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## The 50 Most Powerful Physician Executives in Healthcare, 2009

By Andis Robeznieks

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Power is often measured by the resources people have at their disposal—with money, number of employees or even political influence often at the top of the list.

That theory, however, goes out the window with the person who was chosen the most powerful physician-executive this year by the readers of *Modern Healthcare* and *Modern Physician*: Carolyn Clancy, director of the Agency for Healthcare Research and Quality.

To the general public, AHRQ is an obscure agency buried deep within HHS. But in the healthcare industry, the agency has been recognized as the center of federal government efforts to improve patient safety and healthcare quality, and its approximately 300 employees have been able to show the rest of Washington how to do more with less.



Carolyn Clancy, director of the federal Agency for Healthcare Research and Quality, was voted No. 1 in the 2009 50 Most Powerful Physician Executives in Healthcare competition.

"AHRQ is a unique organization because our goal is to improve the quality, safety, efficiency and effectiveness of healthcare," says Clancy, who finished 27th in last year's voting and 10th in 2007. "We don't provide care like the VA, we don't pay (providers) like the CMS, or regulate like other agencies of HHS. That makes us very good conveners and helpful partners."

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AHRQ advocates have been lobbying for the agency's budget to be "billionized," but for the past seven years or so its budget remained stagnated in the low \$300 million range. Clancy has also seen her agency's budget get siphoned off to provide operating funds for the Office of the National

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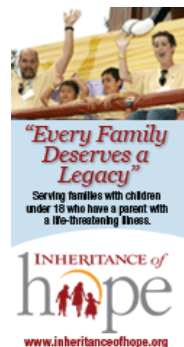
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Recently, however, AHRQ's budget has seen a surge. For fiscal 2009, almost \$326 million had been requested, which would have equaled a 2.7% budget cut of \$8.9 million. Instead, AHRQ's 2009 budget was increased to just over \$372 million, plus an additional \$300 million was appropriated in the American Recovery and Reinvestment Act of 2009, which AHRQ will use to fund comparative-effectiveness research for a two-year period. Since 2005, AHRQ's budget for such research equaled \$15 million a year.

The AHRQ appropriation is part of a \$1.1 billion comparative-effectiveness package, with another \$400 million going to the National Institutes of Health and the remaining \$400 million to be distributed by HHS Secretary Kathleen Sebelius. Clancy was named to a 15-person Federal Coordinating Council for Comparative Effectiveness Research that was created to help coordinate the research and guide investments.

"In 2009, diagnosis, treatment and other healthcare decisions usually have two or more options, and there's not always enough good information to identify which is the best option for a particular person," Clancy says. "Our translation of science into knowledge is too slow, and we can do better."



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She adds that comparative-effectiveness research fits well into AHRQ's mission of providing physicians with unbiased information backed by the highest quality of evidence possible.

Clancy says her clinical experience is helpful when having to brief the HHS secretary or other official because she knows what it's like to talk to patients, how proposed policies may affect clinician workflow and what it's like when a mistake is made.

Clancy was appointed AHRQ director on Feb. 5, 2003, after several months of serving as interim director following the March 10, 2002, death of John Eisenberg. She stopped seeing patients in 2003 as well, but she says it had more to do with timing and logistics than her new workload.

"I did it on Wednesday nights and that particular clinical session was canceled," Clancy says. "I miss it enormously. I get a lot out of it, and I love to see patients. I'm still exploring opportunities to fit into my schedule."

Clancy, who did not place on the inaugural survey in 2005, is the first woman to top the list. Only six other women made this year's 50 Most Powerful list, including Christine Cassel, president and CEO of the American Board of Internal Medicine, who made her first appearance on the list and finished second.

Clancy is also one of only three government executives on the list. David Blumenthal, the national coordinator for IT, finished 12th; while Institute of Medicine President Harvey Fineberg finished 48th. It should be noted, however, that the voting for this year's survey took place before Blumenthal's appointment, and his placement was due more to his former role as director of the Institute for Healthcare Policy at the Partners HealthCare System, Boston.

There were others also in a gray area of working for private organizations that have accrediting authority or have been given some degree of regulatory power by the government. In addition to Cassel, there's Mark Chassin, president of the Joint Commission, who finished third for the second consecutive year; Mark Leavitt, chairman of the Certification Commission for Healthcare Information Technology, who finished 32nd this year (up from 39th in 2008); and Thomas Nasca, executive director and CEO of the Accreditation Council for Graduate Medical Education, who made the list for the first time and finished 47th.

Unlike other appointees of former President George W. Bush, such as Robert Kolodner who came in 38th last year, Clancy doesn't appear to be leaving her post at AHRQ any time soon. "It's a political appointment, and I feel very privileged to be serving as its director," is all Clancy would say on the subject.

Clancy's name had also been circulated as the possible replacement for longtime Joint Commission President Dennis O'Leary before the post was given to Chassin.

"I felt extremely complimented when people mentioned my name," Clancy says, adding "I'm a big fan of Mark Chassin."

Chassin, a former commissioner of the New York State Health Department, notes that his position on the survey had more to do with the standing of the Joint Commission, and not necessarily for anything that he has personally accomplished.

"I think it's really a reflection of the importance and the level of influence that the organization I work for carries in healthcare today, and that's a sobering responsibility and one that I greatly value the opportunity to pursue," Chassin says, adding that it's an exciting time to be working for improved patient safety and quality.

"The days of denial are over," Chassin says. "When I start talking about the Joint Commission's commitment to developing and bringing them more effective interventions, they want them yesterday."

His background as a physician has served him well in discussions with policymakers and legislators of all stripes, Chassin says, and he thinks it's time for more physicians to take healthcare leadership roles. He believes that they probably will do so as more physicians become employees and fewer remain as independent entrepreneurs.

"Discussions can get abstract or ethereal or bogged down in minutiae that has very little to do with taking care of patients," Chassin says. "A physician can bring those discussions back down to earth and make sure the issue of patient care is not lost."

#### Hospitals, systems dominate

Twenty-four of the physician-executives on the 50 Most Powerful list work at hospitals or health systems. These include Lanny Copeland, chief medical officer for LifePoint Hospitals, a 48-hospital system based in Brentwood, Tenn. Copeland, who's making his first appearance on the list at No. 15, says he has been on the job for two years now, and he often finds himself serving as an "interpreter" between the physician and administrative sides of the system.

One time, Copeland says, he was in a budget meeting where they were going to decide which of two mammography machines to buy.

"I asked, 'What do our radiologists think about it?' and, as it turned out, nobody had asked," Copeland recalls, adding that he also has to be the middleman between physicians who want answers immediately and the corporate side, where it may take months to make a decision.

Two challenges Copeland sees ahead are a continued emphasis on quality-of-care measures and patient outcomes, and a new move toward teamwork when CMS reimbursements take the form of "bundled" payments.

"Hospitals that provide good quality of care will be rewarded and those that don't will be penalized," Copeland says. "We're going to have to work more and more together on what's best for the patient and what's economically prudent."

Before becoming an administrator, Copeland was in private practice for more than 20 years in Georgia and Indiana, and

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he served as the 1998-99 president of the American Academy of Family Physicians. Copeland sees physician associations as playing a pivotal role in healthcare reform, and he also says the climate may be right for reform to finally occur.

"It's an exciting time, because I always thought we could deliver better care at less cost, but it would be tough as nails to get it accepted, but this new administration may have the political capital to do it," Copeland says. "I like their emphasis on technology."

Copeland thinks more care will be delivered by physician assistants and nurse practitioners, and hospitalists will have a greater role in providing inpatient care. "I see fewer and fewer physicians seeing more and more hospitalized patients," he says.

Perhaps it's no coincidence then that three hospitalists made the Most Powerful list: Robert Wachter, chief of the division of hospital medicine, University of California at San Francisco Medical Center, who finished 23rd (down from 19th in 2008); Adam Singer, founder, chairman, CEO and CMO of IPC-The Hospitalist Co., North Hollywood, Calif., who finished 49th (and also won Modern Physician's inaugural Physician Entrepreneur of the Year Award); and Ronald Greeno, founder and CMO of Brentwood, Tenn.-based Cogent Healthcare, who finished 50th. Greeno didn't make the list last year, but was also ranked 50th in 2007.

Laurence Wellikson, CEO of the Society of Hospital Medicine, thinks the numbers will rise as more hospitalists become CMOs or head medical informatics divisions. He also says Wachter's star will rise as he makes his mark among hospitalists, and in the quality-improvement and patient-safety movements. "He's a Renaissance man," Wellikson says. "He doesn't get pigeonholed into one thing, but sees the world as a whole."

Wellikson adds that Wachter will ask questions that others won't, such as the time he took issue with the methodology Institute for Healthcare Improvement President and CEO Donald Berwick (fourth on this year's list, down from second in 2008 and third in 2007) used in calculating that 122,342 preventable hospital deaths were avoided in his organization's 100,000 Lives Campaign (Dec. 11, 2006, p. 14).

"Bob wasn't afraid to poke holes in Don's numbers," Wellikson recalls. "Sometimes in medicine you have a tendency to be too polite."

#### Leadership by association

Another well-represented category includes the physician leaders of healthcare associations. They are William Jessee, president and CEO of the Medical Group Management Association, in 10th place; Georges Benjamin, executive director of the American Public Health Association, 22nd; Barry Silbaugh, CEO of the American College of Physician Executives, 31st; William Bria, chairman of the Association of Medical Directors of Information Systems, 38th; Darrell Kirch, president and CEO of the Association of American Medical Colleges, 39th; Michael Maves, executive vice president and CEO of the American Medical Association, 40th; and Jack Lewin, CEO of the American College of Cardiology, 46th.

While Maves finished lower compared with last year's No. 31 spot, two other AMA board members finished above him in the rankings: Robert Wah, CMO of Computer Sciences Corp., El Segundo, Calif., finished ninth (up from 10th last year and 14th in 2007); and J. James Rohack, director of the Center for Healthcare Policy at Scott & White Healthcare, Temple, Texas, finished 20th, making the list for the first time. Rohack is also president-elect of the AMA.

Associations can play a role as the voice for physicians in the healthcare reform debate. The ACPE's Silbaugh says the members of his organization are enthusiastic about getting involved in the cause, noting, "I haven't heard one person saying they desired the status quo."

Silbaugh says he thinks that, because healthcare has been identified as a key to economic recovery, the political status of the industry has risen. Consequently, he adds, it's more important than ever for physicians to stick together and "figure out what we have in common instead of what differentiates us."

The influence of associations also might be seen in the highest finish ever for the MGMA's Jessee, a fixture on the list. Jessee finished 10th this year compared with 22nd in 2008, 21st in 2007, 19th in 2006, and 29th in 2005.

Jessee, however, disagrees.

"My take is that most of the action is still to come this year—it wasn't during the time votes were taken for this list," Jessee says, referring to healthcare reform. "Whatever influence I had and other association executives will wield will be reflected in next year's list."

Jessee also thinks that, no matter what form healthcare reform takes, one certainty appears to be an increasing transfer of risk from insurance companies and employers to the healthcare delivery system.

"That looks like the way things are headed, so how do we as physician leaders respond?" Jessee says. "But that's not what the doc on the street is thinking about. They just want to come in, see patients, get home at a civilized hour, and make a decent living."

Not everything needed to achieve this goal has to be political, as the MGMA has shown through an administrative simplification campaign that seeks to make the lives of physicians a little easier. Jessee has been invited to speak on this subject at an Institute of Medicine public meeting on lowering healthcare costs and improving outcomes scheduled for May 21-22 in Washington. The MGMA has also been promoting the use of electronic swipe-card technology for health plans.

Carla Smith, executive vice president of the Healthcare Information and Management Systems Society, wasn't surprised when told how many physicians specializing in IT made the list.

In addition to Wah at ninth place; Blumenthal, at 12th (he didn't place last year or in 2007 but was 36th in 2006); Leavitt at

32nd (up from 39th last year); and Bria at 38th (up from 48th); there are Brent James, chief quality officer and executive director of the Institute for Health Care Delivery Research at Salt Lake City-based Intermountain Healthcare, 26th (down from 18th in 2008); Paul Tang, vice president and chief medical information officer at the Palo Alto (Calif.) Medical Foundation, 30th (up from 32nd); and John Halamka, chief information officer at CareGroup Health System as well as CIO and chief technology officer at Harvard Medical School, both in Boston, 37th (he didn't place last year, but was 13th in 2007).

"There's a saying, 'You have to walk the linoleum' to understand the day-in and day-out lives of medical professionals," Smith says. "All of them have established a reputation of being a long-term advocate and for having a passion for harnessing the best use of IT by the clinical community to make patient care better and safer."

Smith adds that physicians also tend to like gadgets. "They are not technophobes," she says. "The challenge is to make the technology work for their world."

Harry Jacobson, vice chancellor for health affairs at Vanderbilt University and CEO of the Vanderbilt Medical Center, Nashville, has played the multiple roles of physician and entrepreneur/business executive to bring technology and other advances developed at Vanderbilt onto the commercial market.

In addition to co-founding the Renal Care Group, a dialysis provider that was sold to Fresenius Medical Care for \$3.5 billion in 2006, Jacobson is a member of the board of pharmaceutical giant Merck & Co. In April, he announced that he will retire June 1. Jacobson, who finished 21st on this year's list, up from 35th in 2008 but down from his ninth-place finish in 2007, says that he feels strongly that physicians are needed in executive positions in all areas of the healthcare industry. He says this applies to segments such as medical devices, biotechnology and pharmaceutical manufacturing—not just the delivery of care.

"You need good finance people and good operations people, but I'm a little wary of healthcare companies—for-profit or not-for-profit—if I don't see any doctors," says Jacobson, who placed 32nd on the 2006 list. "That makes me nervous."

Jacobson, who was once described as a "serial entrepreneur," says he doesn't believe in the stereotype that doctors make bad businessmen and businesswomen, but acknowledges that there are some who "tend to have more confidence in their abilities than they should."

"They think, 'If medicine and taking care of patients is tremendously difficult, and I can do that, then this business stuff should be easy,'" Jacobson says, explaining that physicians need mentoring or formal training before they step into the business world.

Jacobson also acknowledges that ethical questions can arise from the mingling of business and medicine.

"There's no question there are potential conflicts of interest that arise when you do these partnerships to develop these products, but they can be managed," Jacobson says. "You find the rules of engagement and enforce them."

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