenses by increasing efficiency and avoiding costs, says Stephanie Baker, RN, CEN, MBA, HCM, a coach with Studer Group, an outcomes-based healthcare consulting firm.

Ms. Baker shares the following four best practices for hospitals to help increase revenue and decrease expenses.

1. Hourly rounding on inpatients. Hourly rounding by nurses on inpatients can help reduce both falls and pressure ulcers, which can be costly to hospitals.

According to a study performed by Studer Group's Alliance for Healthcare Research —and published in *American Journal of Nursing*— hourly rounds can reduce patients' call light use by 38 percent, patient falls by 50 percent and pressure ulcers by 14 percent, while increasing patient satisfaction dramatically.

Studer Group estimates the cost of falls at $11,042, the Centers for Disease Control's national average at the time of the study. Thus, hospitals that are able to reduce falls may significantly improve the financial performance of their facilities. One hospital that Ms. Baker coaches saved $700,000 in seven months by reducing falls and pressure ulcers through hourly rounding.

So how should a hospital institute effective hourly rounds?

"Hourly rounding should be performed in a very prescriptive manner," says Ms. Baker "Nurses should check on all patients every hour and should complete any scheduled tasks for the patients during these rounds, since they're already in the room."

Ms. Baker recommends a protocol for hourly rounding that focuses on "the three P's" — pain, personal needs and positioning.

"The top three reasons patients use the call light is because they are in pain, they need to use the restroom or they need something that is out of their reach," says Ms. Baker. "The 'three P's' directly correlate to these patient needs." In addition to the savings hourly rounds can provide to hospitals through cost avoidance, fewer call lights allow nursing staff to be more efficient by minimizing their interruptions. This improves employee satisfaction by giving nurses more control over their day.

2. Hourly rounding in the emergency department. Hourly rounding in the emergency department increases patient volume by decreasing the likelihood that patients will leave the department without being treated.

"If you have an emergency department where patients are in the waiting room for long periods of time without any information, they are more likely to leave," says Ms. Baker. "Some may think that it's only uninsured patients who are leaving the ED without being seen, but more than likely it's those that have insurance who are leaving since they have other choices."

At $400-$500 net revenue per patient, a 36,000 patient per year ED that reduces the left-without-being-seen rate by 4 percent through hourly rounding would yield an additional 1,440 patients per year, or $720,000 in captured net revenue.

Hourly rounds in the emergency department waiting room should focus on updating patients on wait times and status as well as on managing their pain. Rounds in the treatment area of the ED should include updating the patient on their plan of care and how long tests and labs will take.

"Hourly rounds in the emergency department absolutely create a better experience for patients, and a positive ED experience will spread through word of mouth in your community, improving your reputation and increasing your patient volume," says Ms. Baker. "Hourly rounding also reduces risk through lower litigation."

3. Pre-procedure and post-discharge phone calls to patients. Phone calls to patients with upcoming appointments or outpatient surgeries and post-discharge calls to inpatients can also positively impact hospital finances. By providing a reminder for the appointment, pre-procedure calls reduce the number of no-shows, yielding direct revenue gains, says Ms. Baker.

These calls are best completed 48 hours in advance of a patient's procedure, she says. By including the name of the provider that the patient will be seeing in the pre-call, providers establish a relationship between the patient and the caregiver even before the patient visit.

"If a call is made just 24 hours in advance, it's more difficult to fill slots by patients who want to reschedule," says Ms. Baker. "However, pre-procedure calls, done properly, will greatly reduce your patient no-show rate, which directly increases your revenue."

In fact, if a hospital pre-called 100 percent of its MRI patients and reduced no shows by three patients per day at $400 per patient, it directly increases revenue by $1,200 per day, or more than $400,000 per year.

Ms. Baker also recommends that hospitals perform post-visit phone calls for all inpatients that are discharged home. During these calls, hospital staff can confirm discharge instructions and ask questions about the patient's clinical status, which reduces patient anxiety and improves compliance with physician orders. By asking about patient concerns or complaints, leaders can make immediate changes to improve the patient experience immediately without waiting for survey results.

These calls can also reduce unscheduled readmissions. Since CMS does not reimburse for readmissions within 30 days for some chronic conditions, such as congestive heart failure, these calls can help hospitals avoid significant costs.

4. Peer interviewing. The activities associated with recruiting and replacing staff can be very costly, so strategies to reduce employee turnover are key to improving a hospital's financial picture. Selection strategies, such as peer interviewing, help ensure that the hospital is hiring the best candidate for the organization, which increases retention, Ms. Baker notes.

In the peer interviewing process, Studer Group recommends that candidates are first screened by the human resources department and then the department manager. The department manager then selects 2-3 candidates for each position, passing them along to a panel of 3-6 high-performing employees within the department. When selecting candidates to forward to the panel, it is important that manager only forward candidates that he or she would feel comfortable hiring. Using behavioral-based questions, these peers interview all candidates individually and then meet to decide on their preferred candidate.

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"Peer interviewing requires a group of your top performers to agree and commit to the idea that this is the right person for your organization," says Ms. Baker "If you want to make good choices about hiring, peer interviewing is vital."

Hospitals also need to move quickly through their hiring process in order to attract the best candidates. "We recommend that leaders call and screen potential candidates within two business days of receiving their application," says Ms. Baker. "If you move slowly, you'll lose your best candidates to other institutions."

In addition to selection strategies, Studer Group recommends that hospitals interview new employees at both 30 and 90 days of employment to ensure early retention.

"There are a lot of risks in the first 90 days of employment," says Ms. Baker. "I recommend that all new employees have a formal sit down with their supervisors at 30 and 90 days. At 30 days, ask what is working well and who has been helpful to the employee. Find out about employee concerns and then discuss the employee's performance. At the 90-day mark, repeat these questions and also ask if the new employee knows anyone they might like to refer to the organization for employment."

Determining true financial impact

The best way to determine the true financial impact of these best practices is to use your organization's own real numbers, advises Ms. Baker.

"Since these numbers vary widely from one hospital to another and differ by geographic region, the most accurate measure of cost avoidance or higher revenue comes by calculating real costs in your own organization," she says.

Ms. Baker recommends that hospitals use their own data to determine the answers to questions such as: "What does a fall cost your organization," "how much does it cost you to recruit and train a new nurse" and "what is your cost for an MRI?"

"The best way to get buy-in from administration and staff is to present the data in a meaningful and timely manner," says Ms. Baker. "When you are trying to implement a change, showing a true return on investment will help get others on board so you can move organizational performance." ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

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Hospitals Make CEO, CFO Changes Across the Country

Here is a round-up of 22 of the most recent changes and appointments of CEOs and CFOs made across the country. *Note:* items are listed alphabetically by state.

1. Children's Hospital in Oakland, Calif., appoints Bertram Lubin, MD, as its CEO, after the departure of Frank Tiedemann.
2. Doctors Medical Center in San Pablo, Calif., names Richard Reid as its new CFO.
3. Valley Presbyterian Hospital in Van Nuys, Calif., appoints Gustavo Valdespino as its new president and CEO.
4. The Villages (Fla.) Regional Hospital names Tim Hawkins as its new CEO, replacing Tim Menton who resigned.
5. Grady Health System in Atlanta announces Sue McCarthy as its new CFO.
6. Morgan County (Ga.) Hospital Authority names Brian Riddle as the interim CEO of Morgan Memorial Hospital in Madison, Ga.
7. OSF Holy Family Medical Center in Monmouth, Ill., names Patricia Luker as its CEO and president, following the retirement of Donald Brown.
8. Harbor Hospital in Baltimore names Dennis W. Pullin as its new president.
9. Kenneth Hanover resigns as CEO of the Health Alliance of Greater Cincinnati (Ohio) to become CEO of Beverly (Mass.) Hospital.
10. Elaine Ullian, CEO of Boston Medical Center, announces she will retire in Jan. 2010.
11. Saints Medical Center in Lowell, Mass., names Stephen J. Guimond as its new CFO.
12. The CEO of Three Rivers (Mich.) Health, Matt Chambers, resigns, relocating to Utah.
13. Rainy Lake Medical Center in International Falls, Minn., announces Robert Henshaw as its CFO and Douglas Johnson, MD, as its chief medical officer.
14. Allina Hospitals & Clinics in Minneapolis, Minn., announces Duncan P. Gallagher will serve as executive vice president and CFO.
15. Southeast Missouri Hospital in Cape Girardeau, Mo., names Debra Linnes as its new president and CEO.
16. Liberty Health in Jersey City, N.J., names Paul Goldberg as its new CFO.
17. Marion (Ohio) General Hospital announces John Sanders as its new president.
18. Tim Trottier resigns as CEO of Natchez (Miss.) Community Hospital to take over as CEO of Easton (Pa.) Hospital.
19. Lifespan names Timothy J. Babineau, MD, as the president of Rhode Island Hospital and Miriam Hospital in Providence, R.I.
20. Whidbey General Hospital in Coupeville, Wash., names Tom Tomasino as its new CEO.
21. The CEO of Capital Medical Center in Olympia, Wash., Michael Motte, resigns and a nationwide search for a replacement is underway.
22. St. John's Medical Center in Jackson Hole, Wyo., signs Pamela Maples Maher to a six-month agreement to become the hospital's new CEO, replacing Jim Schuessler. ■

Note: For more information on hospital C-suite changes, visit www.HospitalReviewMagazine.com and sign-up for the free *Becker's Hospital Review* weekly electronic newsletter at www.hospitalreviewmagazine.com/enewsletter.html. Share your C-suite news by e-mailing Scott Becker at sbecker@mcguirewoods.com.

PHYSICIAN-OWNED HOSPITAL UPDATE

Five National Surgical Hospitals Rated as "Best in State" by Consumer Reports

Consumer Reports has ranked five affiliates of National Surgical Hospitals as the highest ranking hospitals in their respective states, according to a National Surgical Hospitals news release.

OakLeaf Surgical Hospital in Eau Claire, Wis.; South Texas Spine and Surgical Hospital in San Antonio, Texas; North Carolina Specialty Hospital in Durham, N.C.; Northwest Specialty Hospital in Post Falls, Idaho; and Cache Valley Specialty Hospital in North Logan, Utah, achieved the highest rankings among all hospital in their home states.

OakLeaf was also the highest ranking hospital in the national survey, with a score of 98.5 out of a possible 100 points.

Consumer Reports recently rated more than 3,400 hospitals in the United States using data from the Hospital Consumer Assessment of Healthcare Providers and Systems survey, which surveys more than 1 million patients. HCAHPS focuses on several areas of hospital performance including communication with doctors and nurses, pain control, cleanliness of room and the patient's overall experience.

See the *Consumer Report* ratings at www.consumerreports.org/health/doctors-hospitals/hospital-ratings.htm. ■

Learn more about National Surgical Hospitals at www.nshinc.com.

Consumer Reports Rates Physician-Owned Hospital as Best Hospital in Colorado

Consumer Reports has ranked Animas Surgical Hospital, a physician-owned hospital in Durango, Colo., as the top hospital in the state.

Consumer Reports recently rated more than 3,400 hospitals in the United States using data from the Hospital Consumer Assessment of Healthcare Providers and Systems survey, which surveys more than 1 million patients. HCAHPS focuses on several areas of hospital performance including communication with doctors and nurses, pain control, cleanliness of room and the patient's overall experience.

See the *Consumer Report* ratings at www.consumerreports.org/health/doctors-hospitals/hospital-ratings.htm. ■

Learn more about Animas Surgical Hospital at www.nshinc.com.

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New Heartland Health CEO Brings Physician's Perspective

By Leigh Page

When Mark Laney, MD, became president and CEO of Heartland Health in St. Joseph, Mo., on Aug. 3, it was the first time in a quarter century that someone new had come into the position. However, he brings substantial experience into the job.

As president of Cook Children's Health Care System in Fort Worth, Texas, Dr. Laney formed one of the largest pediatric multi-specialty practices in the United States, developed a network of neighborhood clinics for low-income families, and introduced advancements in evidence-based medicine, clinical informatics, and quality and safety.

Here, Dr. Laney discusses how his experience will help in his new role and some of the challenges and opportunities at Heartland Health.

Q: How does your background as a physician — in fact, as a pediatrician — serve you as CEO? What challenges do you think it might present?

Dr. Mark Laney: The greatest issues hospitals face are around quality and safety of care. My background as a physician allows me to see through the patient's eyes by means of the physician-patient relationship. It is a significant advantage to have trained and worked as a physician and then to be able to translate that experience into a leadership role.

Having a pediatrics background helps because pediatricians tend to be soft-spoken and have a lot of patience — that's what is needed to treat children — and those characteristics translate very well into leadership. This is why a large number of physician-leaders come from pediatrics.

A physician-CEO is still an unfamiliar figure at most of the 5,000 hospitals across the nation. However, those who are familiar with the Cleveland Clinic, Mayo Clinic and the M.D. Anderson Cancer Center know this special relationship works very, very well.

Q: You are moving from leadership of Cook Children's Health Care System in Fort Worth to leadership of Heartland Health in St. Joseph, Mo., which is not just for children and serves a large rural region. How is Heartland different from Cook's?

ML: The only difference is really serving adults and adult medical problems here at Heartland, in contrast with pediatrics at Cook's. The similarities are far greater than the differences. Both organizations are integrated systems, have multi-specialty physician practices, employ 3,000-4,000 people, have multiple subsidiaries including a charitable foundation and serve very large geographic areas. So the similarities between the two are much more striking. When I told my physician colleagues where I was going and described Heartland, they weren't surprised at all.

Q: At Cook's, you helped found the System Clinical Excellence Program, integrating clinical practice, evidence-based medicine, safety, quality and clinical informatics. Why was that program important and how did you carry it out?

ML: That sort of program is the future of modern healthcare. Payors, the government and patients expect high quality, excellent safety and a very robust clinical informatics program. Integrated systems are judged today by their quality and safety; that's what the benchmark is. In the future, this may affect how institutions are reimbursed and how individuals choose healthcare institutions, through greater transparency on the Internet. We put together a committee of interested physicians and groomed one of them to chair the program. Over several years, he obtained funding to be medical director of the program. We integrated that committee with a clinical informatics committee so that we could build the quality and safety goals and tools into the information system that we were using.

Q: You have described Heartland Health, an integrated delivery system with a 350-bed hospital, 90-physician Heartland Clinic and a health plan, as "a real jewel." What impresses you most about it?

ML: There are two things. One is the people. They are passionate, caring and down-to earth. Whether it's a physician, nurse, therapist or the person who works in the lab or in dietary, people make an institution great. Certainly in healthcare that's true.

The second thing is that over the last 20 years this organization has done a great job of creating the infrastructure of an integrated system, which is ideally suited to successfully face challenges in healthcare. Most hospitals consist of just the hospital; they don't have a physician group, a foundation, community education, home health or hospice. These are the pieces that need to fit together to seamlessly create care across the spectrum. Heartland has it all. We are well positioned to be able to deal with whatever comes along in healthcare.

Also, at Heartland we work not just on quality of care but on improving the health of people in our community and region. Our goal is that you don't have to come to the hospital. This is a completely different mindset from 10 or 20 years ago. Lowell Kruse, my predecessor at Heartland, was a visionary who understood that improving community health doesn't just mean teaching people about diabetes or high blood pressure; it also means boosting the number of kids who go to college, are volunteering and understand what it means to be part of a community. Heartland is very advanced in how it reinvests in the region it serves. We're not just building a great hospital but are also improving lives in the community. That's what excites me. It's a great opportunity.

Q: You want to help raise Heartland Health "from good to great." What kinds of plans do you have in mind?

ML: Today, I don't have any specific plans, because, as I've said, the first thing I want to do is listen. I want to listen to patients. I went and visited a patient today. I just walked into a room and asked her how she was doing. She said, "You're the new CEO, aren't you?" And I said, "Yes I am." I asked her how we were doing and if there is anything we could be doing better. I want to listen to employees and also members of the community.

We have the opportunity to be one of the great integrated health systems in America. We also can have one of the greatest multi-specialty group practices, well aligned with the hospital. I truly believe that Heartland can be the best and

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safest place to receive healthcare, raise a family and live. The size, demographics and resources of the community — they're all here. When people at Cook's asked me why I was leaving I answered that we'd done wonderful things there. The physician group we built was truly amazing. I wanted to go and create some more magic. My strength is in physician relationships, taking a loose affiliation of physicians and molding them over time into a group that is completely aligned with the same goals.

Q: You have said integrated health systems and team medicine have had "a life-long influence" on you, ever since you were a fellow in pediatric neurology at the Mayo Clinic in Rochester, Minn. Can you explain why these concepts are important?

ML: In 1910, Dr. Will Mayo gave a commencement address at Rush College of Medicine in Chicago. He said the time had come for individual physicians to join forces because, at that point in time, the knowledge of medicine was so immense that one person could not know everything. That was almost 100 years ago. He said physicians working together as a group could best meet the needs of the patient. And his divining benchmark was that the needs of the patient come first. Think about how much things have changed, how much more complicated medicine has become today. It only makes sense to me that the team approach of doctors working together would best meet the needs of the patient. It was true 100 years ago and it's even truer today.

Q: What is your biggest goal for Heartland Health in the upcoming year?

ML: My biggest goal is to gain the trust and respect of physicians and staff and articulate my goals and expectations. Remember, this organization had a CEO who was here for 25 years. Even though the hand-off has gone incredibly smoothly, it's still a big change. People need to get used to my style and the fact that I am looking at everything with a fresh set of eyes. That is the most important thing. If we make this transition well, the rest will fall into place.

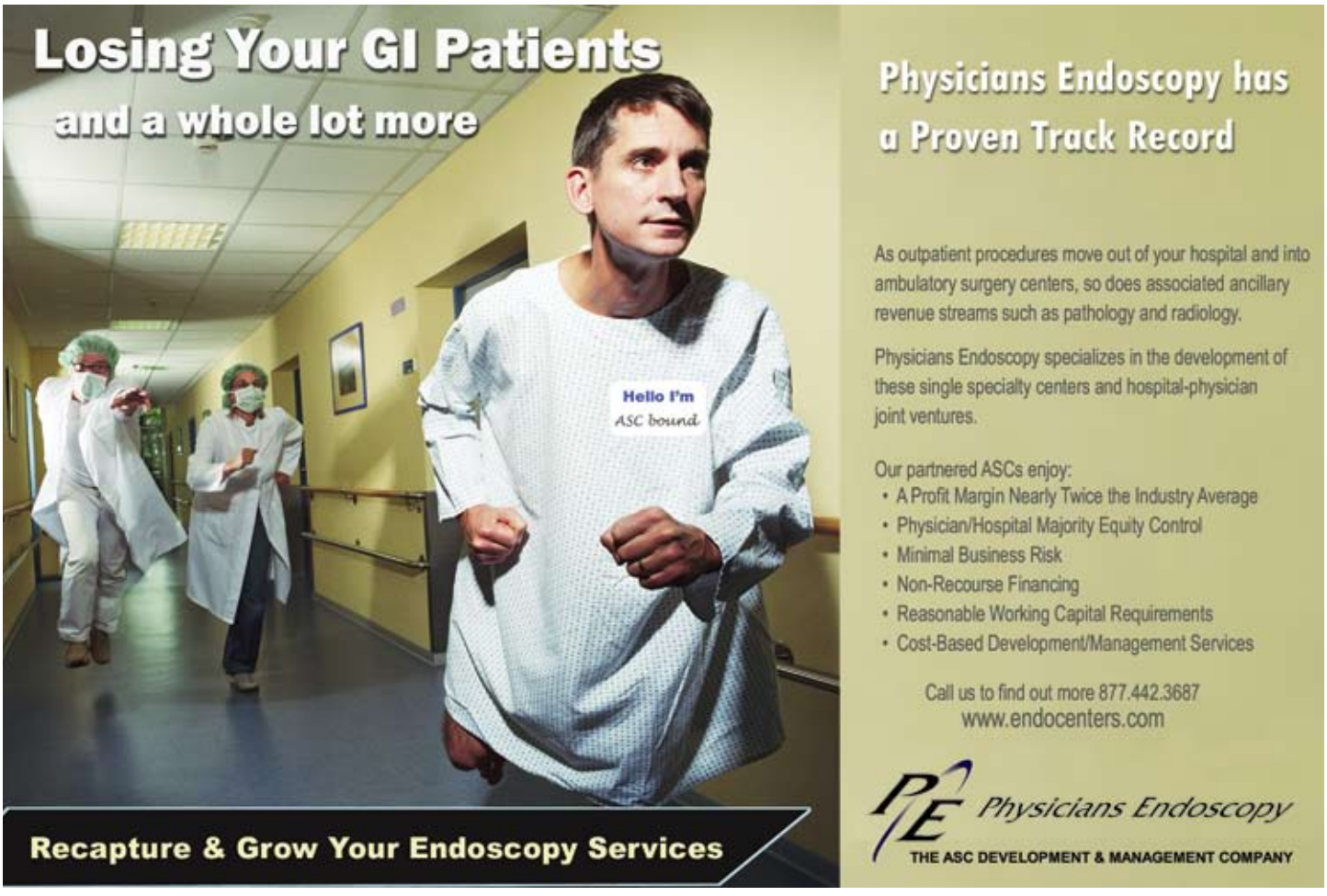
Q: What do you anticipate as the biggest challenge you will face in the future and how do you think you will work to overcome it?

ML: The biggest challenge is dealing with healthcare reform. My anticipation is that hospitals, group practices and integrated systems are going to be asked to take care of more people that have more complex problems with fewer resources. I think the only way for us to do that is to be extremely efficient and aligned in how we are taking care of our patients. We all have to be on the same team in order to create that efficiency.

Q: What is the best advice you've ever received about running a hospital and who was it from?

ML: The best advice I've received came from Russell Tolman, who was the CEO of Cook Children's Health Care System for 25 years. He looked at not-for-profit hospitals as a sacred trust. He said that the goal of the CEO should be to make sure that that institution was there for the children and grandchildren of the community. He also knew and appreciated that healthcare is not just a business; it's far more complicated than that. ■

Learn more about Heartland Health at www.heartland-health.com.



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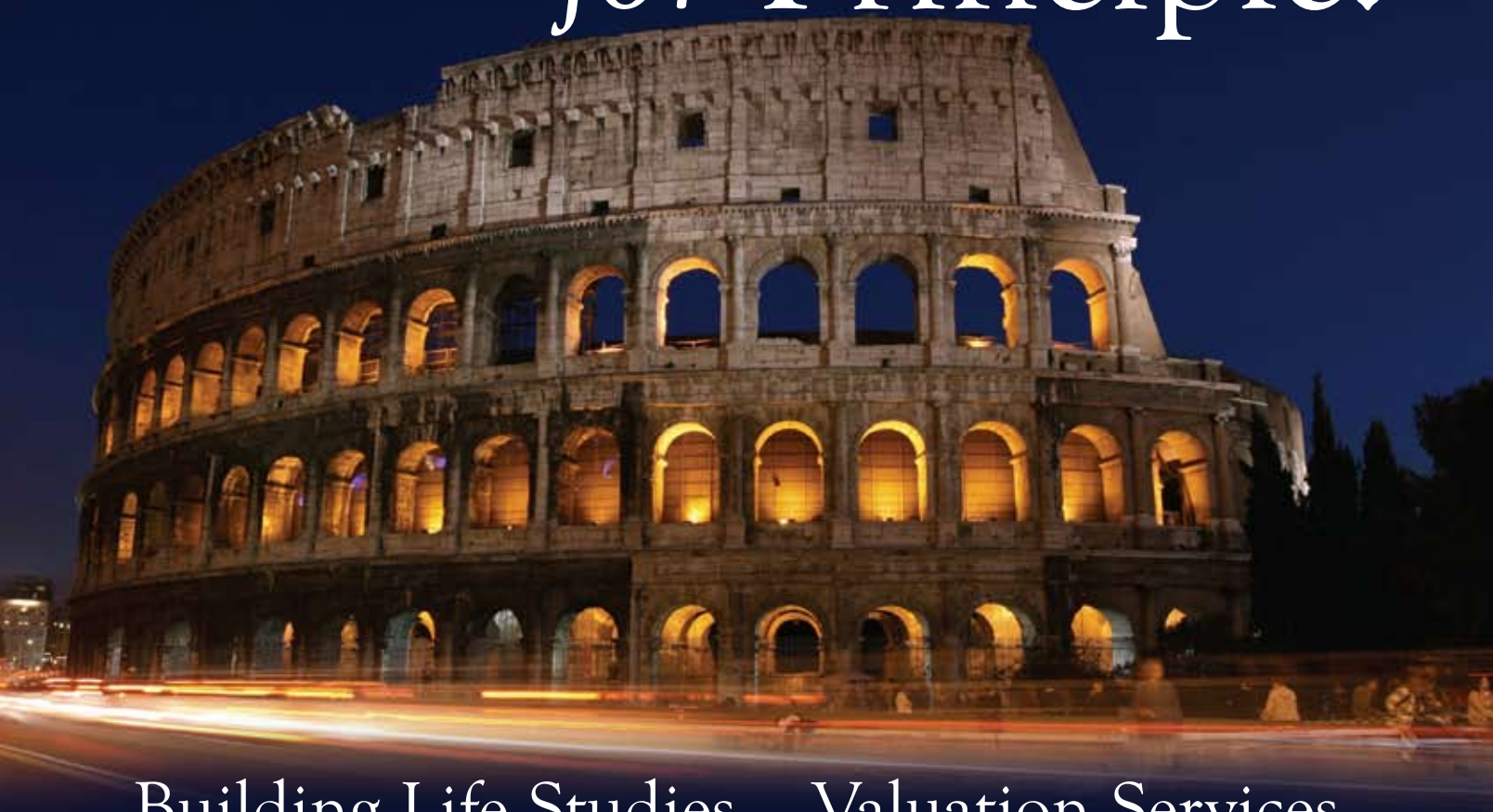

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4 Trends in Hospital Financing: Discussion With Claudia Gourdon of Healthcare Finance Group

By Renée Tomcanin

Financing and access to capital are critical to hospitals' operations, as financing helps hospitals fund projects and provide liquidity to maintain and improve patient care.

However, the economic downtown of the past year has changed how much capital hospitals have access to, and what kinds of projects hospitals can realistically finance.

In this article, Claudia Gourdon, senior vice president of New York-based Healthcare Finance Group, discusses four trends in hospital financing.

1. A bifurcated market

According to Ms. Gourdon, the current credit market has exacerbated the differences between investment grade rated hospitals and non–investment grade rated hospitals.

The investment grade hospitals are generally larger and have a more diverse population base than non-rated hospitals, and, according to Ms. Gourdon, they are the ones with better access to capital in the current market. "They have more resources than the non-investment grade hospitals," she says, "both banks and the public market are more willing to provide financing."

While there has been a general increase in financing costs, the non–investment grade hospitals have seen a relatively higher increase in their rates, as more banks and lenders have become more conservative when considering providing loans, according to Ms. Gourdon.

2. More hospitals looking for working capital, fewer real-estate loans

Ms. Gourdon's company provides asset based revolving lines of credits to the healthcare companies that come to HFG looking for financing.

"Non–investment grade hospitals in particular are looking for assistance with working capital," Ms. Gourdon says. "They are looking for a way to pay for maintenance on their facilities, to cover payroll and to purchase equipment."

Ms. Gourdon notes that, in general, new construction, renovations and equipment purchases have been the biggest drivers of financing in the hospitals market. But, as a result of the credit crunch, Ms. Gourdon notes that "virtually no" real estate loans are being pursued.

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Additionally, she sees little cash flow lending. "Typically, cash flow loans are based off of a hospital's historical and projected earnings. In this environment, there is increased stress on the facilities, and it is hard for lenders to see [or predict] robust net earnings. Therefore, they have been more unwilling to lend on that basis," Ms. Gourdon says.

3. Consolidations and acquisitions can provide opportunities for hospitals

A nascent, and probably increasing, trend in the current hospital market has been acquisitions, joint ventures and consolidations, according to Ms. Gourdon. As a result, many hospitals have been looking to fund these kinds of arrangements.

"Hospitals are coming together," Ms. Gourdon says. "The weaker hospitals are being acquired by the stronger facilities. We have also seen a reallocation of services being provided." Joint ventures with physician groups and/or sales to hospital groups are also increasing in the current market.

For example, HFG recently helped to facilitate the sale of the Anaheim (Calif.) Memorial Medical Center by Memorial Health System to AHMC Healthcare, which operates seven hospitals. HFG provided a $17.5 million accounts receivable backed revolving line of credit to AHMC.

4. Healthcare reform will determine the future of financing for hospitals

In Dec. 2008/Jan. 2009, there was very little activity in the market because the credit markets were frozen, according to Ms. Gourdon. Although the markets have opened somewhat, the outlook for the future of hospital financing is uncertain because of the unknown outcome of the healthcare reform bills in Congress.

"Overall, we know that the monies available to healthcare will be increasing," Ms. Gourdon says. "However, there are a variety of bills that could have many different outcomes for different healthcare provider segments."

Ms. Gourdon says that subsidies are likely to be made available for primary care physicians, healthcare information technology and healthcare facilities in rural settings. Medical education, such as nursing programs, may also see greater government support.

Other sectors of the healthcare market, such as physician-owned specialty hospitals, home health and skilled nursing homes, may face increasing scrutiny under new legislation, according to Ms. Gourdon.

"There is evidence of some of these trends," she says. "It is clear that more money will go toward healthcare over the long haul. I also expect to see more money put into existing programs."

What to look for when looking for financing

Although the market is uncertain, financing is still available. Ms. Gourdon says that hospitals looking for capital should examine their potential lender before going forward with a loan.

It is also important for hospitals to consider the length of time required to close a financing and the process that may be required.

For example, companies looking to finance through HFG undergo a 5-7 week process. After a term sheet is agreed upon and signed, an audit is un-

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dertaken by officials from HFG who gather information on the accounts receivable, IT systems and cash receipts. At the same time, a credit analysis of the company is conducted.

Ms. Gourdon says once the due diligence and underwriting phase is complete, HFG may begin the documentation phase and finally close the loan.

"In general, a healthcare provider should look for companies who have maintained a consistent presence in your particular industry segment over a period of time," Ms. Gourdon says. "Some lenders with a presence in many different industries tend to go in and out of a particular industry or industry segment, and that lack of dedication can hurt a provider when times are difficult."

Ms. Gourdon also notes that hospitals should make sure that the company they choose to work with is solid from a financial point of view.

"You want to make sure that your lender is strong and committed to your industry and understands what you need," she says." You want them to be experienced and knowledgeable about your industry, especially if you need them to fund working capital." ■

For more information about HFG, please contact Claudia Gourdon at (203) 869-6768 or cgourdon@hfgusa.com. You can also learn more at www.hfgusa.com.

For more information or an introduction to any of the following companies, e-mail sbecker@mcguirewoods.com, call (800) 417-2035 or fax with the company circled to (866) 678-5755.

Resources

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