HEALING ARIZONA’S HEALTH CARE INDUSTRY

As Obamacare changes the face of medicine and Arizona struggles with a growing physician shortage, top health industry executives talked with the Phoenix Business Journal about possible cures.

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REAL ESTATE

FORMER ‘WALLACE & LADMO’ STUDIOS SOLD

Treatment Assessment Screening Center Inc. spent $1.93 million on the former KPHO-TV studios and will move its headquarters and drug testing operations there.

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EXECUTIVE INC.

STEVEN NICKOLAS POURS HIS HEART INTO WATER

HEALTH CARE

Aging population may add to physician crisis

Arizona needs more than 2,500 doctors right now to meet the national average per 1,000 population.

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ECONOMY

Utilities, ADEQ examine new carbon limits

The federal government rolled out a new plan to reduce power plant emissions this week, and it might mean higher bills.

ERIC JAY TOLL, 15

Discover how Nextiva is reinventing the business phone system.
HOSPITALS HIRING THOUSANDS

While a physician shortage continues to plague Valley hospitals, they also are having trouble filling therapy and other clinical care positions.

OASIS HOSPITAL

How many do you plan to hire this year? 109
What types of positions? Operating room nurses, medical/surgical nurses, ICU nurses, physical therapists and Certified Nursing Assistants
What positions are you having trouble filling? Physical therapists and clinical analysts

PHOENIX CHILDREN’S HOSPITAL

How many do you plan to hire this year? 150
What types of positions? All positions, both clinical and non-clinical
What positions are you having trouble filling? Positions that require specific experience always need more attention to fill. Talent acquisition and a physician shortage in specialty areas are some of the biggest challenges.

HONOR HEALTH MEDICAL GROUP

How many do you plan to hire this year? Around 3,000
What types of positions? Administrative/clinical, allied health, IT, management, nursing and nursing support, physicians and physician management, professional and skilled workers
What positions are you having trouble filling? Lymphedema therapists, medical assistants, medical office assistants, occupational therapists, physician assistants, primary care physicians, PTs, registered nurses and surgical technicians

BANNER HEALTH

(Not including Banner University Medical Division in Tucson)

How many do you plan to hire this year? Approximately 12,000, including more than 375 providers
What types of positions? More than 4,000 registered nurses, 375 physicians and 100 executives, plus entry-level/non-clinical, administrative and corporate professional jobs
What positions are you having trouble filling? Specialty nursing roles. All of the rehabilitation areas are difficult as well, particularly physical, speech and occupational therapy.

MIDWESTERN UNIVERSITY

How many do you plan to hire this year? 120
What types of positions? Veterinarians, veterinary technicians, campus facilities (groundskeepers, mechanics), administrative support professionals, and various faculty positions
What positions are you having trouble filling? IT recruits are always difficult to locate because of the industry demand.

MAYO CLINIC

How many do you plan to hire this year? 1,400
(includes hires and internal transfers)
What positions are you having trouble filling? Nursing, surgical and instrument techs, nurse practitioners and physician assistants, research, lab medicine, radiology, care management, desk support, and food and nutrition service workers

Arizona’s medical education crisis is making it one of the most severely affected states in the national physician shortage.

With a growing and aging population, the Grand Canyon State has about 1,500 resident physician training spots. But it needs to add 1,000 more just to match the national median of 2,500 physicians per 1,000 population, said Dr. Stuart Flynn, dean of the University of Arizona College of Medicine—Phoenix.

Flynn was one of 11 physicians and hospital executives at the July 23 Phoenix Business Journal executive roundtable, discussing how health care providers and medical schools are being affected by changes in the health care industry.

When students graduate from medical school, there are too few training spots for all of them in Arizona, which means many of them have to go elsewhere for their training.

That’s why it’s crucial for Arizona to find ways to expand its graduate medical education training, which will help attract and keep more physicians in the state.

When students train in any given state, they become accustomed to the lifestyle and culture there and start putting down roots, panelists said. When that happens, about 85 percent of them are more likely to stay and practice medicine there, Flynn said.

Many of Arizona’s teaching hospitals offer residency programs, but they are forced to pay for them because federal funding is limited from the U.S. Centers for Medicare and Medicaid Services.

Maricopa Integrated Health System is subsidizing its residency training program at Maricopa Medical Center to the tune of $12 million a year, said roundtable participant Steve Purves, president and CEO of MIHS.

And it still has more medical students applying to get into its residency program than it can accommodate, he added.
“Arizona ranks 43rd out of 50 states in terms of practicing physicians per 1,000 population,” Purves said. “It’s an issue of how we’re able to afford the training, Medicare, which is a major funder of graduate medical education, has not kept pace. As far as the state is concerned, there is no state funding for graduate medical education here in Arizona. So it’s a funding issue.”

Flynn said it costs about $150,000 per GME slot each year.

“It’s not unique to us, but we’re a state at the bottom of the physician crisis,” he said. “It’s even more urgent than other states in this country.”

Not only is there a strong need for primary care physicians in the state, but also for subspecialty-trained physicians, he said.

To make matters worse, Midwestern University’s Arizona College of Osteopathic Medicine recently had to slow the growth of its residency program, said roundtable participant Dr. Lori Kemper, dean and associate professor of Midwestern’s medical school.

“We were in growth mode, working with various hospitals trying to start new residencies,” she said. The American Osteopathic Association, which was its accrediting organization, voted last year to shift all of Midwestern’s residency programs under another accrediting agency: the American Council for Graduate Medical Education.

It is taking time for Midwestern to apply to ACGME as a sponsoring institution before it can start gearing up for renewed growth, Kemper said.

Of the 250 students who graduated from Midwestern’s medical school in Glendale this spring, only 39 were able to stay and continue their residency training in Arizona.

“We’ll be adding a new internal medicine program in 2016,” said Anspach, also a roundtable participant. “The challenge is funding those spots. For the most part, the hospital has to reach into its general fund to do that.”

Now is the time for the Valley’s medical schools to look at ways to work together to solve this crisis, Flynn said.

“I think there are two new dermatology spots in this Valley – and I imagine in this state – and they’re both at Mayo Clinic,” he said. “When you can’t go see a dermatologist in this state because you can’t get in, that’s when it will feel very personal. And we’re just about there.”

“I suggest the state help support family practices, which is a major funder of graduate medical education here in Arizona. So it’s a funding issue.”

Paula Menkosky, the clinic’s chief administrative officer, said: “We’re growing our program,” she said. “We started an osteopathic residency surgery program.”

Part of the problem is talent acquisition, she said.

“We want to be able to train physicians interested in staying at Mayo Clinic here in Arizona or one of our other sites,” she said. “We hope we are training physicians who want to stay and practice in the Valley and state.”

“Some will come back, but I think the vast majority are going to stay wherever they are,” she said.

Nathan Anspach, senior vice president and CEO of HonorHealth Medical Group, said HonorHealth had hundreds of applicants for a few residency training slots at its hospital system.

“We are growing our program,” she said. “It’s an issue of how we’re able to expand our program.”

Mayo Clinic in Arizona has 285 residents and fellows in 43 training programs, said roundtable participant Paula Menkosky, the clinic’s chief administrative officer.

“We want to be able to train physicians interested in staying at Mayo Clinic here in Arizona or one of our other sites.”

Paula Menkosky, Mayo Clinic
Top industry execs tackle Affordable Care Act, tech, insurance

Following a July 23 roundtable discussion, health care panelists responded to a series of questions posed by Phoenix Business Journal Senior Reporter Angela Gonzales about the impact of the Affordable Care Act and the challenges they are facing as the law goes into effect across the country.

JIM FLINN,
CEO, Oasis Hospital

Is health care more affordable under the ACA? I think the jury is still out on that at this early stage. There is no doubt more people are insured than there was prior to the ACA being signed into law; however, there is no doubt that the costs associated with mandating coverage has impacted individuals and businesses.

DR. WILLIAM ELLERT,
chief medical officer, Abrazo Community Health Network

What would you change about the health insurance industry? I would like to see even more collaboration between providers and health insurers.

Is health care more affordable under the ACA? Millions of Americans now have access to subsidies designed to make health care coverage more affordable. Of the roughly 10 million consumers who were covered through one of the ACA’s health insurance exchanges as of March 31, nearly 8.7 million received a tax credit, which averaged $272 per month. And nearly 80 percent of those purchasing insurance on HealthCare.gov could purchase coverage for $100 or less after tax credits.

DR. LORI KEMPER,
dean and associate professor, Arizona College of Osteopathic Medicine at Midwestern University

How well are electronic medical records working? I do practice with an electronic medical record. Unfortunately, EMRs have increased the workload on physicians and have not increased patient record mobility because they are not interchangeable. Caregivers may have greater access to a clean copy of medications now than in the past.

NATHAN ANSPACH,
senior vice president and CEO, HonorHealth Medical Group

How has the relationship between hospitals and health insurers changed since the ACA was implemented? The ACA has changed how we approach care and how we enter into contracts with payers. We’re focused on population health management, where we assume the financial risk of patients in our market. That means we partner with care providers, physicians, hospitals and ancillary care to improve the health and well-being of patients.

Chuck Lehn, Lori Kemper and Steve Purves listen to William Ellert speak during a roundtable discussion on health care in the Valley.

CHUCK LEHN,
executive vice president for strategic growth, Banner Health

What would you change about the health insurance industry? We would be well served by reducing low-value administrative costs – for example, automating and simplifying all types of transactions between providers, payers and members.

Is health care more affordable under the ACA? Yes and no. Yes, because it drives better provider-payer collaboration for high-value products serving employers and consumers. Conversely, the ACA creates coverage for those who were previously uninsurable. Thus, their healthcare expense is understandably higher. We need to address the underlying issues of poor health in order for health care insurance to be more affordable in the long term.

ROBERT MEYER,
president and CEO, Phoenix Children’s Hospital

What would you change about the health insurance industry? Simplify, simplify, simplify. The complexity of the industry is such that administrative costs are displacing dollars that should be spent on providing health care. Providers and patients are lost in the quagmire of individual insurance product rules and limitations.

How has the relationship between hospitals and health insurers changed since ACA was implemented? While much of ACA rhetoric focuses on improved quality and access to care, more emphasis than ever is on cost. The industry has become a numbers game, with insurers and providers scrambling for market share. With greater-than-ever downward price pressures, neither insurers nor providers can survive without scale. Consequently, we’re seeing more consolidation than ever, resulting in fewer choices for purchasers and consumers.

STEVE PURVES,
president and CEO, Maricopa Integrated Health System

Senior Reporter Angela Gonzales about the impact of the Affordable Care Act and the challenges they are facing as the law goes into effect across the country.
**Physician-scientists play vital role in medical research**

BY HAYLEY RINGLE
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Research and discovery are vital to the rapidly evolving medical field, according to Dr. Eric Reiman, CEO of Banner Research.

“For those of us involved in biomedical and other aspects of research, there’s a chance to address important problems – and do so in a way that diversifies and advances Arizona’s economy and attracts companies and researchers to our state,” said Reiman, who also serves as executive director of Banner Alzheimer’s Institute.

“We have some great research strengths in this state, and it would help to capitalize and build on those strengths and increase the number of stakeholders involved in this endeavor,” he said.

When it comes to research and discovery, it’s important to “always be questioning and learning,” said Dr. Lori Kemper, dean and associate professor of Midwestern University’s Arizona College of Osteopathic Medicine in Glendale.

“Many of the regularly agreed-to standards, such as the use of calcium carbonate for ulcer disease, have been proven to be more harmful than helpful,” Kemper said. “Other things – like smoking, which was considered at one point to be benign, even to the developing fetus – is now known to be very risky.”

The ability to make such discoveries involves an “extremely rigorous” educational journey of seven or more years beyond an undergraduate degree. It takes a combination of medical school and extensive research training to become a medical doctor with a Ph.D., said Dr. Stuart Flynn, dean of the University of Arizona College of Medicine-Phoenix.

“Individuals with the dual medicine and research background are ideally positioned to first understand and experience the complexities of the human body and many of its maladies as physicians, but to then frame probing questions that will lead to the next discovery to understand and possibly cure the disease being studied,” Flynn said.

Our M.D.-Ph.D. physicians represent a specially trained group of physician scientists who not only treat patients today, but may also be discovering the cures for tomorrow,” he said.

A major problem is the cost of such an extensive education, Flynn said. Another is that “our brightest may find alternative careers than medicine, given the increasing bureaucracy of being a physician,” he said.

“If we want to remain one of the global leaders in scientific advancements in medicine, we cannot afford to lose the critical foundation our M.D.-Ph.D.s play in our future,” Flynn said.

Kemper, who trains osteopathic physicians, said it takes a “certain kind of person” to go through the process of earning a Ph.D. on top of a medical degree. Candidates must devote four years to medical school, three or four to a Ph.D. program, and then three to seven additional years to a residency.

“If you start the process in your mid-20s, you are 11 to 15 years older before you can begin to work as a board-certified physician,” she said.

A doctor of osteopathic medicine with a Ph.D. could work in research for the pharmaceutical industry or for a university. He or she might teach in medical schools and specialize in areas that involve clinical research, such as oncology.
Lost in the U.S. Supreme Court challenges, political rhetoric and fights over contraception coverage under the Affordable Care Act are some fundamental shifts the law makes in the way care is delivered. The $3 trillion U.S. health care industry accounts for 17 percent of the nation’s gross domestic product — far and away the most of any industrialized country.

Talk to physicians, hospital CEOs and other health care industry executives, and they will mention the U.S. system shifting from a fee-for-service model to one centered around value-based reimbursements.

The jargon may be lost on patients, but the value-based model looks to change how medical care is provided and paid for, said Dr. Daniel Derksen, a medical professor at the University of Arizona’s Mel and Enid Zuckerman College of Public Health in Tucson.

“There are huge seismic changes to how we are going to do payments,” said Derksen, who recently testified before Congress on Medicare and other health insurance payments. He’s also the director of the UA’s Arizona Center for Rural Health.

The pre-ACA health industry centered mostly around a fee-for-service model. Doctors and hospitals would provide surgery, treatment and other services to patients and then get paid for those specific services by Medicare, insurance plans and the patients.

Derksen said that created a volume-based business for health care providers. The more patients a doctor treated, the more procedures or tests were performed to propel the business.

But it also encouraged expansive price hikes, according to Derksen and other health care policy analysts, including Paul Ginsburg of the University of Southern California’s Schaeffer Center for Health Policy and Economics.

One contention is fee-for-service care encourages medical providers to provide more treatments and insurance companies and hospitals to push up costs to cover their bottom lines.

“You have perverse incentives in a fee-for-service world,” Derksen said.

So, one of the hallmarks of health care reform under ACA is to shift the system to value-based reimbursements. That’s where physicians and providers are rewarded and reimbursed for the quality of care and outcomes, not how many procedures they conduct or patients they see.

The ACA’s value-based approach looks to make the U.S. system smarter and more cost-efficient, and to curtail inflation.

But it’s a titanic task to move to that model. It requires defining new values and reimbursements and getting them to work, while not compromising patient care or physicians’ practices.

The U.S. Department of Health and Services and the U.S. Centers for Medicare and Medicaid Services recently published an 815-page rule changing the provider payment guidelines. Derksen said Medicare reimbursement and payment rules often are mirrored by providers, insurers and others in the health care supply chain.

Skeptics question how value-based care will be defined and whether it will actually control costs or improve care.

“It’s not clear if a lot of the changes are going to change or improve the system,” said Naomi Lopez Bauman, director of health care policy for the Goldwater Institute. The Phoenix-based libertarian group has opposed ACA from the start.

“Parents have the peace of mind that their children can stay on their health insurance until they turn 26. And no American has to ever worry again about being denied care for pre-existing conditions or reaching a lifetime or annual limit for their insurance coverage.”


thank you for letting us play a small role in your delivery of great health care throughout arizona
Bauman said the value-based model gives more price-setting powers to the federal government and includes some mandated coverage that some don’t need or want.

She worries there still is not enough price transparency from hospitals and doctors to give patients and consumers ideas of how much their care costs.

Derksen also sees some challenges in value-based care, including whether hospitals and doctors will tailor patient care and treatments – and even which patients they choose to see – to maximize their bottom lines under a non-volume-oriented model.

Bauman points to some U.S. states where doctors decline Medicaid patients because offering them treatment can be a money-losing proposition. She said private and public employers already are trimming high-end insurance plans in anticipation of a 40 percent federal tax on “Cadillac plans” that goes into effect in 2018. She worries value-based changes and coverage mandates from Washington will push further changes.

Combined with the costs of complying with electronic medical records requirements, that could push more doctors out of independent practice or even into retirement.

Hospital executives say they are spending lots of money employing attorneys, accountants and technology to get themselves and their business models in line with the ACA and all of its changes.

Still, Bauman is skeptical of how much pain the $3 trillion industry is feeling. “I call it a crane index,” she said of hospitals and the industry. “They cry ‘poor’ all the time, but how many wings are they adding?”

Politically, Democrats continue to back the ACA and point to its popular provisions. Republicans still hammer the law and hope the 2016 change in the White House will be in their favor so they can get rid of the reforms.

“Parents have the peace of mind that their children can stay on their health insurance until they turn 26. And no American has to ever worry again about being denied care for pre-existing conditions or reaching a lifetime or annual limit for their insurance coverage,” said U.S. Rep. Ruben Gallego, D-Ariz.

U.S. Rep. Trent Franks of Arizona and other Republicans continue to push constitutional arguments against the ACA and its taxing elements.

“Obamacare as a tax that originated in the Senate is, quite simply, unconstitutional,” said Franks, who is part of another GOP push to undo the law on constitutional grounds.

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(Percentage of national GDPs spent on health care, 2013. Major industrialized and other notable countries. Source: World Bank.)

Daniel Derksen

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Doctors shifting from private practice to corporate clinics

BY ERIC JAY TOLL
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The kindly family doctor in a white lab coat stood for decades as the stereotypical image of the American physician — practicing alone or with a partner or two, backed up by stern but lovable nurses and a crotchety, efficient office manager.

The Affordable Care Act has pushed the independent physician out of private practice and into corporate clinics.

“There are regulatory and compliance costs, technology requirements and medical school loan payments that make it impossible for today’s graduating (doctor) to open a private practice,” said Robert Dudley, senior vice president and health care services manager for Bank of Arizona’s holding company, Bank of Oklahoma. “Today’s (medical) graduate just wants a job.”

Dr. Wyatt Decker, CEO of Mayo Clinic Arizona, said the three basic forms are the employee model, the fee-for-service model and the blended model. The fee-for-service model is dominant in Arizona.

“There are benefits to all systems,” he said. “Mayo uses a physician-employee model for a number of reasons.”

Banner Health uses a different approach across its seven states. Jim Brannon, CEO of Banner Medical Group, said the physicians group looks at both an employment model and contractual arrangements through the Banner Health Network. Brannon’s group handles the employment contracts.

Brannon said his organization grows through both acquisition and recruitment. Asked whether new doctors prefer an employment model, he said, “Absolutely. More and more, this is the case.”

“Most young doctors today leaving medical school are recruited to join Banner,” he said. “With the amount of debt being carried and the cost of starting a private practice, they want to be on salary in a hospital or large independent group.”

Decker and Brannon both said one aspect of health care changed by the ACA is the new emphasis on wellness and preventive medicine.

“At Mayo, we use an integrative approach to treatment,” Decker said. “The employment model assures our patients that every professional on their case is a Mayo Clinic professional. From our perspective, it sets a high bar that gives a patient a certain level of confidence.”

Brannon said the Banner model is a combination of convenience and integrated care.

“Our system is designed to ensure coordination of care,” he said. “We want our primary practitioners to be located in areas convenient to the patient. If specialized care is needed, our network has referral options.”

Acquisition is a different type of recruitment for Banner, according to Brannon. It’s being driven by the change in the health care model.

“As a practice matured, an established doctor and partners would take in younger associates,” said Dudley. “They would grow the practice and, along the way, the associate would buy in to take it over.”

In some cases, private practices acquired real estate or medical office condos. The Great Recession and changes in medical technology and practice hammered those values.

“Without the young associates, established practices don’t have the value a physician might have planned,” said Brannon. “Some of our expansion has come from acquiring these practices. If the location is right and the real estate efficient, we might acquire that as well.”
Students taking on the endeavor of becoming doctors face a new world of education that is more collaborative, technology-based and learning-intensive. This has replaced the old culture of “the buck stops here at the doctor,” according to Dr. John Shufeldt, who graduated from medical school in 1986.

Back then, physicians were taught that they were the last line of defense for a patient and were led to believe they were kings, according to the CEO of MeMD. That “fortunately has gone by the wayside,” he said.

Now, young medical students are taught to collaborate with the entire medical staff to give better care to the patients. Another change has erased the image of a nervous medical student learning to put an IV into a live patient’s arm. Today’s medical students learn key procedures through simulations long before they have the chance to practice on patients.

“By the time they go out, it’s a lot less scary than it was for students of the past,” said Dr. Lori Kemper, dean of Midwestern University’s Arizona College of Osteopathic Medicine.

“Standardized patients” are part of the picture now, too. A volunteer will pose as a patient with symptoms, then give feedback to the medical student, said Dr. Stuart Flynn, dean of the University of Arizona College of Medicine–Phoenix. This helps students better interact with patients.

A common complaint in the past was that doctors weren’t very sociable with staff and patients, but now they’re being trained to be more sociable, Flynn said.

With more technology, new procedures and more medical discoveries, training physicians to be up to date has been a big challenge.

“(The) biochemistry I was taught in school is rudimentary compared to what they’re learning now,” Kemper said.

The amount of knowledge available to medical students is much greater now and continues to expand, she said.

Schools are teaching students research methods to attain new knowledge and implement new procedures they learn about, instead of forcing them to memorize every piece of information available.

Teaching medical students how to increase their knowledge isn’t new, said Kemper, but it has become more important with the wider availability of information and newer technology.

Electronic medical records have been a point of contention among physicians, as some have called the technology clunky. Teaching it to new students doesn’t seem to be much of a problem, however, because they are already so tech-savvy, said Flynn.

The professors at Midwestern still teach students to take notes by hand to further hone their critical thinking skills and come to a proper conclusion without the help of a computer program, Kemper said.

Which computer program being used depends on the hospital or clinic the medical student eventually will work at, so they still have to take notes the old-fashioned way, she said.

Through all of these changes, critical thinking has remained one of the most important things to teach students, the doctors said.

Thanks to more hands-on training through simulations, technology and the wealth of information available to them, even on their smartphones, medical students are much better equipped.

“If we’d had this conversation 20 years ago, I would have had little to say,” Flynn said.
HEALTH CARE

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NOTEBOOK

Aging population contributes to physician shortage

A recent study by the Association of American Medical Colleges concludes that the nation will face a shortage of between 46,000 and 90,000 physicians by 2025.

The nation’s growing aging population accounts for the majority of the increase in demand for physicians, while the Affordable Care Act is having minimal impact on the shortage.

“There’s no way to slice and dice this; there’s gonna be a physician shortage,” said Dr. Alan Leibowitz, chief academic officer of Banner Health and chairman of the Department of Medicine at the University of Arizona College of Medicine–Phoenix.

He’s worried about the future workforce of physicians as millennials replace retiring doctors.

“Will they want to work the same hours and see the same number of patients?” Leibowitz wonders.

Mayo Clinic and Arizona State University are working on a unique partnership to open a branch of Mayo Medical School at Mayo Clinic in Scottsdale by July 2017.

The new curriculum will teach students not only to provide the high quality, patient-centered care that is the hallmark of Mayo Clinic, but also provide medical students the tools required to flourish in the changing health care environment, said Dr. M. Edwyn Harrison, associate dean of academic affairs for Mayo Medical School in Arizona.

“Mayo medical students will be the first in the nation to be exposed to essential principles of systems management, engineering, economics and information technology, in a comprehensive program called the Science of Health Care Delivery,” Harrison said. “Students who are inspired to pursue further studies in this new discipline will have the option to complete a master’s degree from Arizona State University within their four-year program.”

Dr. Craig Phelps, president of A.T. Still University’s Arizona College of Osteopathic Medicine in Glendale, said she is inspired to pursue further studies in this new discipline will have the option to complete a master’s degree from Arizona State University within their four-year program.

Physicians are needed now, and many physicians from other countries are serving in physician shortage areas in rural and urban America,” he said.

“This trend will continue until 2035, when most of the baby boomers have moved on.” Phelps said Arizona is in particular need of physicians because of its vast rural areas, unfavorable reimbursement for services, lack of tort reform, economic homogeneity, and low educational and high poverty rankings.

“Many young and experienced physicians choose not to practice in Arizona due to these and additional concerns,” Phelps said.

It’s going to take a new type of physician for the future of health care, he said. “Tomorrow’s physicians and additional health care team members will need to be educated in areas of interdisciplinary collaboration, leadership, critical thinking, community health, applied technology, cultural proficiency, social responsibility and interpersonal skills.”

Dr. Lori Kemper, dean of Midwestern University’s Arizona College of Osteopathic Medicine in Glendale, said she is trying to improve access for primary care.

“We matched over half our 250 graduates to family medicine, internal medicine and pediatrics residencies in 2015.” Kemper said.

NEW CT SCAN UNVEILED AT ANIMAL SURGERY CENTER IN SCOTTSDALE

Animal Medical and Surgical Center in Scottsdale now has a $250,000 cone beam computed tomography machine for pets.

The new CT scanner offers more detail and manipulation than traditional X-rays and is much faster than standard CT machines, said Dr. Rory Lubold, veterinary and medical director for AMSC.

This NewTom 5G Cone Beam CT can scan a pet within 18 seconds, compared with 20 to 30 minutes on standard CT scanners, he said.

CLOSER LOOK

Congress is looking for ways to help address the physician shortage by increasing the number of graduate medical education spots nationwide.

HR 2012 and companion Senate Bill S1148 both seek about 15,000 residency positions between 2017 and 2021, said Jason Bezozo, vice president of government relations for Banner Health.

“Both bills are important for ensuring access to care, especially as the Medicare program grows in population and individuals have increased access to insurance,” he said.

INNOVATION

MERCY MARICOPA FACILITY COMBINES MENTAL, PHYSICAL CARE

Mercy Maricopa Integrated Care is getting its first fully integrated behavioral and physical health care center.

Assurance Health & Wellness Center–Phoenix, which is wholly owned by SinFonia HealthCare, will offer these services for members of Mercy Maricopa, which has a contract with the Arizona Department of Health Services to operate as the Regional Behavioral Health Authority, or RBHA, to oversee public behavioral health care.

As I’ve written in the past, one of the reasons the state health department changed its RBHA contracts is because integrated programs can remove barriers to primary care and help people get the treatment, services and support that they need. Life expectancy for people living with serious mental illness is 25 to 30 years less than the general population, largely because of medical conditions, such as diabetes and heart disease, which are treatable, and preventable risk factors such as smoking, obesity, substance abuse and inadequate access to care.

THE ADVANCE

Provided by Animal Medial and Surgical Center

Dr. Rory Lubold, medical director for AMSC, works with technician Samantha Hernandez to CT-scan a cat.

PHOENIX BUSINESS JOURNAL

Senior Reporter
Angela Gonzales