BY JAY GREENE

While many provider-owned health plans have lost money or failed to live up to expectations in the past decade, 38,600-member Clear Choice Health Plans is planning for growth in 2006 with the help of a $7 million in-state stock sale.

Last October, the Bend, Ore.-based plan sold 250,000 shares to 400 new shareholders in Oregon at $30 per share. For-profit Clear Choice was formed in 1998 by a provider coalition representing about 200 shareholders, mostly physicians and hospitals in the plan’s network.

Flush with cash, Clear Choice expects to look at product and geographic expansion and potential acquisitions of third-party administrators and small companies, says Patricia Gibford, the plan’s chief executive officer. “To grow the company, we needed access to capital that could not come from the medical community itself,” she says.

Clear Choice considered a nationwide

Continued on p. 2
Continued from p. 1

initial public offering, but the costs were too high, says Gunnar Hansen, the plan’s chief financial officer. “We had a great story to sell and wanted to broaden our shareholder base. It had been dominated by providers in the community,” Hansen says.

During the 1980s, physician- and hospital-led integrated delivery networks began forming health plans as part of a strategy to protect patient volume and combat the growing market clout of health insurers. But management problems led to financial losses.

With its growth plans, Clear Choice is betting against statistics: There’s been a 22% drop in hospital-owned HMOs to 682 in 2004 from 870 in 2000, according to the American Hospital Association. At the same time, the nation’s 10 largest managed-care companies have increased market share to 55% of total HMO enrollment in 2005 from 47% in 1987, says HealthLeaders-InterStudy, an information company.

“We see continued consolidation in the industry. Most of the activity we see is of provider-sponsored health plans being acquired,” says Ed Fishman, managing director with the investment banking firm Cain Bros. But “in specific regional or small markets, (provider-sponsored plans) may do well.”

A lack of capital for expansion is one reason why provider-owned HMOs have had difficulty competing, Fishman says. “It is not unusual for provider-owned HMOs to issue stock, but it is unusual for them to use the money for expansion,” he says.

Clear Choice’s members include 21,000 Medicaid enrollees; 10,000 Medicare Advantage members; 3,700 commercial members in small- and large-group plans; and 3,900 enrollees under third-party administrative arrangements.

Despite losing money on Medicaid, Clear Choice finished 2004 with net income of $9.6 million on revenue of $123.7 million. That was up 32% from net income of $6.5 million on $107.9 million in revenue in 2003.

Numbers from 2005 are not yet available. “We project very favorable growth” in 2006, Hansen says. “We have been averaging a 15% annual growth rate in membership and revenue the last five years.

‘We had a great story to sell and wanted to broaden our shareholder base. It had been dominated by providers in the community.’

—Gunnar Hansen
Chief financial officer
Clear Choice

We expect similar growth trends in the future.”

Gibford says diversification has kept Clear Choice growing. “We saw an opportunity to grow into Medicaid managed-care business” in 1997, she says. “We cut our teeth with a difficult Medicaid population and that helped us with Medicare.”

Clear Choice’s growth also has been stimulated by a healthy regional economy and stabilized by an organized hospital and physician network, Gibford says. The network includes 525 physicians, with a 50-50 mix of specialists and primary-care physicians in Central Oregon IPA, and nine hospitals that are part of the Central Oregon Hospital Network. “We have about 98% of the doctors and 100% of the hospitals in our network,” she says.

Early on, Gibford says Clear Choice made a critical management decision to contract with network hospitals and physicians in a “user-friendly” yet businesslike manner.

“Bad business decisions get you in trouble,” she says. “We looked at a lot of provider-sponsored plans and the big ‘P’ (provider) is the hospital systems, but we are not a hospital system.”

Gibford says she is not surprised that hospital-driven plans fail. “We believe our success is to develop a user-friendly relationship with all the players—members, employers, physicians and hospitals—and manage our administrative and medical dollars well.”

Clear Choice also has avoided the No. 1 mistake many unsuccessful provider-owned health plans often make: paying doctors and hospitals rates they want. “This is a business model, not a physician-reward endeavor,” she says.

Hansen says Clear Choice pays providers market-competitive rates but takes the extra step by working with providers on how to effectively manage healthcare costs. “We pay close attention to financials and we share a lot of information” with network providers, Gibford says.

Meanwhile, working closely with providers and members helps keep the plan’s administrative expenses low. “Our administrative expenses are 8%,” Hansen says.

A low member-turnover rate helps, Gibford says. “Our voluntary disenrollment for Medicare is very low,” she says. “We have lost one...
Like many small health plans, Gibford says, Clear Choice is challenged by a lack of electronic medical records. “We do not have EMRs. Some physicians have EMRs, mostly the larger groups that are doing their own thing,” she says.

But the company invests regularly in information technology to pay claims, track data and distribute clinical and financial information to network hospitals and doctors, Gibford says.

Another step Clear Choice plans this year is to develop a bonus incentive program to encourage physicians to improve quality. “We put simple things in place like radiology standards by taking dollars out of surplus,” Gibford says. “We will develop HEDIS (Health Plan Employer Data and Information Set) incentives soon for pay-for-performance.”

While a number of provider-owned health plans are part of integrated delivery networks, Clear Choice maintains an arm’s-length relationship with its shareholder doctors and hospitals to avoid conflict-of-interest charges, Gibford says.

“If I am a competing hospital, do I want to contract with an HMO that may be directing its patients to owner doctors and hospitals? I would think there is tension,” Cain Bros.’ Fishman says.

Fishman says competing insurers sometimes feel they are at a disadvantage because of the close relationship that provider-owned health plans have with their network doctors and hospitals. But Gibford says she hasn’t heard from insurers that they feel they are at a competitive disadvantage because Clear Choice’s shareholders are also doctors and hospitals in their network. “A couple years ago a hospital asked us to pay them better rates,” Gibson says.

A spokesman for LifeWise Health Plan of Oregon, a competing health plan also based in Bend, says HMOs in the central Oregon market compete fiercely on premiums and provider reimbursement.

Hansen says Clear Choice pays network providers rates similar to those of other health plans. “We make sure there is a relationship with the hospitals and physicians and us,” he said.

‘This is a business model, not a physician-reward endeavor.’

—Patricia Gibford
Chief executive officer
Clear Choice

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Jay Greene is a former Modern Healthcare reporter and now a freelance healthcare writer based in St. Paul, Minn. Contact Greene at jaywriter@comcast.net.
Surgery battle heats up
Tenn. association opposes out-of-hospital procedures

BY MICHAEL ROMANO
The Tennessee Hospital Association, which lost a court battle two months ago over new state guidelines governing office-based surgery, will now ask state lawmakers to overturn the new rules that officials say will greatly expand the kinds of procedures performed outside of hospitals, creating new safety risks for many patients.

Craig Becker, president and chief executive officer of the association, says the guidelines, which took effect in mid-October 2005, will increase the kinds of procedures allowed in doctors’ offices, including complicated Level III surgeries that last as long as six hours and require as much as 12 hours of recovery time. Two months ago, the Davidson County Chancery Court rejected the association’s request for a temporary restraining order to overturn the guidelines. The next step, Becker says, is the political process.

“The battle is still going on,” Becker says. “Basically, we’re going to the Legislature and take the battle there … we are certainly concerned about this, and we think the Legislature will share those concerns.”

The guidelines, established by the state Board of Medical Examiners, could endanger patients by increasing the number of office-based surgeries requiring anesthesia, Becker says. He says no one can accurately predict the rate of increase in complicated office-based surgeries, but says the new rules are almost certain to boost physicians’ business at the same time it reduces revenue at local hospitals.

“That’s what it’s all about—revenue,” he says. “It drains commercial-paying business from hospitals at the same time we’re seeing a tremendous increase in charity care.”

Yarnell Beatty, director of legal and government affairs at the Tennessee Medical Association, argues that the rules would actually decrease the number of office-based surgeries because the rules add additional oversight and regulations for any use of anesthesia. “These are rigid guidelines,” he says.

State officials say it was necessary to change the regulations because many complex medical procedures, including face-lifts, were routinely being performed in doctors’ offices without any oversight at all.
BY ANDIS ROBEZNIEKS

Along with buying such items as socks, corn chips and shampoo, consumers can now get a quick medical diagnosis from a nurse practitioner or physician assistant at dozens of retail stores across the country. Drugstores such as Bartell, Eckerd, Osco and Rite Aid as well as chains such as Cub Foods and Target are installing in-store clinics with specialist companies like MinuteClinic, Minneapolis, and Take Care Health Systems, Conshohocken, Pa.

The growth of such clinics prompted the American Academy of Family Physicians, which has worked with MinuteClinic and Take Care, to develop a list of necessary attributes for such clinics. The AAFP says in-store clinics should have:

■ A well-defined and limited scope of clinical practices;
■ Evidence-based and quality-improvement-oriented clinical services and treatment plans;
■ Formal connections with community physicians;
■ Codified systems for referring patients when symptoms exceed a clinic’s scope of services;
■ Electronic health records systems that can communicate with the patients’ family physicians.

Last year, the AAFP decided against fighting the growth of such clinics. In a memo, AAFP Board Chair Mary Frank, M.D., stated that “rather than expending energy in an ultimately unsuccessful attempt to ‘stop’ the retail clinic model,” the goal should be to ensure that the clinics provide accurate information and operate under desired AAFP guidelines.

There are indications of strong support for such clinics. In a Wall Street Journal Online/Harris Interactive Health-Care Poll in October 2005, 83% of respondents agreed that retail clinics could provide basic medical services on weekends or evenings, when doctors’ offices are typically closed.

That same month, the AAFP passed a resolution at its scientific assembly calling for an investigation into the growth of retail health clinics; identification of the essential elements that the clinics should include; and leadership for helping clinics meet community needs. A working group came up with the list of attributes, which was distributed to AAFP members Dec. 21, 2005, and posted on the AAFP Web site, aafp.org, in January.
Clinic wins McGaw Prize
Venice (Calif.) Family Clinic won the $100,000 Foster G. McGaw Prize for excellence in community service. Prize judge Susan Manilow, chairwoman emeritus of not-for-profit Sinai Health System, Chicago, commended the clinic’s “breadth and depth of primary healthcare and supportive services” for low-income, uninsured and minority patients in western Los Angeles County, according to a news release. Nearly 500 physicians volunteer to treat the clinic’s 22,000 patients. The annual award is sponsored by the American Hospital Association, Baxter International Foundation and Cardinal Health Foundation. Three finalists received $10,000 each: Franklin Community Health Network, Farmington, Maine; Health Communities Initiative of Bartholomew County, Columbus, Ind.; and Pitt County Memorial Hospital, Greenville, N.C.

Mayo pursues rural hospital
Mayo Health System, Rochester, Minn., agreed to lease and eventually own Cannon Falls (Minn.) Community Hospital. Beginning April 1, Mayo will govern, manage and lease the 16-bed rural hospital and Cannon Family Health Center for $1 per year from the Cannon Falls Community Hospital District. Glenn Christian, chief executive officer at Cannon Falls. The district will continue operations during the seven-year lease to raise $2 million for a replacement hospital, Christian says. Ownership will transfer to Mayo ahead of schedule if construction finishes before the lease expires. Mayo Health System owns 15 hospitals. Mayo family physician Greg Angstman will become Cannon Falls’ president, CEO and medical director; Christian will become the hospital’s administrator. Christian says Cannon Falls sought six requests for proposal and selected Mayo for exclusive negotiations in August 2005.

An unlikely source of capital
In a bid to restructure the debt of one of its hospitals, for-profit cardiovascular-care hospital company MedCath Corp. has arranged to borrow $20 million from a local not-for-profit health system. MedCath’s Harlingen (Texas) Medical Center will receive the loan from Valley Baptist Health System, a not-for-profit integrated healthcare system also based in Harlingen, to pay off debt and expand services. The first half of the loan will automatically convert to equity for Valley Baptist after three years if Harlingen Medical meets undisclosed financial thresholds, giving Valley Baptist a minority ownership stake in the general acute-care facility, says Art Parker, MedCath’s treasurer. Valley Baptist would then have the option of converting the remaining portion of the loan to ownership, but it would still be minority owner, Parker says. Harlingen used proceeds from the investment, along with a $40 million

Continued on p. 7

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Continued from p. 6

mortgage loan from a third-party lender, to repay an existing debt of $60 million to its majority owner, MedCath, Parker says.

**JCAHO taps doc expertise**

The Joint Commission on Accreditation of Healthcare Organizations named 18 doctors to a “physician engagement advisory group” in an effort to boost the medical community’s participation in the accreditation process and broaden physicians’ involvement in the JCAHO’s quality-of-care and patient-safety initiatives. The new advisory group includes physician quality directors and educators, chief medical officers, private-practice physicians and other leaders in the medical community. It will be chaired by William Jacott, the commission’s special adviser for professional relations. The JCAHO has identified efforts to boost physicians’ involvement in the accreditation process as a strategic priority.

Greater involvement by doctors is “critically important to the success of patient-care and patient-safety improvement efforts,” Jacott says.

**P4P penetration not too deep**

There is more buzz than bucks in physician pay-for-performance programs so far, according to an issue brief by the Center for Studying Health System Change, based on visits to 12 communities. Of the 12 communities, only Orange County, Calif., and Boston have significant physician pay-for-performance programs, according to the issue brief. In the remaining communities, “almost no physicians have received quality-related payments to date” and “physician attitudes about (pay-for-performance) range from skeptical to hostile,” the center says. The barriers to successful programs include physicians’ reluctance to submit to multiple performance-measurement sets, the difficulties in arriving at a consensus set and the prevalence of small-group practices.

**Faculty stressed out, too**

Stress among faculty members at U.S. medical schools has led to high levels of job dissatisfaction and anxiety, especially among younger faculty, with about 20% showing symptoms consistent with clinical depression, according to a report in the January issue of *Academic Medicine*. The report, based on survey responses from 1,951 academic physicians and basic science faculty at four medical schools, says the rapidly changing healthcare environment, financial instability and work-related strain have affected faculty members’ mental health and job satisfaction. About 35% of survey respondents say strain from work interferes with family life, and 30% say they are more on edge than before. “This study raises the concern that current medical students are being taught by faculty who are increasingly stressed and dispirited,” the authors wrote.

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OPINION

Conflicting priorities
Doc businesspersons should learn from Cleveland Clinic

When physicians become businessmen and businesswomen, the intersection of clinical practice and business interest can be very dangerous. Just ask the prestigious Cleveland Clinic, which seems to have run a red light (See Special Report, p. 10).

It all started in December 2005, when Eric Topol, M.D., a renowned cardiologist, was forced out as the head of Cleveland Clinic’s medical school. The move came shortly after Topol testified on behalf of a plaintiff in one of the cases against drugmaker Merck over its actions regarding its Cox-2 inhibitor, Vioxx. Not long after, he criticized the clinic’s chief executive, Toby Cosgrove, M.D., for the latter’s myriad outside business interests.

Cosgrove recently resigned from the board of directors of AtriCure, a medical-device company whose surgical products have been used extensively at the clinic. The clinic is an investor in the company that is a supplier to the clinic. In addition, the clinic and Invacare are investors in NeuroControl Corp., another Cleveland-area medical company, and collaborators on a state-funded project to create a clinical tissue-engineering center that would develop new therapies.

There are many executives who make hundreds of thousands of dollars per year at their day jobs while taking lucre from vendors. They should devote themselves to that work and not to outside interests about which they feel the need to keep quiet.

Docs do IT for themselves

As president of a large independent practice association in Rhode Island, I wanted to let you know of another approach to information technology adoption by physicians here (January, p. 10). Our group, Rhode Island Primary Care Physicians Corp., is composed of 165 pure primary-care physicians in the fields of family practice, internal medicine, pediatrics and obstetrics/gynecology. We are responsible for the medical care of about 340,000 Rhode Island residents. In early 2002, after viewing 10 to 12 available EHRs, we decided to produce our own system. As a result, our sister company, Polaris Medical Management, embarked on the ambitious task of producing our own EHR.

In 2003, we introduced EpiChart, which has evolved into a fully functioning EHR system. The system has been completely designed and constantly updated by member physicians along with our IT team. It is currently used by about 100 physicians both from our group as well as doctors outside of our group. We feel that our uniqueness lies in the fact that our system is constantly improved and updated through the input of current user physicians, providing a highly user-friendly system.

Albert J. Puerini Jr., M.D.
President and chief executive officer
R.I. Primary Care Physicians Corp.
Polaris Medical Management
Cranston, R.I.

And some fan mail

I love the new electronic version of Modern Physician. Thank you!

Ronald E. Loveless
Vice president for healthcare
Hilb, Rogal & Hobbs of South Florida
Coral Gables, Fla.

Just a quick note that I really like the new Web approach you’re taking with Modern Physician. I look forward to seeing how this evolves throughout 2006.

Paul Berthiaume
Senior supervisor promotional writers
Medical Information Technology
Westwood, Mass.

What do you think? Let us and your fellow Modern Physician readers know. Send your letter to the editor to moddoc@crain.com.
A three-step program
Activism, grouping and technology can benefit docs

BY RICHARD L. REECE, M.D.

What can doctors do to improve their business prospects in 2006? Place your bets on three activities: political and business activism; creative grouping; and physician entrepreneurs using “disruptive technologies” to improve productivity.

Political activism is fundamental. Take the case of Tim Norbeck, who recently retired as executive director of the Connecticut State Medical Society. In 2001, with the help of other state medical society leaders, Tim and colleagues in other states launched an anti-racketeering lawsuit against national HMOs. In 2004, the lawsuit was settled in the doctors’ favor. The losing HMOs have funded two foundations—the Physicians’ Foundation for Health Systems Excellence and the Physicians’ Foundation for Health Systems Innovation—with $98 million. The money is being used for grants to help doctors become more efficient and to improve their practices, particularly in their use of electronic medical records.

Norbeck and his colleagues’ efforts show organized medicine can win business and political battles. Most of the $16 million in initial grants awarded went to primary-care organizations.

My other advice on political activism is this: Repeatedly inform your political representatives that Medicare cuts will create a political crisis among seniors, 65% of whom vote. Already 30% to 40% of doctors say they will not accept new Medicare patients if a 4% rate cut goes through this year. Medical student enrollment is dropping; fewer physicians are entering primary care; and a 50,000-doctor shortfall is predicted by 2010, a deficit expected to reach 200,000 by 2020. Politicians will soon be hearing from seniors who can’t find a doctor.

Physician-led economic grouping takes various forms—consolidation of small groups into larger groups, joint ventures with hospitals, ambulatory surgery centers, independent practice associations and community consortiums for implementing EMRs. My point is, in groups—tight or loose, even of “independent” practices—reside expertise, marketing clout and discount clout. The $16 million in grants awarded went to aggregated groups of doctors.

Should doctors team with hospitals or go it alone? Together is preferable, apart if necessary. It depends on physician relationships with hospital chief executive officers. It may depend on Stark laws, state certificate-of-need laws, or inspector general’s office regulations. Right now the feds are considering safe harbor exemptions for joint hospital-doctor EMR ventures. Generally hospitals have the brand-name recognition and other resources, including capital, to make a joint venture better than a solo deal. Also keep this in mind: Most hospital executives have concluded that partnerships with physicians are required for long-term survival. Success will depend on a critical mass and mix of hospital and doctor skills that appeal to consumers.

To crawl out of their economic holes, physicians must make the most of new technologies. The business world often speaks of “disruptive technologies,” which are just simpler, more-convenient and cheaper ways of doing things. James Weintrub, a plastic surgeon in Providence, R.I., with the help of a software expert, Greg Brownell, has converted the 400-page CTP code book and the 900-page ICD-9 book into one electronic volume. For $99 per year, you and your coding people can subscribe to this book by going to the Web site dpnx.com.

Why is this “disruptive”? Well, one, you can toss those bulky code books. Two, you can save time looking up those codes. Three, you can find out how codes really work. Four, you can speed health plan pre-authorization requiring codes. Five, you can control and capture charges for those procedures you perform out of your office.

What about EMRs? Don’t they qualify as disruptive technologies? Many are promoting EMRs as a holy grail. Everybody knows, except for practicing doctors, that EMR implementation is the thing to do. It’s being pushed by government, health plans, pundits, economists, and more than 100 EMR vendors, all of whom benefit one way or another by EMR implementation.

Certainly EMRs are disruptive. But they are not simple. They change workflow, initially lower productivity, suck up lots of money—as much as $44,000 per physician the first year—and encounter resistance from many physicians within any given group. But the handwriting is on the wall. By 2010, EMRs will probably be necessary for practice marketing and survival.

Richard L. Reece, M.D., is a pathologist, author and speaker based in Old Saybrook, Conn. He is also editor of Physicians Practice Options, a national monthly newsletter.
Walking the line
Cleveland Clinic navigates conflicts

BY MICHAEL ROMANO

The Cleveland Clinic ranks among the best-known hospitals in the nation, joining institutions such as Johns Hopkins Hospital and the Mayo Clinic among healthcare’s aristocracy.

But the elite institution is now struggling with ethical issues that have triggered an uncomfortable self-examination over potential conflicts in its business practices and the cozy relationships that exist between top officials, physicians and the high-tech vendors that sell products to the clinic.

Yet, despite the self-analysis and outside criticism, the brash Cleveland Clinic announced plans to co-sponsor a new educational track with a local university to better train future healthcare industry leaders (See sidebar).

Cosgrove ordered outside review of conflict policies.

Cosgrove, the hospital’s president and chief executive officer, asked for an independent review of conflict-of-interest policies just days after news reports in mid-December 2005 detailed his role as a board member of a medical-device company that the clinic helped found through a venture-capital partnership. The clinic reportedly owns about $7 million worth of stock in AtriCure, whose products are used by clinic doctors to correct atrial fibrillation.

Cosgrove, a well-known cardiac surgeon, invested in the venture-capital fund and served as a general partner until he cut his ties about late last year.

The well-publicized controversy at the famous hospital could trigger soul-searching at other institutions grappling with this potentially volatile mixture of private industry, academic research, patient care and profits.

For example, revelations of the Cleveland Clinic’s arrangements with vendors led to a critical reappraisal of the 3-year-old conflict-of-interest policy at the Johns Hopkins University School of Medicine in Baltimore, says Julie Gottlieb, assistant dean for policy coordination.

“I think many institutions are evaluating what policies and procedures they have in place to capture and manage or eliminate conflicts of interest,” Gottlieb says. “This (situation with the clinic) is a very high-profile case. It’s a strong reminder to all of us in this business that we need to make sure we have robust policies.”

Injecting reality
Ohio clinic, school team up to teach

BY MICHAEL ROMANO

The Cleveland Clinic is teaming with Case Western Reserve University’s Weatherhead School of Management on an educational program for healthcare executives as a way to boost the skills of tomorrow’s healthcare leaders.

As many as four “health-management scholars” will begin their studies this fall in the school’s MBA program, with a concentration of health systems management. The students also will fulfill “action learning” requirements through working on a real-life project for a local organization, a summer internship at the hospital and seminars taught by clinic managers.

Roomkin: A natural progression.

Weatherhead Dean Myron Roomkin says he knows of no other health-management program in the country with such a close relationship to an institution such as the Cleveland Clinic.

The clinic, he says, will help select the “elite” scholars and provide a learning laboratory that features the hospital’s top practitioners and administrators as teachers.

He says the collaboration, which provides considerable hands-on training to future leaders of healthcare institutions, is a natural progression in the long-term relationship between the two Cleveland institutions. Top clinic executives often enroll in the school’s executive education program, and the school is a pipeline for top managers at the hospital.

Continued on p. 11
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Continued from p. 10

that do business with their institutions, a situation that can generate at least the perception of a conflict of interest.

In February 2005, the National Institutes of Health unveiled a strict policy prohibiting all employees from taking drug-company money in the aftermath of news reports that raised questions about those relationships.

And just last month, an article published in the Jan. 25 Journal of the American Medical Association calls for rigid guidelines that would prohibit drug companies from providing physicians with gifts of any kind, saying that long-standing financial ties between the medical profession and pharmaceutical industry erode research integrity and hurt patient care. “No matter what you are told by any physician or administrator, these gifts—no matter how small—influence doctors’ behavior,” says David Rothman, president of the Institute on Medicine as a Profession in New York.

The think tank at the Columbia University College of Physicians and Surgeons helped fund the report by a group of about a dozen medical experts who urged academic medical centers to take the lead in abolishing gifts of any size, including meals, payment for travel or for participating in continuing medical-education programs, and to strictly regulate ties between doctors and drug companies.

Other recommendations include: replacing direct drug samples with a system of vouchers for low-income patients and insulating continuing medical education from industry influence by requiring companies to contribute to a central academic office that would disperse funds to individual programs.

“There’s kind of a tsunami of trouble out there for healthcare in terms of these kinds of conflicts,” says Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania. “The situation with the Cleveland Clinic may be a big wave, but it’s just one of many. It definitely gives the clinic a black eye. I think they’re going to have some work to do to rebuild their reputation.”

Like Gottlieb, Caplan says he thinks the harsh media attention focused on the Cleveland Clinic sends a “strong message” to other institutions that “You’d better re-examine policies and stances on conflicts of interest.” While he suggests that the industry “doesn’t know or have an agreement on how to manage conflicts of interest,” he says the simple formula boils down to two key principles: “One: Where there are conflicts, disclose them; and, two: Don’t study what you own.”

“I think the biggest lesson from the Cleveland Clinic situation is that no institution—even our best—has figured out a way to manage conflicts of interest.”
MATCHMAKING CHALLENGES

Finding the right kind of doctor is hospitals’ biggest physician-recruiting challenge, far outweighing hospitals’ ability to offer competitive incentives, according to a survey by Merritt, Hawkins & Associates. In addition, meeting the requirements of a physician’s spouse presents a significant challenge to hospitals’ physician recruiters, according to Merritt, Hawkins.

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<thead>
<tr>
<th>Challenge</th>
<th>Percentage of respondents rating it among most difficult</th>
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<tr>
<td>Finding physicians who fit facility’s parameters</td>
<td>55%</td>
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<tr>
<td>Geographic location of facility</td>
<td>50%</td>
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<tr>
<td>Meeting requirements of the physician’s spouse</td>
<td>43%</td>
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<tr>
<td>Overall physician shortage</td>
<td>35%</td>
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<tr>
<td>Ability to offer competitive incentives</td>
<td>29%</td>
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Source: Medical Group Management Association and Merritt, Hawkins & Associates 2005 Survey of Physician Recruiting Trends

PUTTING IN THE HOURS

Mean clinical service hours worked per week for selected physician specialities

- Cardiovascular surgery: 48.9
- Cardiology: invasive, interventional: 47.5
- Orthopedic surgery: general: 41.1
- Internal medicine: general: 37.9
- Family practice (without obstetrics): 36.7
- Pediatrics: general: 36.4

Source: MGMA Physician Compensation and Production Survey, 2005 report based on 2004 data

BIGGER PRACTICE, BIGGER PAYCHECK

Medical group CEO pay by practice revenue

- $2 million to $5 million: $106,685
- $5 million to $10 million: $128,448
- $10 million to $20 million: $153,910
- $20 million to $50 million: $189,317
- $50 million or more: $291,554

Source: MGMA Management Compensation Survey, 2005 report based on 2004 data
ASSOCIATIONS

GROUPS
Karl Ulrich, M.D., a psychiatrist who is a division medical director of the Marshfield (Wis.) Clinic, was named president of the medical group and health-care system. Ulrich is the 19th doctor to serve as the leader of the 728-physician group practice, replacing internist Frederic Wesbrook, M.D., 60, who completed his fourth term as president. Ulrich, 56, joined Marshfield in November 1995 and chaired the clinic’s department of psychiatry and behavioral health from 1997 to 1999.

HOSPITALS, SYSTEMS
Michael Eleff, M.D., was named medical director of the Cancer Institute of New Jersey at the Robert Wood Johnson University Hospital at Hamilton. Eleff, 51, was most recently chief medical officer for ITA Partners, an oncology disease-management company in Philadelphia … St. Luke’s Episcopal Hospital, Houston, promoted its chief medical officer, David Pate, M.D., to senior vice president and CEO. Pate, 49, a specialist in internal medicine, has both a medical degree and law degree. He is an adjunct professor at the University of Houston Law Center. The 685-bed hospital is the flagship of St. Luke’s Health System, Houston … Robert Ryan, M.D., was named chief medical officer of Bon Secours Hampton Roads Health System, Norfolk, Va. Ryan, 59, is replacing Thomas Thames, M.D., 50, who held the job on an interim basis and is now vice president of medical affairs at Bon Secours DePaul Medical Center in Norfolk. Ryan spent the past two years consulting with healthcare organizations, particularly on information technology adoption.

INSURERS
Aetna Chairman and Chief Executive Officer John Rowe, M.D., will retire to become a consultant for the health insurance giant at the end of 2006 when his employment contract expires. As of Feb. 14, Aetna President Ronald Williams, 56, will become CEO and take over management responsibility from Rowe, 61, who will trade in his chairman title for executive chairman through the remainder of his contract. Aetna, Hartford, Conn., says Rowe, as executive chairman of the board, will “continue to be an active, full-time executive” until his retirement and then be hired as a consultant to allow the company to tap into his “significant expertise on specific business issues related to health.”

SUPPLIERS, VENDORS
Russell Holman, M.D., 38, was promoted to senior vice president of Irvine, Calif.-based Cogent Healthcare, a provider of hospitalist programs. Holman, who will continue in his current role as national medical director, will help direct the overall medical operations and physician-development programs at Cogent, which manages hospitalist programs in more than 16 states … Richard Kremsdorf, M.D., 58, president and chief executive officer of CliniComp International, a San Diego-based provider of clinical information tools for acute-care hospitals and academic medical centers, resigned to become president of Five Rights Consulting in San Diego.