Agenda

1. Business of academic medicine
2. Why change?
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4. Physician supply/demand
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6. Integration/alignment
7. Compensation/reimbursement
8. AMC’s & Disruption of business models
9. Way forward
THE UNITED STATES SPENT 17.4% OF THE GDP ON HEALTHCARE IN 2013.

ACADEMIC MEDICINE MAKES UP APPROXIMATELY, 20% OF THESE COSTS ($540 BILLION)

Clinical 85%

2010 9% of clinical revenue to fund research/education
Academic medical centers: Should we continue to feed the beast?

“justifying the cost” to “earning the business.”

Federal funding GME cost: $16 billion annually (MC 9.5B DME 3B, IME 6.5B; MCD 2B; VA/HRSA 4B; States MCD)

Distinctive strength

A unique hybrid of business and academics

MGMA Oct 2013

Distinctive weaknesses

• Reliance on clinical margins to support the missions because:
  – Education is not profitable?
  – Research is not profitable?

• Unclear accountability measures so efficiency is hard to measure

• Leadership conflicts (e.g., University, Deans, Hospital, Health System, Institutes, Centers, etc.)
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9. Way forward
Main Campus
Northeast Ohio
International Index Locations
Index Main Campus
Northeast Ohio
Family Health Centers
Northeast Ohio
Regional Hospitals
Northeast Ohio
Specialty Centers
Northeast Ohio
Emergency rooms
Florida
Canada
Nevada
Abu Dhabi
Why change is coming

• The weaknesses are no longer sustainable
• The current and coming environment is forcing changes in the ways universities and health systems operate, making internal inefficiencies unaffordable –
Why is it different now?

- Cost Unsustainable
- Regulatory requirements
- Healthcare ‘reform’
- Physician shortages
- Recruitment difficulties
- Generational change for physicians
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Announced Hospital Mergers and Acquisitions, 1998 – 2012


In 2006, the privatization of HCA, Inc. affected 176 acute-care hospitals. The acquisition was the largest health care transaction ever announced.
Emory University and WellStar Health System announce discussions for new, unified health system

split off from university control in an independent transaction
1. Inpatient not a growth area
2. Subsidies
3. DSP gone
4. Sequestration
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HHS: physician supply will increase by only 7 percent in the next 10 years.
Census Bureau: 36 % growth in the number of Americans over age 65
Workforce Issues

The Impending Shortage and the Estimated Cost of Training the Future Surgical Workforce

Thomas E. Williams, Jr., MD, PhD, FACS,* Bhagwan Satiani, MD, MBA, FACS,* Andrew Thomas, MD, MBA,† and E. Christopher Ellison, MD, FACS*

Predicted shortage of Vascular Surgeons in the United States: Population and workload analysis

Bhagwan Satiani, MD, MBA,* Thomas E. Williams, MD, PhD,* and Michael R. Go, MD,* Columbus, Ohio

The Impact of Employment of Part-Time Surgeons on the Expected Surgeon Shortage

Bhagwan Satiani, MD, MBA, FACS, Thomas E Williams, MD, PhD, FACS, E Christopher Ellison, MD, FACS

Trends in the general surgery workforce

Bhagwan Satiani, MD, MBA, FACS,a,b, David A. Etzioni, MD, MSHS, FACS, FASCRS,b, Thomas E. Williams, MD, PhD, FACS,a

* Department of Surgery, Wexner Medical Center at Ohio State University, W 10th Ave, Columbus, OH 43210
b Department of Surgery, Mayo Clinic College of Medicine, Phoenix, AZ

A Critical Deficit of OBGYN Surgeons in the U.S by 2030

Bhagwan Satiani, Thomas E Williams, Mark B Landon, E. Christopher Ellison, Steven G Gabbe
From the Departments of Surgery & Obstetrics and Gynecology
The Ohio State University College of Medicine

A comparison of future recruitment needs in urban and rural hospitals: The rural imperative

Thomas E. Williams Jr, MD, PhD, Bhagwan Satiani, MD, MBA, and E. Christopher Ellison, MD, Columbus, OH
More Physicians Approaching Retirement Age

25,000 Physicians Enter Training Each Year

Number of Physicians Reaching Age 63

Source: AMA Physician Masterfile (January 2008).
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Attrition cost

- The recruitment, hiring, and lost clinical income cost of replacing a generalist was $115,554; for replacing a subspecialist, the cost was $286,503; as high as $500,000.

- The average annual cost of turnover for the departments of medicine and surgery exceeded $400,000.

So, what does this mean?

- Retention strategies for hospitals will acquire greater significance.
- AMC’s may have trouble recruiting/retaining faculty due to salary differentials.
- Robust on-boarding medium to long term.
  - Assistant Professors/Clinical track: CULTURE/VALUES

A Review of Trends in Attrition Rates for Surgical Faculty: A Case for a Sustainable Retention Strategy to Cope with Demographic and Economic Realities

Bhagwan Satiani, MD, MBA, FACS, Thomas E Williams, MD, PhD, FACS, Heather Brod, MA, David P Way, MEd, E Christopher Ellison, MD, FACS

J Am Coll Surg 2013
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Disappointing results with other models

Significant cost

Unlikely to increase bottom line from direct practice income

More likely to increase revenue from better coordination of care given the right incentives (Physicians)

Opportunity cost of ROI compared to investment in facilities/technology, IT etc
Will healthcare costs go down with increasing hospital employment? “economies of scale”

- 32% costs increased after a hospital or health system bought a doctors’ group.
- 5 percent said costs went down,
- 16 percent said costs stayed the same.

459 responses from ACPE’s 11,000 members
Hospital based physicians growing at a compounded annual growth rate of 2.3% compared to 0.9% for practice based physicians between 2000 and 2013.


McLaughlin. The guide to healthcare reform HAP 2015

Employment: alignment NOT synonymous
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Physician Contracts

**OLD**

1. Volume Based
   a. Productivity (rvu’s)
   b. Patients seen
   c. Procedures performed
   d. Dollars collected

**New**

1. Value based
   a. Outcomes
   b. Patient Satisfaction
   c. Cost savings
Compensation trends

- Choose the right metrics

Physician incentives may not be aligned with their health system employer. What is a physician to do?

Bhagwan Satiani, MD, MBA, FACS, Columbus, OH
• Increasing expectations of clinical productivity while holding the physician compensation down (productivity at 75\textsuperscript{th} percentile, compensation at 50\textsuperscript{th} percentile)

• Faculty willing to forgo compensation in lieu of academic activities = below fair market value
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We are positioned for “disruptive innovation”

• “Disruptive innovation,” a term coined by Clayton Christensen, describes a process by which a product or service takes root initially at the bottom of a market and then relentlessly moves up market, eventually displacing established competitors by creating a new market and value network.
What is leading the disruption?

• Changes in societal needs and values
• Disease Patterns
• Economics, including the marketplace
• Globalization
• Politics
• Population demographics
• Science and technology

Wartman SA. http://s36.a2zinc.net/clients/mgma/mgma2013/Custom/Handout/Speaker0_Session268_1.pdf
Opportunity

Changing Skill Requirements

- Personal leadership skills
- Management skills
- Technical skills

Relative Skill Importance

Professional/Individual → Manager → Leadership

High

Low
The Faculty Leadership Institute
Faculty Advancement Mentoring & Engagement (FAME)

Improving People's Lives through innovations in personalized health care

MANAGING CHANGE
Conclusions

- Adapt & embrace disruptive innovation in all three areas
- Be prepared for even more of a shift to OP care, shared appointments, retail care, tele-medicine, part-time physicians, licensure disputes
- Community based care; engage
- Funding for research will tighten more, shift to private sector
- Role of ‘big data’ and how to leverage it
- Challenge: Change without altering core values

From ‘feed the beast’ to ‘be THE beast’
Business model

“justifying the cost” to “earning the business.”

- Adopt for profit models:
  - Cost effectiveness
  - Accountability
- Moving the majority of primary and secondary healthcare delivery into the community (BJC, UPMC, UIowa 52 H alliance)
- Cost: UMHS $200M/3.2B, CCF $360M/3.2B, V $320M/3.3B
- Research: large data
- Net retention rates; 5% operating budget
Conclusions

- Business of academic medicine, integration, consolidation, shortages, compensation & reimbursement, retention
- Disruption in models of care & academic medicine; Change to become agile, shed traditional structures and ‘solution agnostic’
- Episodic to continuous change: whole different muscle set, mindset and emotional set (Kotter)
- Technology will be king
- Change is good! How? Values, passion, learning
- You are going to be part of the solution.
“We demonstrate resilience as optimism, self-confidence and a willingness to embrace change.”
Fasten your seat-belts, it's going to be a bumpy night.

Margo Channing (**Bette Davis**),

*All About Eve* (1950)