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, health care 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

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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**

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<th>Fiscal 2006-08</th>
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<tr>
<td>• Create Carilion Clinic Physicians, a not-for-profit, as parent company</td>
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<tr>
<td>• Recruit nine department chairpersons</td>
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<td>• Launch research joint venture with Virginia Polytechnic Institute and State University. Invest $6 million in first two years, $5 million annually thereafter</td>
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<th>Fiscal 2009-13</th>
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<tr>
<td>• Hire clinic physicians</td>
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<td>• Begin four fellowship programs</td>
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<td>• Fine-tune operating model</td>
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<th>Fiscal 2013 and beyond</th>
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<tr>
<td>• Build clinic reputation and stature</td>
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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 “upsided 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

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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. 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.