BY JAY GREENE

Total compensation jumped an average of 13% in 2005 for chief medical officers at hospitals and nearly 19% for CMOs at medical groups, according to a new survey by the Physician Executive Management Center, a search firm that specializes in physician-executives.

CMOs at integrated health systems and managed-care-type organizations also enjoyed total compensation increases of 14% and 16%, respectively. Total compensation includes base salary and end-of-year bonus payments.

Driving the double-digit percentage increases is the evolving strategy by healthcare organizations in rewarding CMOs with bonuses for meeting a combination of financial, quality, satisfaction and performance-related targets, says David Kirschman, president of the Tampa, Fla.-based management center. The organization released the 20th annual Physician

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“We are being graded and evaluated for quality improvement by a whole host of external organizations,” says Jeffry Komins, M.D., CMO at 266-bed Mercy Hospital of Philadelphia. “As those scores go up, hospital reimbursement goes up, market share goes up, and we are rewarded for our contributions through incentives.”

The survey includes data on base pay, incentives, benefits, contracts and several categories of job satisfaction. About 400 CMOs responded to the survey in four categories—hospitals, systems, physician groups and managed care.

Kirschman says healthcare organizations are placing greater value on CMOs because entities such as the CMS, the Joint Commission on Accreditation of Healthcare Organizations, payers and other information companies are tracking and publicizing quality data. “Organizations are recognizing that CMOs are a valuable part of the management team and are rewarding those contributions through higher compensation,” Kirschman says.

As key team members, CMOs are responsible for helping healthcare organizations improve clinical quality, patient safety, satisfaction and financial performance, Komins says.

For hospital-based CMOs, total compensation increased an average of 12.9% in 2005 to $273,712 from $242,507 in 2003. Over the past decade, total compensation has increased 41% for hospital CMOs. Bonus payments for 2005 averaged 17% of base pay for hospital CMOs. “Except for 2003-2004 (when total compensation dipped 3%), total compensation has steadily risen since 1991,” Kirschman says.

At integrated systems, CMO average total compensation increased 14.4% last year to $350,044 from $305,879 in 2003. Over the past 10 years, total compensation has risen 71%. Bonuses for 2005 averaged 21% for system CMOs. “Pay is highest here because CMOs at systems are responsible for multiple hospitals and have a larger scope of strategic responsibility,” Kirschman says. CMOs in group practices saw average total compensation increase 18.6% to $274,623 in 2005. Total compensation has risen 89% in the past 10 years. Bonuses for 2005 averaged 18% for group practice CMOs.

At managed-care-type organizations, CMOs enjoyed a 15.8% increase in average total compensation to $278,773 in 2005 from $240,674 in 2003. Total compensation has increased 44% over the past 10 years. Bonuses for 2005 averaged 25% for managed-care CMOs.

Compared with average compensation of practicing physicians, CMOs appear to be catching up with their specialist cousins. For example, sister publication Modern Healthcare’s 13th annual Physician Compensation Survey, which tracks surveys by professional medical organizations and physician recruiters, showed that noninvasive cardiologists in 2006 averaged $370,000, an 7.5% increase from 2005. General surgeons averaged about $284,000, a 1.8% pay hike.

“Going back a few years, CMOs were not reimbursed at the same level as practicing physicians,” Komins says. “I was a practicing obstetrician and gynecologist for 31 years and have enormous respect for the people at the front line. CMOs also have a very demanding job with long hours and the challenge of keeping up with regulations and integrating doctors and nurses into a team.”

Because of the ability of healthcare organizations to track and measure quality, the role of the CMO has changed over the past decade, says Paul Convery, M.D., CMO of 12-hospital Baylor Health Care System, Dallas.

In the past, healthcare organizations did not have defined methods to measure clinical quality, and CMOs were more involved in improving physician relationships.
which includes Alabama, Florida and North Carolina—to $283,000 in the 21-state West region, which includes Alaska, Louisianna, Nevada and North Dakota. Total-compensation data show the 12-state Northeast region, which includes Connecticut, Maryland, New York and Virginia, at $317,000 and the 10-state Midwest region, which includes Illinois, Missouri and West Virginia, at $302,000.

Kirschman recommends CMOs negotiate written employment agreements. Only 55% of hospital CMOs have contracts. Some 56% of CMOs at integrated systems have contracts, but only 43% for CMOs at managed-care organizations do. However, 75% of CMOs at group practices are under contract. “Contracts provide a certain degree of security that physicians will want more of as negotiations become more formalized,” Komins says. “Group CMOs have more contracts because they were practicing physicians with contracts with the group before, and when they emerged into a management capacity, they expected to continue in a contractual arrangement.”

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.

Convery says the increasing use of bonuses shows that many CMO compensation packages are tied to performance. Healthcare organizations “have expectations that (CMOs) will perform and show measurable improvements,” he says.

While not all healthcare organizations track all clinical measurements, Convery says Baylor tracks some 50 different clinical and patient-safety measures. “We develop teams of doctors and nursing leadership to improve care across the continuum,” he says.

The survey found that the use of incentives varies somewhat depending on the type of healthcare organization. For example, the top three incentive priorities for hospitals, integrated systems and groups are meeting financial objectives, quality and patient-satisfaction goals.

However, the top three goals for managed-care-type organizations are financial, strategic and utilization control/resource management, the survey showed. It was the first time the Physician Executive Management Center surveyed CMOs on incentives.

From a regional perspective, average CMO total compensation ranges from $328,000 in the seven-state Southeast region—

Cover Story

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Convery: The role of the CMO has changed.
Triad’s challenge
Joint venture faces big competition in Tennessee

BY VINCE GALLORO
Triad Hospitals has been the biggest proponent among investor-owned hospital chains of establishing joint ventures with not-for-profit systems. A recent deal, reached in June with four-hospital Baptist Health System of East Tennessee, Knoxville, could be the most challenging of the 10 joint ventures it has completed or agreed to.

The Plano, Texas-based company signed a letter of intent to acquire an 80% interest in Baptist. The plan is to form a joint venture under the Baptist name; Baptist would own a 20% stake and split the governing board members 50-50 with Triad. Physicians, who will be able to invest in the joint venture, would make up at least 50% of each hospital’s board.

While terms were not disclosed, Triad’s price would be large enough to allow Baptist to immediately pay off its $217 million debt. Triad also is granting Baptist a $40 million line of credit and has committed to spending at least $80 million on capital projects over the first five years of the joint venture, says Richard Cramer, chairman of Baptist Health System. The deal requires the approval of the executive board of the Tennessee Baptist Convention and the state attorney general, and should close by Oct. 31, Cramer adds.

Baptist Knoxville lost about $50 million over the past five fiscal years, Cramer says. In fiscal 2005, ended June 30, Baptist Knoxville recorded an operating loss of $9.4 million on net patient revenue of $254.6 million. Overall, the system recorded a net loss of $8.3 million on net revenue of $272.4 million.

“We had a positive cash flow; we were able to make our payments on our bonded indebtedness, but we couldn’t reinvest in our equipment like hospitals have to do nowadays to stay competitive,” Cramer says. With the debt paid off, the joint venture will have $25 million to $30 million more in operating funds that can go toward purchasing equipment, he says.

Cramer says there’s plenty of competition in Knoxville, a city of about 178,000 in which Baptist is the smallest of four hospitals for adults. The other competitors are Covenant Health, with two hospitals in Knoxville; St. Mary’s Medical Center (a member of Catholic Healthcare Partners, Cincinnati); and the University of Tennessee Medical Center.

The path to providing quality health care is clear

With over 2,500 accredited organizations throughout the ambulatory community, the Accreditation Association for Ambulatory Health Care (AAAHC/Accreditation Association) is the leader in ambulatory health care.

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To learn more about how the Accreditation Association for Ambulatory Health Care can put your organization on the path to quality health care, contact us at 847/853.6060 or info@aaahc.org, or visit www.aaahc.org.
Imaging issues
Radiologists worry proposed caps will cut revenue

BY JENNIFER LUBELL

Proposed caps to physician payments for certain imaging services have ignited concerns among members of Congress and radiologists that patients will end up getting shortchanged on care as radiologists take a big hit in revenue.

The change could result in “draconian payment reductions” for some imaging services in non-hospital settings, said cardiologist Pamela Douglas, M.D., who testified on behalf of the Coalition for Patient-Centered Imaging at a hearing of the House Energy and Commerce health subcommittee last month. Payments for positron emission tomography exams used to diagnose cancerous tumors, and bone densitometry studies to detect osteoporosis would be reduced by 50% and 40%, respectively, she says.

The Congressional Budget Office has projected that the caps could save Medicare $2.8 billion over five years, but the American College of Radiology estimates that the cost to medical providers could be twice that amount.

Patients could be hit hard, too. “Many physicians may be forced to limit the number of Medicare patients they accept,” and beneficiaries in turn could experience increased wait and travel times, particularly in rural areas, if these projected cuts are enacted in 2007, said American College of Radiology Chairman Arl Van Moore Jr., M.D., another witness at the hearing.

The Deficit Reduction Act of 2005 contained several provisions that affected Medicare payments for imaging services. One of the new policies would cap the “technical” component for physician office imaging (equipment, supplies and overhead) at the payment level established by Medicare’s hospital outpatient prospective payment system. This means that Medicare would not pay more under its physician fee schedule than it would pay under the outpatient PPS for the same procedure.

Medicare is often paying significantly larger amounts under the physician fee schedule than the hospital outpatient PPS for the same imaging service, depending on whether it’s administered in a hospital outpatient department or in a physician’s office, said Herb Kuhn, director of the CMS’ Center for Medicare Management, during the subcommittee hearing.

Van Moore: Docs may have to limit Medicare patients.
Docs to sell surgery center
LifePoint Hospitals, Brentwood, Tenn., says it has signed a definitive agreement to acquire Havasu Surgery Center, Lake Havasu City, Ariz., for undisclosed terms. The physicians who own the surgery center and others who practice in the market also will be invited to buy a share of the hospital-surgery center venture, says Brent Cherne, chief executive officer of the surgery center. The surgery center, which has annual revenue of about $5.5 million according to LifePoint, has cut into the business of 138-bed Havasu Regional Medical Center, Lake Havasu City, since opening in 2001. The surgery center in December 2002 filed a three-count antitrust lawsuit in Maricopa County Superior Court, Phoenix, against the hospital, then owned by Province Healthcare Co. The surgery center dropped one count and the judge in the case dismissed the other two in separate rulings, Cherne says. The center had an appeal pending, but Province made some concessions in return for ending the appeal in late 2004, Cherne says.

Troubled hospital changing hands
Vibra Healthcare, Mechanicsburg, Pa., says Oregon’s Human Services Department approved the company’s letter of intent to buy the former Physicians’ Hospital, Portland, for about $13 million. Thirty-nine bed Physicians’ Hospital has been closed since late May, when it rescinded its license. A spokesman for the state’s licensing department says the approval lets Vibra bypass the certificate-of-need process and gives the company until May 2007 to reopen the hospital. Vibra is in due diligence and expects to complete the acquisition by this month. It plans to renovate the facility before reopening it as an acute-care hospital in early 2007. The company then must wait six months before it can apply to the CMS to convert the facility to a long-term, acute-care

room, diagnostic services, surgery, and women’s and children’s health-care. The facility is expected to cost about $9 million. Mat-Rx will own 20% of the hospital, and physicians will own 80%, Mat-Rx Chief Executive Officer Greg Weiss says. Weiss declined to disclose the number of physicians involved with the project. Mat-Rx also owns 5% of an 18-bed, for-profit, general acute-care hospital that opened in Arlington, Texas, in 2003. Not-for-profit Texas Health Resources owns 25% of the Arlington hospital and physicians hold a 70% stake.

Doc-owned hospitals going up
Mat-Rx Development, Irving, Texas, says it will begin construction on a physician-owned, general acute-care hospital in Fort Worth, Texas, this month. The hospital, scheduled to open next summer, will have 15 to 20 beds, with room for expansion, and it will offer an emergency daily dose

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hospital. If the CMS approves the conversion, the facility would be the first long-term, acute-care hospital in Oregon, Vibra says.

MedCath’s change of heart
MedCath Corp., Charlotte, N.C., will sell its entire interest in the Tucson (Ariz.) Heart Hospital to Ascension Health’s Carondelet Health Network, Tucson, giving Carondelet a majority ownership in the 60-bed facility. Financial terms were not disclosed. The transaction, still subject to closing conditions, is expected to be completed by late September. Since 1999, MedCath—which focuses on the diagnosis and treatment of cardiovascular disease—has owned 58.8% of the Tucson Heart Hospital, while Carondelet has a 20% stake and physician partners own the remaining 21.2%. This deal will leave Carondelet with 78.8% ownership. O. Edwin French, president and chief executive officer of MedCath, says the company decided to sell now mainly to help engage the Tucson Heart Hospital in a managed-care network, which will happen after the hospital is integrated in Carondelet’s network.

Medtronic settles kickback charges
Medtronic, Minneapolis, will pay $40 million to settle civil whistle-blower charges that its Sofamor Danek division from 1998 to 2003 paid kickbacks to physicians, including lavish trips and sham consulting agreements, for using its spinal-implant products. The settlement includes a five-year corporate integrity agreement that focuses on employee training and sales and marketing compliance programs. Medtronic didn’t admit wrongdoing. The company says it cooperated fully with the federal investigation.

New medical campus in Florida
Boca Raton (Fla.) Community Hospital plans to build a $700 million replacement hospital on land leased from Florida Atlantic University, Boca Raton. The hospital will be part of a new four-year medical school campus that Florida Atlantic and the University of Miami’s medical school are developing. The Boca Raton community now has no resident-training programs, officials say. Michael Friedland, Florida Atlantic’s vice president for medical affairs, says the new campus is expected to enroll its first class of 64 students in 2007. The campus eventually will provide 200 to 300 medical residents to Boca Raton Community, which will be the school’s principal teaching hospital, and to four or five other hospitals in Palm Beach County, Friedland says. Boca Raton Community officials say the 530-bed hospital will replace the current 380-bed hospital and be financed by existing assets, operating funds and community contributions. Construction is expected to begin in 2008 and be completed by 2011.

Fran Hawkins Knows Healthcare!

Congratulations to Fran Hawkins, Hospital Planning Consultant with F. Hawkins & Associates, Lakemont, GA, on winning Modern Healthcare’s 30th Anniversary Trivia Contest!

Fran won hotel and air accommodations for two to New York City, along with tickets to the Broadway play of her choice!

We thank everyone who participated in our trivia contest. CLICK HERE to view all ten trivia questions and answers!

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Bridging a gap
Va. physician-run clinic could set standard for quality

Across the nation, physicians and hospitals continue their fractious ways. Hospital administrators are being forced out by unhappy doctors. Entire departments of physicians are leaving, setting up competing specialty practices such as imaging centers.

Meanwhile, physician incomes fell by an inflation-adjusted 7% from 1995 to 2003, according to a recent survey, and hospitals are losing revenue from competing facilities that siphon off the most lucrative procedures.

One hospital system has seen enough and wants to find a way out of the morass. Carilion Health System, Roanoke, Va., has launched a bold and risky plan to convert to a physician-run clinic focused on research and training (See story, p. 10). It’s a worthy experiment. If it succeeds it may be a model for other health systems, even for the healthcare system as a whole.

Edward Murphy, Carilion’s president and chief executive officer, says giving doctors control may end the competition that has hurt both sides of the doctor-hospital divide.

The incentive pay at the heart of the employment concept is key to the entire experiment. The medical chairs who will run the specialty departments will see their compensation linked to Carilion’s research and education achievements. Of course, none of the bonuses will happen if the clinic as a whole isn’t meeting financial targets.

Other strategies for aligning doctors with hospital goals all seem to have significant downsides. Physician-hospital organizations have been subject to rigorous federal enforcement actions as have far more risky physician relocation arrangements. Early results of gain-sharing programs, which give physicians incentives to reduce use of medical devices, found that most of the savings were coming from lower prices, not reduced use of supplies.

No doubt about it, Carilion’s plan is a huge gamble. Its plan to expand its market to become a national center of excellence is a significant reach.

At a time when everyone is pushing for higher quality of care, Carilion’s most exciting promise is to adopt evidence-based medical practices and use its new research capabilities to advance the medical knowledge that undergirds those quality standards.

LETTERS

Insurers and transparency
In the debate over transparency in healthcare, I would like to see more emphasis on insurance companies’ important role as a provider of information for consumers. While providers work diligently to answer patients’ questions and provide cost estimates for needed healthcare services, going to a specific provider for this information only gives the consumer information about one provider. Insurance companies, on the other hand, are in a position to provide cost-estimation tools and consultation that would allow patients to compare one provider with another based upon the consumer’s specific insurance plan coverage and the insurance company’s contracted rates.

Providing cost estimates to patients is not a controversial issue for hospitals. The issue is whether “public posting” of prices is of benefit to consumers. However, posting a price does not provide the complete financial picture to an insured consumer because it may differ from the insurance company’s negotiated price. Likewise, the posted price may not reflect applicable discounts to any individual uninsured consumer. Ultimately, any movement toward greater transparency should result in meaningful information for a broad base of consumers—most of whom have insurance.

Elaine Anderson
Senior vice president and chief compliance officer
Texas Health Resources
Arlington

Nurses and ER overcrowding
Regarding the recent Institute of Medicine report, The Future of Emergency Care in the United States Health System, I was curious about the lack of recognition of the supply and demand for nurses as a key finding requiring national attention. As most hospitals and health systems have begun efforts to improve efficiency or add inpatient capacity to place patients, they are also facing a rise in competition for the most important person to providing patient care—the nurse. The demand for nurses in other ambulatory settings continues to outpace the supply.

Terry Murphy
Executive vice president and chief operating officer
Bayhealth Medical Center
Dover, Del.

What do you think? Let us and your fellow Modern Physician readers know. Send your letter to the editor to moddoc@crain.com.
Questioning quality info
The data may be sound, but may not tell whole story

BY STEVEN CORWIN, M.D.

Hospital quality metrics are becoming more important in healthcare. Some insurers compensate hospitals at more favorable rates if they meet specific quality goals. The federal government requires public reports on various quality measures. And consumers are scanning a number of government and private Internet sites for hospital quality information.

But this information must be approached with caution. Much of it provides an incomplete and possibly inaccurate view of care provided by a particular hospital. The problem is not with the information but in what we expect it to say.

Much of the current information does not detail the actual interventions delivered in the hospital or if the patient got better because of the care in the hospital. As such, the publicly reported indicators do not always give patients the full picture of differences among hospitals.

The data measures for heart attacks, for instance, focus on whether certain medicines were provided in an emergency room, including aspirin, beta blockers and angiotensin-converting enzyme, or ACE, inhibitors, and will soon include measures of how long it takes to get treatment. The measurements look at each medicine individually. So results will show whether a patient received that medicine, which is a good measurement of adherence to accepted medical practices. A good measurement of quality, however, would look at the percentage of patients who received every medicine they should have received, which is not done now.

In addition, current medical literature says the preferred method to treat a heart attack is primary angioplasty. But not all hospitals provide primary angioplasty, and no public quality measures indicate which ones do.

The data also can be analytically skewed, unintentionally painting a negative picture about hospital quality even when good practices are followed. A hospital not offering primary angioplasty might transfer patients to one that does, an example of a good medical practice. But that risks leaving behind those patients who are too ill to transfer, which could negatively skew the hospital’s mortality rate.

To try to compare like populations, the Medicare program has become a source for many quality reports. The advantages of Medicare information include its size and its availability in the public domain. Medicare data also are uniform, unlike data found in private carriers, which allow comparison. However, sourcing from Medicare skews measurements toward ailments in older patients, such as pneumonia and heart attack. With no similar databases to draw from for children, for example, little public quality information exists on pediatric programs in hospitals.

In some cases, quality reports cite measurements that scientific literature may not agree are a benefit to patients. For instance, one measurement looks at the percentage of patients with pneumonia who received an antibiotic within four hours of coming to an emergency room. The scientific literature on pneumonia shows a clear benefit when a pneumonia patient receives an antibiotic within six to eight hours of coming to an emergency room. However, there is no clear consensus that receiving an antibiotic within four hours is necessarily better for a patient.

Overall, what is measured now is too superficial.

Board certification rates of doctors, equipment repair rates, turnover of staff and patient satisfaction often are measured by hospitals but are rarely included in publicly available quality reports. To include such data could help create a better picture of capability, expertise, preparedness and care.

There are many other measurements that should be considered. Medical professional organizations are setting standards of quality in their specialties and should be part of the national discussion. We need to measure whether medicines such as antibiotics are used appropriately. And once all these measurements are set, time and money must be invested to bring best practices and compliance throughout the entire healthcare system.

Information technology also will allow hospitals to gather more information and begin the arduous process of correlating interventions to outcomes. With an in-depth study of the data and public reporting of the outcomes, hospitals will be able to demonstrate a much more vivid picture of what they do so patients can make a more-informed determination of quality.

It is more important to do the hard work and truly define quality than simply to rely on easily available statistics regardless of whether they mean anything to patient care.

Steven Corwin, M.D., a cardiologist, is executive vice president and COO of New York-Presbyterian Hospital.
From system to clinic
Why Carilion Health System wants to put physicians in charge

BY MELANIE EVANS

Edward Murphy, M.D., head of seven-hospital Carilion Health System, says he believes the Virginia system won’t last without drastic changes. The end isn’t far off either, according to Murphy, the system’s president and chief executive officer.

Murphy says he sees the system’s finances steadily—and irreversibly—being eroded despite garnering operating profits that jumped almost 313% to $35.1 million in 2005 from $8.5 million in 2003. His solution is to do what no other not-for-profit system has ever done—a more than $100 million gamble to convert Carilion from a typical not-for-profit health system into a physician-run clinic with an emphasis on research and subspecialty training.

Carilion’s expenses will permanently overtake its revenue shortly, Murphy’s projections show, as costs steadily escalate while Carilion’s revenue rises only modestly. Closing or consolidating Carilion’s faltering business can only cut costs so far, he says. The “spread” between surging costs and sluggish revenue will push Carilion into the red in 2011. Every year thereafter, Carilion’s finances will weaken.

The idea, if successful, could be an answer not only for Roanoke, Va.-based Carilion, but also for hospitals across the U.S. that are under mounting pressure to curb costs and stop fatal medical errors, Murphy argues. Putting doctors in charge while giving them a stake in hospitals’ operations and performance may wipe out inefficient, crippling competition between powerful doctors and hospitals, he says.

Success depends heavily on the doctors’ reaction, healthcare and financial analysts say. “Physicians are a funny, very distinctive breed of animal. They’re very autonomous,” says Hoangmai Pham, M.D., a senior health researcher with the Center for Studying Health System Change. Until very recently, doctors entered medicine with expectations of one day owning their own business. “It really cuts against the grain for most physicians in most markets to turn around and say ‘OK, I’ll take a salary.’ ”

Carilion’s proposed clinic could work in similar markets across the U.S., but it faces significant hurdles to success, says Richard Wade, a spokesman for the American Hospital Association. “Culturally, you have to have a way to bring everyone together,” he says, which is no easy task.

Carilion’s conversion may be an extreme example of a push to employ doctors that appears to be gaining steam. Buying up doctors’ practices may be on the rebound after acquisitions went bust in the late ’90s, leaving hospitals with painful losses and wary of similar investments. But Carilion’s plans go much further than strategically hiring specialists, a plan that appears to already be on the rise as doctors seek ways to handle flat reimbursement, capital-intensive technology needs and rising malpractice rates.

Physician practice consultants, financial analysts and hospital executives call Carilion’s conversion a rare move, though not totally surprising as private practices seek economic partnerships with hospitals. “You don’t see that happening in a lot of markets,” says Donald Fisher, president and CEO of the American Medical Group Association. Carilion executives “see where healthcare is heading, and they’re trying to get ahead.”

To do so, Carilion will be led by a physician-dominated board of directors. By early October, Carilion will create a not-for-profit, Carilion Clinic Physicians, which will become the parent company for the system’s subsidiaries. Carilion will hire an undetermined number of specialists, eventually employing all its physicians, and launch at least four subspecialty fellowships: cardiology, critical care, gastroenterology and pulmonology.

“It’s unusual for someone to just flip the switch” from health system to physician-led clinic, says Kevin Kennedy, a principal with ECG Management Consultants. “It’s much more common for it to be a slow evolution.”

Murphy says he hopes the ambitious plans will greatly expand Carilion’s nine-county market and boost its reputation in line with well-known, established clinics such as the Mayo Clinic, Rochester, Minn., or the Cleveland Clinic. Murphy adds: “I’d hate to sound maniacal and pick the one or two that everyone...”

Continued on p. 11
knows. There are a lot of good clinics around, and I think we can be in the hunt with them.”

Carilion executives say the switch will take roughly eight years and $100 million to $125 million to expand its Roanoke campus; recruit and hire subspecialists; and launch a research joint venture with Virginia Polytechnic Institute and State University in neighboring Blacksburg.

The clinic’s 11-member board of governors—which includes Carilion’s chief operating, financial and nursing officers plus eight doctors, including Murphy—began its tenure recently. And Carilion’s existing independent board of trustees, which will have oversight over the whole operation, recently ratified the board of governors’ membership.

Carilion Clinic leadership will continue to report to the board of trustees, Murphy says.

The clinic’s management will be divided under nine medical chairs: anesthesiology, emergency department, medicine, obstetrics and gynecology, pathology, pediatrics, psychiatry, radiology and surgery.

The system currently employs 103 doctors who teach in its seven residency programs and another 190 primary-care physicians, general surgeons and neurosurgeons.

Stephen ReMine, M.D., who previously worked for the Lahey Clinic, Burlington, Mass., and the Cleveland Clinic, joined Carilion as its first surgery department chairman; he is the first of the medical chairpersons to be hired.

ReMine says competition between private doctors and hospitals forces both to closely guard their own economic interests. “Some win, some lose and in the next round of fights, it’s vice versa,” he says.

In order to minimize economic tension and also to focus on the system’s research, quality and education targets, Carilion will rely on incentive pay, officials say. For ReMine and his medical chair colleagues, compensation will be tied to Carilion’s research and education goals with incentives for published research or conference presentations, he says.

Under Carilion’s new physician employment contract, a base salary will make up 80% of pay with another 20% tied to meeting quality, patient satisfaction, research and education goals.

### CONVERSION TIMETABLE

| Fiscal 2006-08 |  
|----------------|---
| Create Carilion Clinic Physicians, a not-for-profit, as parent company  
| Recruit nine department chairpersons  
| Launch research joint venture with Virginia Polytechnic Institute and State University. Invest $6 million in first two years, $5 million annually thereafter |

| Fiscal 2009-13 |  
|----------------|---
| Hire clinic physicians  
| Begin four fellowship programs  
| Fine-tune operating model |

| Fiscal 2013 and beyond |  
|----------------|---
| Build clinic reputation and stature |

Source: Carilion Health System

Doctors will be eligible for another bonus, equal to 20% of overall pay, based on productivity. However, the productivity bonus is contingent on physicians’ quality, research and patient-satisfaction performance. Finally, both bonuses are contingent on overall financial performance. If the system can’t afford the bonuses, doctors won’t get incentive pay. However, should Carilion have an unusually strong year, there is “upsid potential,” Murphy says.

Well-designed incentives motivate doctors to provide quality and efficient care without losing sight of overall financial performance, says Mark Werner, M.D., Carilion Medical Center’s chief medical officer and senior vice president. Incentives also show Carilion believes finance isn’t the only key to a healthy bottom line, Werner says. “Financial success without quality is irrelevant,” he says. “Quality success without finance is unsustainable. They are inextricably linked.” Werner hopes to convert Carilion’s physicians to new contracts when its fiscal year ends on Sept. 30.

Pham says quality incentives among doctors are far less common than productivity bonuses. The Center for Studying Health System Change’s 2004 survey of 6,800 doctors found 22% of employed doctors reported a quality bonus compared with 74% who received a productivity incentive, she says.

Previously, Carilion’s doctors were paid purely based on productivity. “For them, it was just about producing widgets,” Werner says.

The AMGA’s Fisher says productivity incentives—or the “eat what you kill model”—do little more than push doctors to churn through patients. “That has physicians running after procedures,” he says, “because everything they do they get paid for.”

Carilion’s executives also cited strong financial reasons driving their decision. Converting to a multispecialty clinic run by doctors will hopefully improve Carilion’s efficiency, boost its market share and woo new patients from outside its market of roughly 1 million people, its officials say.

By switching to a clinic model, Carilion executives projected an initial $27 million annual boost from more efficient operations and a “modest” 2% increase in market share, Murphy says.

Executives analyzed Carilion’s Medicare cost reports and found the system lost $13.5 million annually caring for patients covered by the safety-net insurer, he says. The same analysis of
Medicare revenue for 10 clinics, including the Mayo Clinic and Scott & White, Temple, Texas, found “positive to substantially positive” financial returns, Murphy says. “Clearly, that group performed well.” If Carilion improves its operations to mirror those of already established clinics, the system could save as much as $16 million.

Overall, Carilion holds 59% of its market; competitor Lewis-Gale Medical Center, an HCA hospital in Salem, Va., claims about 32%, according to ratings agency Moody’s Investors Service.

Murphy says he plans to make gains in specialties where Carilion’s market share lags, such as neurosurgery, where its surgeons make up about 46% of the market. That’s compared with 62% for Carilion’s open-heart surgeons.

Carilion isn’t the only player in Roanoke’s market buying specialty practices. Lewis-Gale hired roughly 80 specialists from a financially failing multispecialty clinic in Roanoke.

James Thweatt Jr., president and CEO of 521-bed Lewis-Gale, says economic strain might have bankrupted the clinic and forced specialists to leave the market.

Thweatt says it’s unclear how Carilion’s push to hire specialists—including local physicians—will affect Roanoke’s market. “We’ll have to wait and see,” he says. “We have always been a strong healthcare provider. We are another choice.” Lewis-Gale’s parent company, Nashville-based HCA, owns 182 hospitals and ranked as the largest U.S. health system by patient revenue, according to sister publication Modern Healthcare’s 2005 survey of hospital systems.

Carilion’s and Lewis-Gale’s willingness to hire specialists mirrors a national trend, though Carilion’s push to employ all of its doctors goes well beyond more-targeted recruitment seen by Garey Fuqua, director of Fitch Ratings’ public finance healthcare group. “That’s the exception rather than the norm right now,” he says. However, among hospitals and health systems that Fitch rates, employing doctors appears to be a trend. “You want your doctors to be, ideally, your partners,” he says. “Heaven forbid they’re your competition.”

One of those partnering more with physicians is Sentara Healthcare, Norfolk, Va., which now employs 280 doctors, up from 100 physicians five years ago, says the six-hospital system’s CEO, David Bernd. Fifteen doctors now work as Sentara managers or executives, and physicians account for 25% of Sentara’s board members. “I think that’s the way the industry is headed,” Bernd says, describing interest in Sentara’s market as “accelerating.” Bernd, a former AHA chairman, credits mounting economic pressure for the push to add physicians to hospitals’ payrolls.

Economics were behind Cardiovascular Surgical Associates’ decision to join with Carilion, according to Carilion cardiovascular surgeon Christopher Wells, M.D. The group’s patients are increasingly complex but its reimbursement does not keep pace, he says. The five-surgeon group admitted 80% of its patients to Carilion’s hospitals and 20% to Lewis-Gale until March, when the group shuttered its practice and became Carilion employees. “It’s a step of faith,” Wells says. No more worries about making payroll, but no more independence, he explains.

Carilion will continue to grant hospital privileges to private physicians, Murphy says.

But not all independent physicians are eager to go on a payroll. Lawrence Monahan, M.D., has a practice that competes with the Carilion Medical Group—Roanoke-based Jefferson Internal Medicine Associates. Monahan’s practice largely employs family practice and internal-medicine physicians.

Employed doctors give up control of operations and expenses to a bureaucracy, he argues. Patients question the loyalties of doctors employed by systems that operate multiple businesses by referrals, he says. “If we work for our patients, there’s no questions about allegiance, responsibility, caring, compassion,” he says.
**BY THE NUMBERS**

**WHERE DOES THE TIME GO?**
The Medical Group Management Association surveyed 132 full-time physician-executives on time allocation between administrative and clinical duties. Only associate/assistant medical directors spend more than 25% of their time on clinical activities.

**Physician CEO/president**
Mean percentage of time devoted to administration: 77%
Mean percentage of time devoted to clinical activities: 23%

**Medical director**
Mean percentage of time devoted to administration: 75%
Mean percentage of time devoted to clinical activities: 25%

**Associate/assistant medical director**
Mean percentage of time devoted to administration: 66%
Mean percentage of time devoted to clinical activities: 34%

Source: MGMA’s 2005 Management Compensation Survey

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**THE COST OF DOING BUSINESS**
Breakdown of total operating costs of multispecialty groups

- Physician: 45%
- Support staff: 31%
- Building and occupancy: 6%
- Medical and surgical: 3%
- Ancillary services: 2%
- Other general operating: 10%
- Nonphysician provider: 3%

Source: MGMA’s 2005 Cost Survey for Multispecialty Groups

**BALANCING THE BOOKS**
Of 812 single and multispecialty physician-owned groups reporting, more than 90% of respondents use cash-basis accounting.

- Integrated delivery system or hospital-owned medical group: 96% cash-basis, 4% accrual-basis
- Physician-owned medical group: 93% cash-basis, 7% accrual-basis

Source: MGMA’s 2005 Cost Survey
EDUCATION
Richard Shannon, M.D., a pioneer in the national movement to reduce hospital-acquired infections, is leaving his post as chairman of medicine at Allegheny General Hospital in Pittsburgh on Oct. 1 for the University of Pennsylvania School of Medicine in Philadelphia. Shannon, 52, will be a professor of medicine and vice chairman of clinical affairs for Penn’s department of medicine, responsible for program development across clinical lines for its health system.

HOSPITALS, SYSTEMS
Kent Bottles, M.D., was named vice president and chief medical officer of the Iowa Health System. Bottles, 54, previously was president and CEO of the Grand Rapids (Mich.) Medical Education and Research Center for Health Professions. The Iowa Health System is composed of 12 hospitals in Iowa and Illinois. ... Triad Hospitals, Plano, Texas, promoted E.A. Clark, M.D., to take the newly created position as chief medical information officer. Clark, 56, will be responsible for working with physicians to implement the clinical and practice-management application set and the electronic medical-record system, both of which are goals of Triad’s partnership with Perot Systems, McKesson Corp. and Lawson Software, which was announced in January. ... HCA, Nashville, hired Jonathan Perlin, M.D., undersecretary of health for the Veterans Affairs Department, to be HCA’s senior vice president of quality and CMO, effective Aug. 17. Perlin, 45, became acting undersecretary in 2004 and subsequently was named to the permanent position. As such, he served as CEO of the nation’s largest health system. Before joining the VA seven years ago, Perlin was medical director for quality improvement at the Medical College of Virginia Hospitals-Virginia Commonwealth University Health System, Richmond. At HCA, he will replace Frank Houser, 65, who is retiring at year-end after 12 years with HCA. ... Bon Secours Baltimore Health System announced the retirement of CEO Percy Allen II. Samuel Ross, M.D., senior vice president and chief medical officer at Parkland Health and Hospital System, Dallas, will replace Allen in mid-August. Allen, 65, will remain during a transition period and consult with Bon Secours after the transition, according to a spokeswoman. ... HCA, Nashville, hired Jonathan Perlin, M.D., undersecretary of health for the Veterans Affairs Department, to be HCA’s senior vice president of quality and CMO, effective Aug. 17. Perlin, 45, became acting undersecretary in 2004 and subsequently was named to the permanent position. As such, he served as CEO of the nation’s largest health system. Before joining the VA seven years ago, Perlin was medical director for quality improvement at the Medical College of Virginia Hospitals-Virginia Commonwealth University Health System, Richmond. At HCA, he will replace Frank Houser, 65, who is retiring at year-end after 12 years with HCA. ... Bon Secours Baltimore Health System announced the retirement of CEO Percy Allen II. Samuel Ross, M.D., senior vice president and chief medical officer at Parkland Health and Hospital System, Dallas, will replace Allen in mid-August. Allen, 65, will remain during a transition period and consult with Bon Secours after the transition, according to a spokeswoman.

SUPPLIERS, VENDORS
Barry Schoenbart, M.D., was hired as the first medical director of Reliance Software Systems, a healthcare-software provider in Farmington Hills, Mich. Schoenbart, 50, who has a background in clinical informatics, clinical analysis and information technology, will also have a hand in developing the RelWare clinical-process re-engineering group.

OTHER ORGANIZATIONS
Donald Holmquest, M.D., a former physician-executive with the IT division of McKesson Corp. was named CEO of the California Regional Health Information Organization, the San-Francisco-based state RHIO development group. He most recently served as director of physician adoption for computerized physician-order entry at McKesson, where he helped design and implement CPOE systems. Holmquest, 67, a former astronaut, also has worked with NASA in Houston on the Apollo and Skylab programs.

Making news? Send your personal and personnel stories to moddoc@crain.com. Please attach a color photo of your Modern Physician News Maker with your submission.