BY JAY GREENE

The job of medical-group-practice administrator has changed greatly over the years as the healthcare industry has moved into the age of increasingly complex technology, information and regulation.

While hundreds of office managers at small practices of two to three physicians manage finances, maintain operating systems and oversee human resources, a growing number of practice administrators at larger groups are also responsible for a variety of tasks that may include strategic planning, purchasing, reviewing utilization, billing and collecting, negotiating managed-care contracts and maintaining patient and physician satisfaction.

But the most important responsibility of a practice administrator—and possibly the trickiest—is maintaining the bridge between the clinical and business worlds, says Lee Myers, a practice administrator and vice president of community practice with
Continued from p. 1

Danville, Pa.-based Geisinger Health System, an integrated healthcare system with four hospitals and 650 physicians. Myers oversees 11 practice administrators at 41 clinics staffed by 180 physicians in its community practice network.

“Friction between business and clinical backgrounds is much less an issue here because we have a teaming culture,” Myers says. “When working on a project, we make sure we have a physician and (a practice administrator) around the table from the beginning, so we are not developing something and springing it on the physicians.”

As physicians become overwhelmed by the sometimes conflicting demands of patients, payers and regulators, they are delegating more responsibilities to the practice administrator, experts say.

“Practice administrators are more like chief operating officers than CEOs,” says Steve McDermott, chief executive officer of Hill Physicians Medical Group, an independent practice association based in San Ramon, Calif. “Depending on the size and type of the practice, practice administrators have a variety of authorities, accountabilities and responsibilities.”

They also hold a variety of titles, including CEO or executive director, administrator, practice manager, operations manager, office manager and clinic manager, according to the 2005 Management Compensation Survey by the Medical Group Management Association. Their titles are as diverse as the groups themselves.

With 19,913 medical groups of three physicians or more in the U.S., some 62.3% of the groups have six or fewer physicians and account for about 21.5% of total physicians in groups, according to an American Medical Association 2005 survey. About 30% of all physicians are in groups of three physicians or larger, nearly triple the percentage since 1965, the AMA says.

Some 6.3% of groups—representing 49.4% of total group physicians—are larger than 25 physicians each, the AMA says.

For example, of Hill Physicians Medical Group’s 1,600 practices, some 40% of the groups’ 3,000 physicians are solo practitioners. The remaining physicians are in groups that range in size from two to 25, McDermott says. “Our typical practice administrator is a 40-year-old woman, college-educated and making about $50,000 a year,” he says.

The MGMA survey indicates a range of salaries in 2004 that includes a mean of $228,133 for the nonphysician CEO at a group with 26 or more physicians; $105,048 for the administrator of a seven- to 25-physician group; $50,303 for a branch-clinic manager; and $46,932 for an office manager.

One of the more recent trends found among leading group practices is hiring experienced practice administrators and creating a team-management system that links physician-managers with administrators, says Andrea Rossiter, MGMA’s senior vice president of professional development. The association certifies practice administrators with about 2,700 certified and another 2,300 working on their certification. “The physicians are in charge of the clinical side with the practice administrator taking care of the supporting business- and clinical-management systems,” Rossiter says. “It’s a partnership, one in which they respect each other and work closely to create a quality, patient-centered practice.”

But conflicts sometimes can arise because practice administrators are trained in working with groups of people, and physicians are mainly trained in the one-on-one, patient-doctor environment, McDermott says (See related story at modernphysician.com).

“The most challenging part of my job is taking care of staff scheduling and coming up with (the) best operational plan for the day, especially when there are sick calls and unexpected vacancies,” says Charles Brown, a practice manager with the Fallon Clinic, a 250-physician 30-site group based in Worcester, Mass. He oversees three clinic sites that include 25 employees and clinicians and 10 physicians. Brown is responsible for the business side, and a physician oversees the clinical side. The two share some overlapping responsibilities, including strategic planning, budgeting and physician recruiting. Another high priority is making sure patient visits and procedures are properly coded and information is correct before it is sent to payers, Brown says.

“The toughest part of the job of practice administrator is when you have a group of physicians who do not have an understanding of the job description,” says George Conomikes, president of Conomikes Associates, a medical-practice management consulting firm. “You have seven doctors in a practice, and three of them say the administrator should be fired, and two say you are doing a good job. The others don’t know. It creates conflicts.”

Problems generally arise when decisions need to be made on major purchases and adding satellite offices. In these instances, “The practice administrator does
Berthelsen, M.D., chairman of 300-physician Kelsey-Seybold Medical Group, Houston, was asked to take over.

“The medical and administrative leadership group has probably never been stronger than it is now,” says Berthelsen, who also became managing director of Kelsey-Seybold’s management company.

“As the future unfolds, the business and medical side will require everyone’s best efforts and thinking,” Berthelsen says. In 2002, Kelsey-Seybold’s management company was sold to St. Luke’s Episcopal Health System, Houston, which provides management staff for the clinic.

Increasingly, Berthelsen says, groups are looking to see if they have the right amount of business expertise within their group. “If not, they are seeking that in consultants, hiring professional managers or merging with larger groups to find that expertise,” he says. “Medical-group practice is a low-margin business. There is more pressure to perform. Physician groups of all sorts need to get the best business expertise that they can attract and afford.”

Jay Greene is a former Modern Healthcare reporter and now a freelance healthcare writer based in Thompson, Conn. Contact Greene at jaywriter@charter.net.

Geisinger’s team approach is clearly defined, Myers says. The operations manager and the medical director work closely to jointly set budgets and develop marketing plans, and the two collaborate with the system’s recruiting department in hiring new physicians, he says.

For groups that don’t use a team approach, Conomikes says one solution for creating physician involvement is to have an executive committee of three or four physicians assist the administrator.

But there are always exceptions. At Kelsey-Seybold Clinic, when the administrator left in 2005, Spencer

McDermott cites two instances of groups with 20 or more physicians that slowly became disorganized as chief partners took over critical decision-making responsibilities. “There was a high turnover of capable administrators because responsibilities were not clear,” he says. In one group that failed, McDermott says, the management structure allowed no clear delegation of authority among the doctors.

Administrators have a variety of duties.
BY JESSICA ZIGMOND

If you lift it, they will come.
That seems to be the message specialty-hospital developers are sending to legislators now that the CMS has eased the threat of extending the moratorium on physician-owned specialty hospitals. Just days after CMS Administrator Mark McClellan testified at a Senate hearing that the CMS will likely not extend the ban past Aug. 8, there are signs of growth.

In Dayton, Ohio, the Medical Center at Elizabeth Place announced that 60 physicians would have a 90% stake in a 26-bed facility set to open in September. Regent Surgical Health, a developer of surgery centers and surgical hospitals, will own the remainder of the 40,000-square-foot facility, housed in the former St. Elizabeth’s Hospital.

Tom Mallon, chief executive officer and founder of Regent, says the facility reflects the successful concept of a “medical mall” because it shares space with other organizations to recycle a hospital that failed as a 300-bed facility. The new Medical Center at Elizabeth Place is one of 75 tenants on the campus, which spans 26 acres, according to Patsy Boatright, the facility’s senior property and leasing manager. Other tenants include Kindred Healthcare, with a long-term acute-care facility there, and United Rehab, which manages the Dayton Rehabilitation Institute.

Regent also would like to convert an existing ambulatory surgery center in northwest Indiana into a nine-bed, physician-owned specialty hospital partnered with a multispecialty clinic, Mallon said.

Healthcare development and management company Cirrus Health is readying the California Heart and Surgical Hospital in Loma Linda, a $75 million, 25-bed facility, to open in November 2007, says John Thomas, the company’s president and chief development officer. Thirty-eight physicians will own 75% of the hospital, which will offer a broad service line. Cirrus and some other local investors own the remaining portion.

Despite these projects, some insist that the development of new specialty hospitals will not be quite as rapid as some believe. “The fears that they will grow like mushrooms after a rainstorm is absolutely unfounded,” says Randy Fenninger, a lobbyist for the American Surgical Hospital Association.

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.

For over 25 years, the Accreditation Association has been using an educational, consultative and peer-based survey approach to help all types of ambulatory health care organizations provide the best possible care to their patients. Recognized by third party payors, medical societies, governmental agencies and the general public, AAAHC accreditation is a symbol that an organization is committed to excellence in quality health care.

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McClellan: Ban is not expected to be extended.
Gain-sharing works, but ...

Savings come from supplier negotiations: study

BY JOSEPH MANTONE

Hailed as the next great cost-cutting strategy, gain-sharing may turn out to be a long-term flop unless physicians can break their expensive habits, early results of the programs show.

Most of the savings gain-sharing generates come from lower prices and not reduced use of supplies, according to researchers from Arizona State University’s School of Health Management and Policy. The research only examined stents and included four of the six gain-sharing programs that have been approved by HHS’ inspector general’s office.

“Price discounts give one-time savings,” says Jonathan Ketcham, one of the researchers and an assistant professor at Arizona State. “To slow the growth of spending, there needs to be an additional change in behavior.”

However, gain-sharing did provide the physicians with more of a reason to speak with vendors’ sales representatives about lowering prices, Ketcham says.

He adds that developing standards of care that reduce the variation in spending per procedure can lead to long-term savings on supply costs. The hope with gain-sharing is that physicians will devise lower utilization by only opening disposable products as needed during procedures or using less costly supplies that produce the same quality.

Over three years, PinnacleHealth System, Harrisburg, Pa., has saved $5.7 million through gain-sharing and had targets of $8 million in savings.

Much of the savings have been attributed to lower supply prices, and that’s because physicians are taking part in the negotiating prices that vendors charge, says Jean Wiest, PinnacleHealth’s vice president of cardiovascular and pulmonary services.

Physicians at PinnacleHealth did lose out on payments from savings that were generated under gain-sharing because surgeons didn’t improve cost efficiency during stent procedures.

For example, PinnacleHealth was able to reduce spending on buying stents by $366,000 in the second year of the program from April 2004 to March 2005, but physicians didn’t qualify for a cut of that because they didn’t limit utilization.
AHA seeks doc disclosure
The American Hospital Association urged the CMS to adopt several standards to address potential conflicts in physician ownership of specialty hospitals, including capping individual physician investment at 3%. The recommendations are part of a six-page letter commenting on the CMS’ interim report to Congress on physician-owned specialty hospitals. The AHA says the CMS report did not talk enough about how to monitor and regulate physician investment in specialty hospitals. The association reiterated its opposition to physician self-referral and says if the CMS plans to allow self-referrals to specialty hospitals to resume in August (See related story, p. 4), it should set tougher standards to limit conflicts of interest and should clarify the services that specialty hospitals are required to offer. In its letter, the AHA said physician owners in specialty hospitals should be required to report their investments to HHS annually for public posting, and to disclose their investments to patients when scheduling admissions to the hospitals.

Doc hospital gets a CEO
Olympia Medical Center, Los Angeles, named John Calderone, 58, as its chief executive officer, effective immediately. He succeeds Chief Operating Officer Lee Suyenaga, 56, who has acted as interim CEO since a group of physicians bought the 141-bed for-profit hospital from Tenet Healthcare Corp. in late 2004. Suyenaga will continue as COO. Calderone most recently served as CEO of 228-bed Corona (Calif.) Regional Medical Center.

More docs using IT
Physicians are making more use of information technology in their clinical practices, but in some cases that use may be fairly basic, such as looking up information on the Web as opposed to using a printed reference source, the Center for Studying Health System Change says in a report (See By the Numbers, p. 12). The report compared the survey responses of more than 6,600 physicians in 2004-05 with the responses of about 12,000 physicians in 2000-01. The results are “good news in the sense that the number of doctors using any IT at all for any important clinical functions is going up,” says Joy Grossman, a senior health researcher at the center. For example, 64.8% of doctors in the most recent survey said they had access to IT to obtain treatment guidelines, up from 52.9% in 2000-01.

Shortage of intensivists looms
The U.S. will run short of critical-care physicians, known as intensivists, as demand for the emerg-
ing specialty outpaces supply, according to a report by the HHS’ Health Resources and Services Administration. The number of intensivists will rise to a projected 2,800 by 2020 from about 1,900 in 2000. If the proportion of intensive-care patients treated by such specialists grows to a “more optimal” two-thirds, from about one-third today, demand for intensivists will reach 4,300, the report said.

The HRSA says additional financial incentives might be needed to alleviate the shortage as well as increased use of remote monitoring by intensivists. The American College of Chest Physicians, which posted the report on its Web site, says it and other critical-care societies are working with lawmakers to develop solutions.

**Investing in pathology**

Private-equity firm Water Street Capital, Chicago, staked a majority ownership in Lakewood (N.J.) Pathology Associates, which provides multispecialty anatomic pathology services to outpatient surgical centers in more than 21 states. Financial terms were not disclosed. With the acquisition, Water Street becomes a majority shareholder, while the Lakewood management team retains “a significant ownership” and continues to lead the daily business, officials said in a news release.

Water Street committed $50 million in equity financing to help accelerate Lakewood’s growth in part by the acquisition of small and midsize surgical pathology service providers nationwide. Water Street officials noted that the diagnostic testing business is a highly fragmented, $40 billion-plus market in the U.S., giving Lakewood considerable opportunity to grow. Wall Street Capital Partners is focused exclusively on health care.

**Wanted: Primary-care docs**

Primary-care doctors, who have taken a back seat for years to surgical and diagnostic specialists in the physician-recruiting wars, are in high demand again, according to a new survey from a national search firm. Indeed, internists and family physicians top the list of the most sought-after physicians in a survey by Irving, Texas-based Merritt, Hawkins & Associates, which tracked more than 3,000 of the firm’s search assignments from March 31, 2005, to April 1, 2006. Officials say the company fielded more requests for internists and family practitioners than for any other type of physician over that period. Compared with the previous year, requests for family physicians increased 55% to 257, and requests for internists rose 46% to 274. The most-requested physicians after those two specialties were radiologists, orthopedic surgeons, cardiologists and general surgeons.

**Names of award applicants may be used by sponsors for marketing purposes.**

**Nomination Criteria**

Click here for details on criteria and how to nominate.

**DEADLINE:** July 10

For more information on nominations, please call David at 312.649.5439.
Practice administrators have your back

When physicians push away from the examination table and get comfortable at big walnut desks in the executive suite, they often are lauded as having made the successful transition from clinicians to businesspeople. But behind every financial success story is someone keeping the books. As this issue’s cover story points out, in the case of physician practices, that someone is the practice administrator.

Practice administrators typically are not physicians. Many have financial or management backgrounds, and they’re hired by doctors to run practices. They function more like chief operating officers than like chief executive officers. Their annual salaries can run as low as $50,000 and up to $250,000 or more, depending on the size of the practice they manage and their responsibilities. Those responsibilities can include finance, human resources, strategic planning, purchasing, utilization review, information technology and contract negotiations.

According to Andrea Rossiter, senior vice president of professional development at the Medical Group Management Association, the relationship between physician and practice administrator can best be described as a true partnership.

Now, I’m not a practice administrator, and I’m certainly not a physician, but I have a hard time believing in that utopia. I have a hunch that if you sat down with 10 practice administrators, the conversation would be short about how physicians treat them as equals or how wonderful it is to work with them in a true partnership.

Frankly, I wouldn’t be surprised if they formed a posse within minutes and hit the streets looking for some unsuspecting orthopedic surgeon to show that good doctor the real meaning of torn ligaments. I’m not naive. Much the same thing would happen if you asked 10 reporters to discuss their editors.

Practice administrators are among the healthcare industry’s unsung heroes. They’re caught in the middle between patients demanding to be seen at once and physicians who are running late because of an unexpected case and, not to mention, between payers refusing to pay a claim and physicians who are demanding to be paid before a long vacation. Yet, without practice administrators, the system breaks down. Show them a little respect.

Connecting with advisers
I find your article, “Need a diagnosis?” (June 2006, p. 16) well-reported and balanced. I thank you for presenting the benefits of physician-advisers and the options that healthcare institutions have for implementing these programs. I hope in time that healthcare institutions can overcome the disconnect between the back office and caregivers.

Robert Corrato, M.D.
President and chief executive officer
Executive Health Resources
Newtown Square, Pa.

Overcoming lack of trust
The move by the insurance industry to create portable personal health records should be applauded. Given the dismal state of health information technology in our country, any new project should be greeted as a potential step forward. Unfortunately, I believe that many physicians will be skeptical of an initiative that leaves large amounts of patient and physician data in the hands of big insurers.

This distrust is the legacy of two decades of battling over denied claims, contract language and definitions of medical necessity. As we move forward together, physicians and health plans should focus on solutions that meet two criteria:

■ They improve physician office workflow so they can be implemented easily with little added cost.
■ Any medical record that is created remains under the primary control of the physician.

James Weintrub, M.D.
Chief medical officer
Digital Physicians Network
Middletown, R.I.
Corporations must leave hierarchies behind

At a time when high-profile corporate scandals have destroyed businesses and the trust of their stakeholders and the public, why would anyone choose to write about the topic of building trust? This sentiment was voiced by two well-informed colleagues, one going on to say: “What we need is less trust and more scrutiny.”

Indeed, scrutiny is the expected and reasonable backlash to the misdeeds of our business leaders and the impetus behind the Sarbanes-Oxley Act of 2002. These regulations serve as a safety net for the public and are aimed at replenishing the confidence lost because of the scandals.

However, all the examination and wariness will require a great deal of time and effort, and will eventually exhaust us into complacency. In fact, I would argue that all the laws and regulation will not fulfill this need, but, instead, might offer us a false sense of security that will surely be compromised without trust. Our focus now must be on building, maintaining and recovering trust.

Healthcare has become a very dynamic, often chaotic business, filled with opposing stressors that threaten its very existence. Faced with similar circumstances, retired Marine Lt. Gen. Paul Van Riper, who is prominently featured in Malcolm Gladwell’s book Blink, opines that we need “decisive, rapid-fire decisions under conditions of high pressure and with limited information.”

Note that these are the same conditions found in war, emergency rooms and Wall Street trading floors.

Unfortunately, in the course of career advancement and education, most successful people learn to be competitive with their peers and protective of their reputations. When faced with analogous crises, many managers and executives retreat to the “command and control” structure in which they are most comfortable.

They assume that dotting every “i” and crossing every “t,” while re-examining every decision and re-prioritizing every action, will increase accuracy, improve information and better manage the internal and external pressures.

A cohesive team working in an environment of reciprocal trust is paramount to success during times of extreme change. When people trust their leaders, they willingly get onboard with a strategy, thereby harnessing speed and agility to help navigate great change. In contrast, it takes more time and effort to convince them with facts. The level of commitment attained with trust is much greater than using facts—the heart trouncing the head.

Command-and-control structures can align strategy, execution and feedback to obviate the criticality of trust. However, these systems are based on the view that the world and individuals are ungrateful and selfish. They promote that management is best-achieved through fear, coercion and uniformity.

Hierarchal organizational structures hard wire a command-and-control attitude in the organization. The structure is easy to develop and equally straightforward to monitor. The difficulty is in adjusting or fine-tuning the structure to meet the ever-changing needs of the organization. The relationship, at its best, is based on respect and obedience of managers and employees.

In The 8th Habit, Stephen Covey reports that only 23% of employees indicated that everyone understands their organization’s strategy and goals and 15% felt that their organization fully enables them to execute key goals. The hierarchal organization does not put decision-making authority close to the front lines but reserves that for the few top executives.

Conversely, a flat structure reflects the trusting culture of the organization. It emphasizes a decentralized approach to management that encourages high employee involvement in decisions. Employees, in turn, trust the leadership to set the global strategy, create a challenging and satisfying environment, and align rewards and accomplishments. In a trusting flat organization, managers constantly strive to eliminate waste and excess; they share knowledge and credit easily; and they would rather collaborate than compete.

It takes enormous amounts of personal strength and perseverance for a leader to transform an organization and embed trust in its structure. The weight of the past corporate culture creates great inertia that can threaten to overwhelm the most committed leader. But once a leader has gotten past the initial phase of designing a trusting structure and populating it with trusting managers, the playback is generous and self-perpetuating.

Akram Boutros, M.D., is executive vice president, chief operating officer and chief medical officer of South Nassau Communities Hospital, Oceanside, N.Y.
Winning strategies
AMDIS honorees transform paperwork with IT

BY REBECCA MIELCARSKI

The 2006 AMDIS award winners for distinction in applied medical informatics are all working toward one common goal: to implement an electronically based record system that will create a faster, more-accurate medical practice within their healthcare system.

The Association of Medical Directors of Information Systems has recognized five individuals and three healthcare teams with its annual award. From more than 60 nominations, the winners each deserve special recognition for their excellence and successful achievements, says Rich Rydell, president and executive director of AMDIS. The almost 1,800-member organization of physician-technology leaders designated six judges. This year the judges decided on the following professionals:

Dick

Richard Dick is the founder, chairman and CEO of You Take Control, a privacy-management firm that gives members the opportunity to essentially take control of and make a profit from all sensitive information about themselves. The firm, located in Alpine, Utah, allows outside research companies, both organizational and governmental, to send a request to view information that members then approve them to see.

The main goal of this company—one of Dick’s many ventures—is to empower individuals by giving them the opportunity to sell access to their personal data. “If (outside sources) have to obtain permission to access your data, then you decide if they can have it and at what price to have it for,” Dick says.

Dick has maintained a long career in informatics. Esther Dyson deemed him a “key man” in the history of electronic medical records in the January 2005 issue of Release 1.0. Dick says he will continue to work on finding ways to “remove ambiguity in data” and distributing it. “I try to work on things that have the broadest overall impact, which may take more than my lifetime to see (its) completion,” Dick says.

Cort Garrison

Cort Garrison, M.D., is the medical director of informatics for 417-bed Salem (Ore.) Hospital Regional Health Services and has been working to computerize the physician office for about 10 years. His main focus is completing the Epic EMR system for the organization. His goal is to have 100% computerized physician-order entry established by 2007.

“Impatient retrieval is the bottom line. There’s no reason I can’t get the files I need when I need them. And if the only barrier is to put them in an electronic format, then we will.”

However, like other IT specialists, Garrison has to contend with a significant learning curve. He says many of the physicians “don’t know how to use a computer. Do they understand why it’s doing what they want it to do or do they click around to find what they want?” Garrison says.

Garrison is providing voluntary “Computer 101” classes for those who are unfamiliar with computer programs that will be important when Epic launches. Garrison’s team started the rollout in November 2005 with 18 physicians, and plans to start official training for the rest of their 440-member physician group in October 2006.

Eric Pifer

Eric Pifer, M.D., has led the implementation and customization of clinical information systems with the University of Pennsylvania Health System, Philadelphia, since 1998. As chief medical informatics officer and associate professor of medicine at UPHS, Pifer has succeeded in having 100% CPOE performance. Its CPOE system has been in use since 1997. Pifer was not available for comment at deadline.

Michael Russell, M.D., is the associate chief information officer, associate professor and practicing pulmonologist at the 753-bed Duke University Hospital in Durham, N.C. He earned an AMDIS award for leading Duke in installing a CPOE system for 650 beds and more than 680 physicians. This represents all adult services with peaks of about 30,000 orders per day.

“CPOE is not for the faint of heart,” Russell says about implementing the Horizon Expert Orders system that Duke launched in September 2004. “It’s invasive to the workflow and the way people get their work done … so anytime you change the relationship between the doctors and nurses and pharmacists, it’s a challenge.”

During his 22 years at Duke
Aside from his CPOE responsibilities, Seidberg spends about 50% of his time working in the ICU. He enjoys the balance of the two careers and says he can’t choose a favorite. “They’re both so different in some ways, but in a lot of ways they’re the same; it’s the same kind of problem-solving so sometimes it’s a natural progression. It’s trying to make care better for your patients,” he says. “They give different challenges. It’s been a fascinating little ride.”

Covenant HealthCare in Saginaw, Mich., is the sixth-largest hospital in the state with 521 beds; providing the only neonatal, pediatric and pediatric ICU services in the region. Covenant assembled a team to find potential technology solutions to the system’s time-consuming paper-based processes. They decided to use a physician portal and mobile applications from PatientKeeper.

The data-management system provides physicians with updated patient lists through a Web browser that is accessible to administrative teams throughout the office via personal digital assistants. Covenant piloted the project with a small group of physicians in August 2005, and its current user count is more than 200, says Keith Grantham, Covenant’s director of information technology. According to Grantham, Covenant recently elected to go with the Epic EMR system. Its goal is to implement Epic and go live by fall 2007 with hopes of having 100% CPOE by 2008.

Adjusting to a new system in a short amount of time is a challenge. “Some (physicians) have a learning curve; some are just technologically challenged,” Grantham says.

To counter that, Grantham says the team has employed refresher courses and physician assistants to help speed things along to ensure a full understanding. “We want to walk before we run,” he says.

Marshfield (Wis.) Clinic was recognized because of its work with tablet PCs. According to John Melski, M.D., medical director for clinical informatics and practicing dermatologist for Marshfield, the rollout with tablet PCs has been better than expected. The clinic has about 1,900 physicians who currently work with tablets, and Melski estimates that 2,500 will be in the system by 2007.

The team is working to improve the quality of the system and better streamline the entire electronic-research process. Ensuring the system is perpetually up and running is another issue because “People become dependent on the technology and increasingly intolerant of disruptions,” Melski says.

Having a solid infrastructure is important, and Melski says it will be something the team will continuously work on to advance. “I think the big frontier is IT support, the fundamentals and the basic framework of medical informatics is to collect the information,” he says. “(And) looking at what’s happening in our practice and looking for any opportunity to try and do it better.”

Piedmont Healthcare, a three-hospital system in Atlanta, achieved 100% CPOE usage in all their hospitals within two years of the system’s implementation. The team took on the task in January 2004 and accomplished a full adoption rate in March 2006.

“On March 1, we incinerated them all,” says William McClatchey, M.D., chief medical information officer for Piedmont, in a recent story for Health Management Technology magazine. At Piedmont, “No one writes any orders on any kind of paper anymore.”

The team uses a CPOE system from Eclipsys Corp., a product called Sunrise Clinical Manager.
IMPACT OF EHRs ON INFORMATION SERVICES AND MEDICAL RECORD STAFF SALARIES

Costs per FTE* physician

**Single-specialty groups**
Information technology expense per each FTE physician
- **Electronic health record**
  - $5,460
- **Paper medical record**
  - $4,335

Medical records expense per each FTE physician
- **Electronic health record**
  - $10,447
- **Paper medical record**
  - $6,340

**Multispecialty groups**
Information technology expense per each FTE physician
- **Electronic health record**
  - $5,849
- **Paper medical record**
  - $3,685

Medical records expense per each FTE physician
- **Electronic health record**
  - $6,728
- **Paper medical record**
  - $6,824

* Full-time equivalent

ONCOLOGY TOPS SPECIALTY EXPANSION
Of the 25 hospitals in five regions that were studied, cardiac care, women’s health and pediatrics also ranked high as areas of focus for specialty service-area expansion in 2005.

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<td>Neurology</td>
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<td>Other</td>
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*Numbers don’t add up to 100% because of multiple expansions
Source: Center for Studying Health System Change

I.T. RISES IN PHYSICIAN PRACTICES
Percentage of physicians using IT in their practices for specific clinical activities in 2000-01 and 2004-05

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<td>Obtain guidelines</td>
<td>52.9%</td>
<td>64.8%</td>
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<tr>
<td>Exchange clinical data</td>
<td>40.6%</td>
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<td>Access patient notes</td>
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Source: Center for Studying Health System Change
ACCRREDITATION

Dennis O’Leary, M.D., president and CEO of the Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Ill., said he will retire from his position at the end of 2007. O’Leary, 68, who has headed the JCAHO since 1986, hinted last year that 2007 would be the end of his tenure at the accrediting agency.

ASSOCIATIONS

Jack Lewin, M.D., longtime leader of the 35,000-member California Medical Association, was named CEO of the American College of Cardiology, Bethesda, Md. Lewin, who has served as CEO and executive vice president of the nation’s second-largest state doctors’ association for 11 years, will take over as the top executive of the 34,000-member medical society when it relocates in September to new headquarters in downtown Washington. At the ACC, he replaces Christine McEntee, who left in December 2005.

HOSPITALS, SYSTEMS

Caritas Christi Health Care System, Boston, named John Chessare, M.D., its senior vice president for quality and patient safety, as interim president and CEO. Chessare, 54, succeeds former president and CEO Robert Haddad, M.D., who resigned from the six-hospital Roman Catholic system amid sexual harassment accusations. Caritas’ board of governors had voted to fire Haddad, 52, should he not resign. Chessare is also president of Caritas Norwood (Mass.) Hospital. He joined the system in September 2005 after seven years as chief medical officer at Boston Medical Center. … Raymond DeCorte, M.D., has been named vice president and medical director at not-for-profit East Jefferson General Hospital, Metairie, La. He will oversee and direct the policies and actions of the medical staff with an additional focus on medical staff emergency preparedness. DeCorte, 47, has worked as a member of the East Jefferson medical staff for 16 years and will continue to serve as a general surgeon. … Roger Hudgins, M.D., has been named the first chief medical officer of the neurosciences program at Children’s Healthcare of Atlanta. Hudgins, 53, arrived at Children’s in 1988 and serves as medical director of the brain and spinal cord tumor program and as the surgical director of the Children’s Epilepsy Center. … James Madara, M.D., was named CEO of the University of Chicago Medical Center. The medical center includes three hospitals, a medical school and a biological sciences division. Madara, 55, was dean of the medical school and its division of biological sciences and vice president of medical affairs. The university said the next president and CEO of University of Chicago Hospitals will report to Madara. The school has yet to name a replacement for Michael Riordan, 47, who earlier resigned from the posts, effective this month. … The Rehabilitation Institute of Chicago appointed Joanne Smith, M.D., 45, as interim president and CEO, effective Aug. 31, after the resignation of Wayne Lerner, 56. Smith was president of the institute’s National Division, which works to build alliances with facilities outside Illinois.

PHILANTHROPIES

James Mongan, M.D., president and CEO of Partners HealthCare System, Boston, was named to the Commonwealth Fund board of directors. Mongan is expected to be added to the board this month and will be the 12th board member. Mongan, 64, will also continue to serve as chairman of the Commonwealth Fund’s commission on a high-performance health system, which is seeking to develop ways for the U.S. healthcare system to broaden access to care and improve the quality of care.

SUPPLIERS, VENDORS

John Halamka, M.D., 44, chief information officer of both CareGroup Healthcare System and Harvard Medical School in Boston, joined the medical advisory board of Healthline. San Francisco-based Healthline is a for-profit Internet search engine, healthline.com, designed to help consumers make better healthcare choices.