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- » Head and Neck Oncologic Surgery
- » The Early Years

# Demographics

- US population in 2000 (282,000,000)
- US population in 2050 (420,000,000)
- Absolute increase in number of cancer patients
- Dramatic increase based on aging population

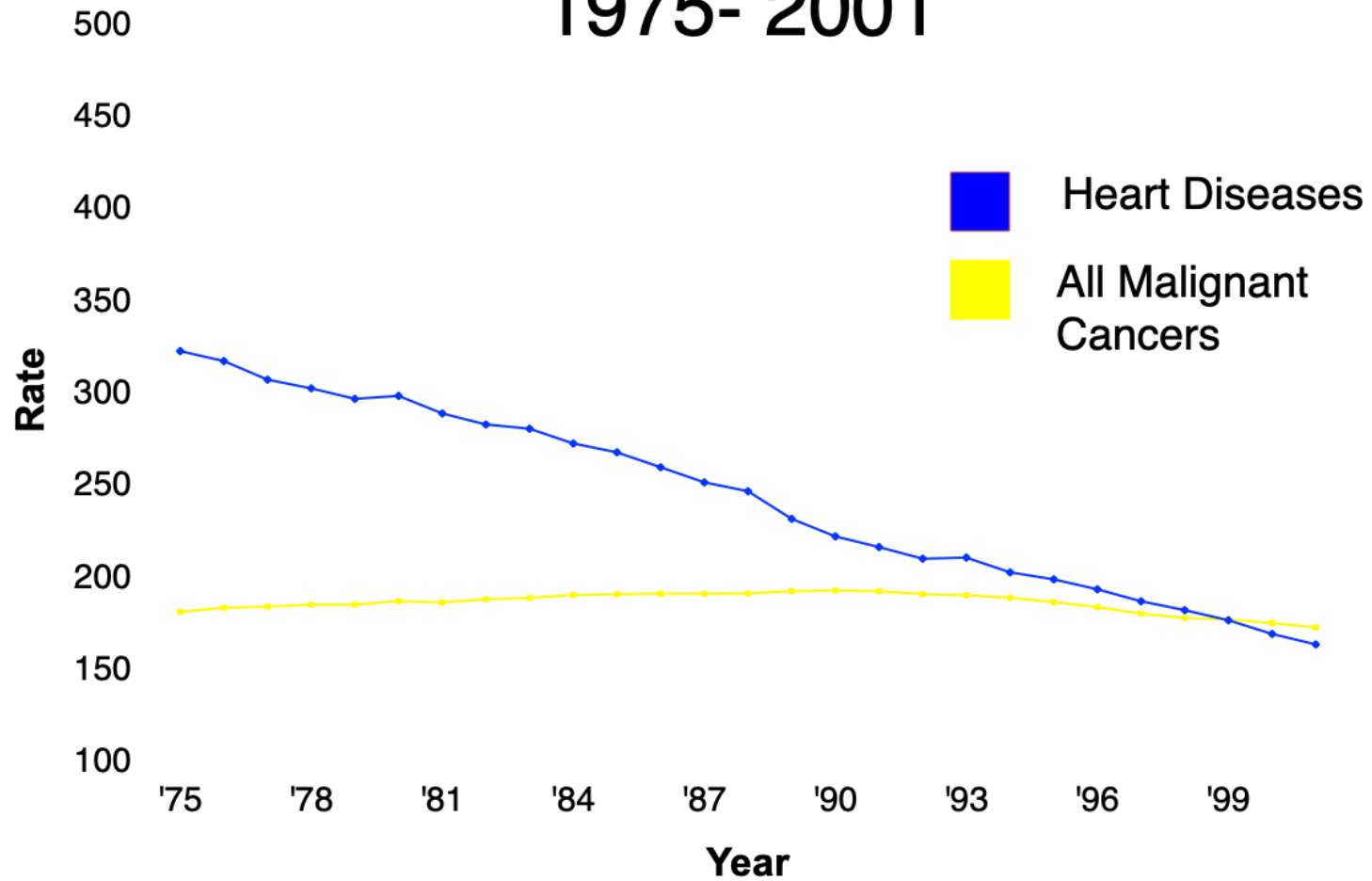
# Absolute Number of Cancers

- US 2000 (1,300,000)
- US 2050 (2,600,000)
- 25% increase from 2000 to 2010
- NE 2000 (8,210)
- NE 2050 (16,420)

## Cancer in an Aging Population

- 2000 to 2030 patients over 65 doubles
- 2000 (389,000) over 75 with cancer
- 2050 (1,102,000) over 75 with cancer
- Number of cancer patients over 85 X 4

# Trends in Mortality from Cancer and Heart Diseases for Ages 85 and Under in U.S. 1975- 2001



Incidence and mortality rates per 100,000 and age-adjusted to 2000 US standard population  
SEER Cancer Statistics Review 1975-2001.

## The Problem

- » Fellowship applications have decreased significantly over the past 10 years
- » Declining reimbursements, lack of support, and lifestyle issues are possible reasons for a critical shortage of future applicants
- » Academic chairs consider head and neck surgery a revenue loser
- » To date no financial study of the specialty has been performed

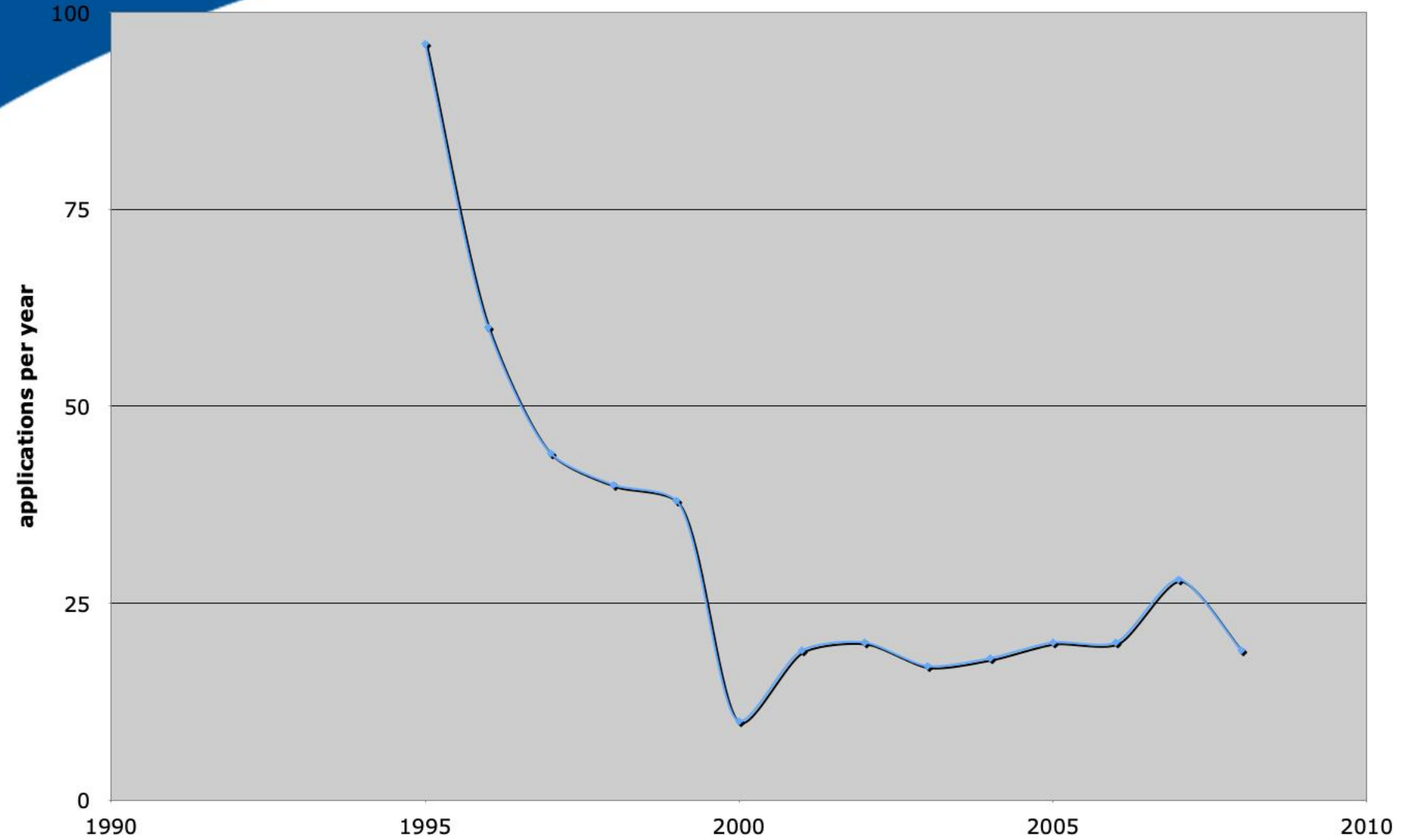
## The View from Presidential Addresses

- » MacComb 1969- Numbers of HNS not adequate
- » Goepfert 1995- Surgeon-Scientist, service oriented work necessary to capture reimbursement
- » Medina 2000- declining number of HNS applicants and declining reimbursement
- » Heller 2002- academic over private practice, declining reimbursement, lifestyle issues

## Presidential Addresses (cont)

- » Levine 2003- reimbursement
- » Shah 2004- Head and Neck Surgery in crisis: long working hours, declining patient volumes, declining reimbursement

Head & Neck Fellowship Applications



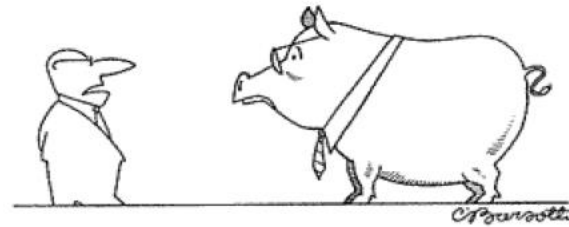
## Current Assumptions

- » Cancer, including HNC, is a chronic disease
- » Cancer patients are centrally referred
- » Multidisciplinary care is necessary
- » Need to evaluate these services to understand the entire financial margin
- » Hospitals can recognize the value of a HNC practice

## Hypothesis

- » The physician reimbursement represents a small fraction of the financial benefits of a head and neck surgical oncology practice to a hospital system.

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*"Basic economics—sometimes the parts are worth more than the whole."*

## Study Parameters

- » All hospital charges related to services rendered to patients of the HNS partners between January 1, 2003 and December 31, 2003.
- » All charges related directly to services rendered by the partners, CT, Hospital charges, etc.
- » New and Return patients
- » Geographic patient distribution
- » Payer mix

## What You Can Deliver

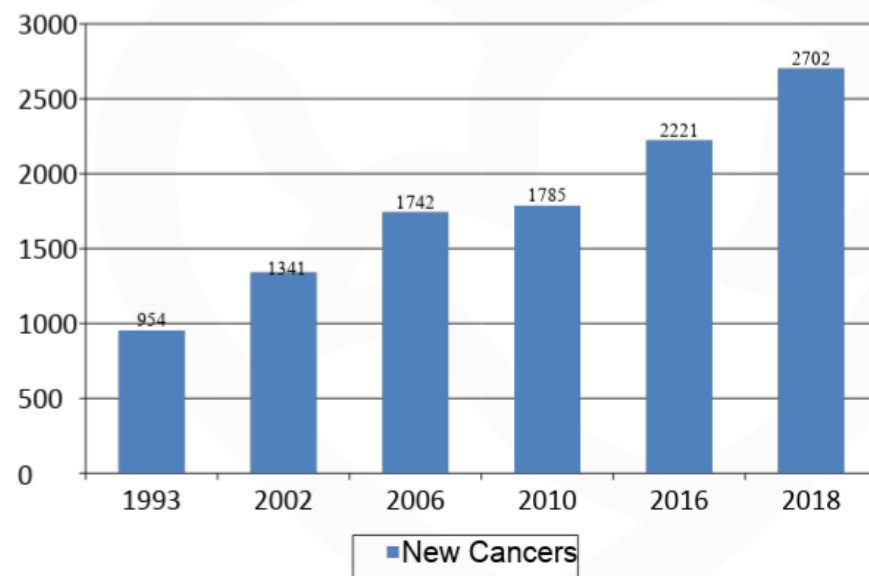
- » Down stream revenue is significant
- » Stress importance of decreasing length of stay through innovative programs and outpatient care
- » Train residents in how to practice more efficiently in and out of the operating room
- » Large practice with long term follow-up
- » New patients to the system from regional referrals
- » Develop Clinical Research to test hypotheses of care models
- » Work with the AHNS on quality initiatives

## Life Style

- » With a team approach, cases can be done before 4-5 PM
- » Multiple partners means fewer weekends on call and rounding
- » Monetary rewards can be supported by alternate means
- » Collegiality among team members enhances interest and enthusiasm

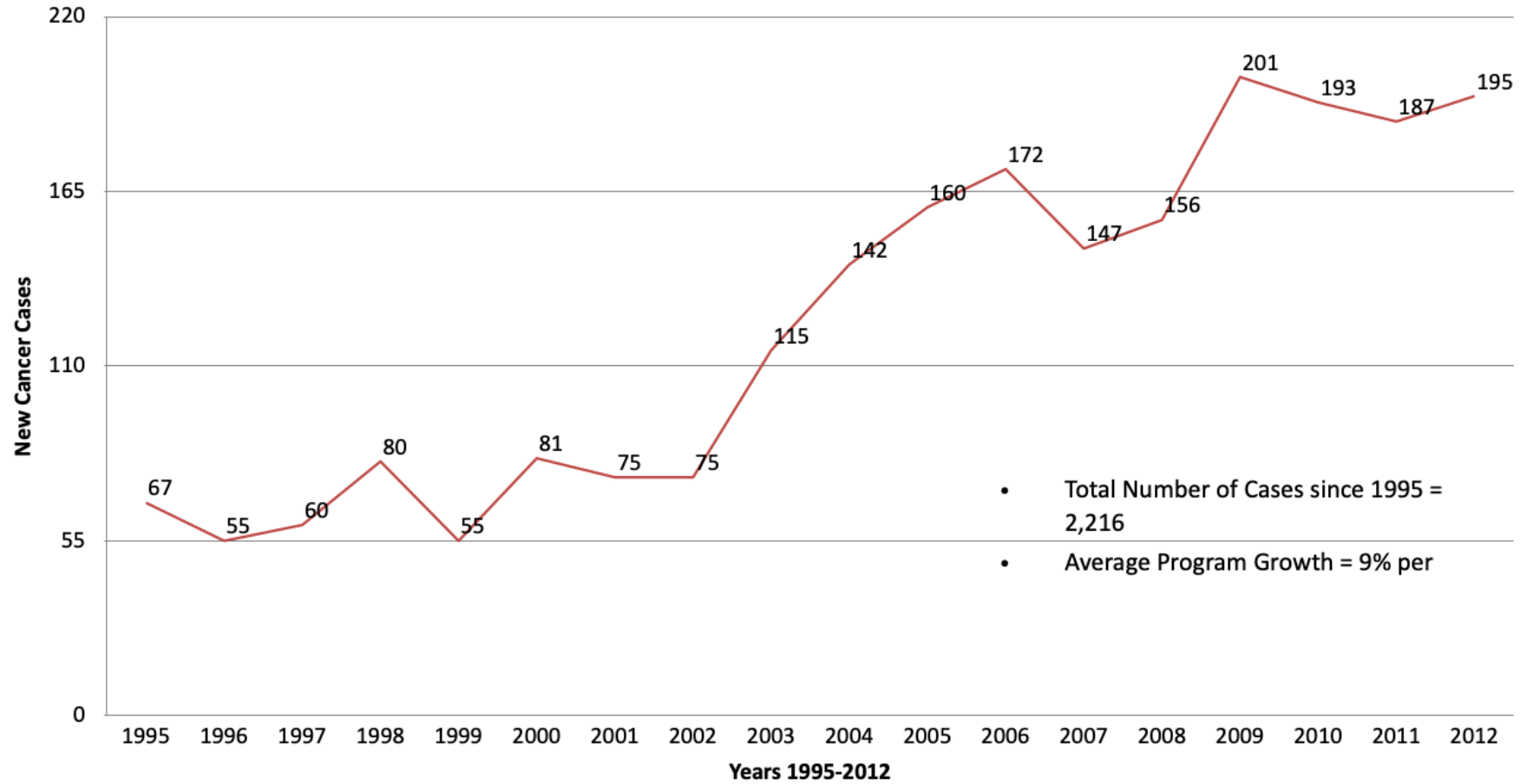


## Methodist Estabrook Cancer Center Increase in New Cancer Cases

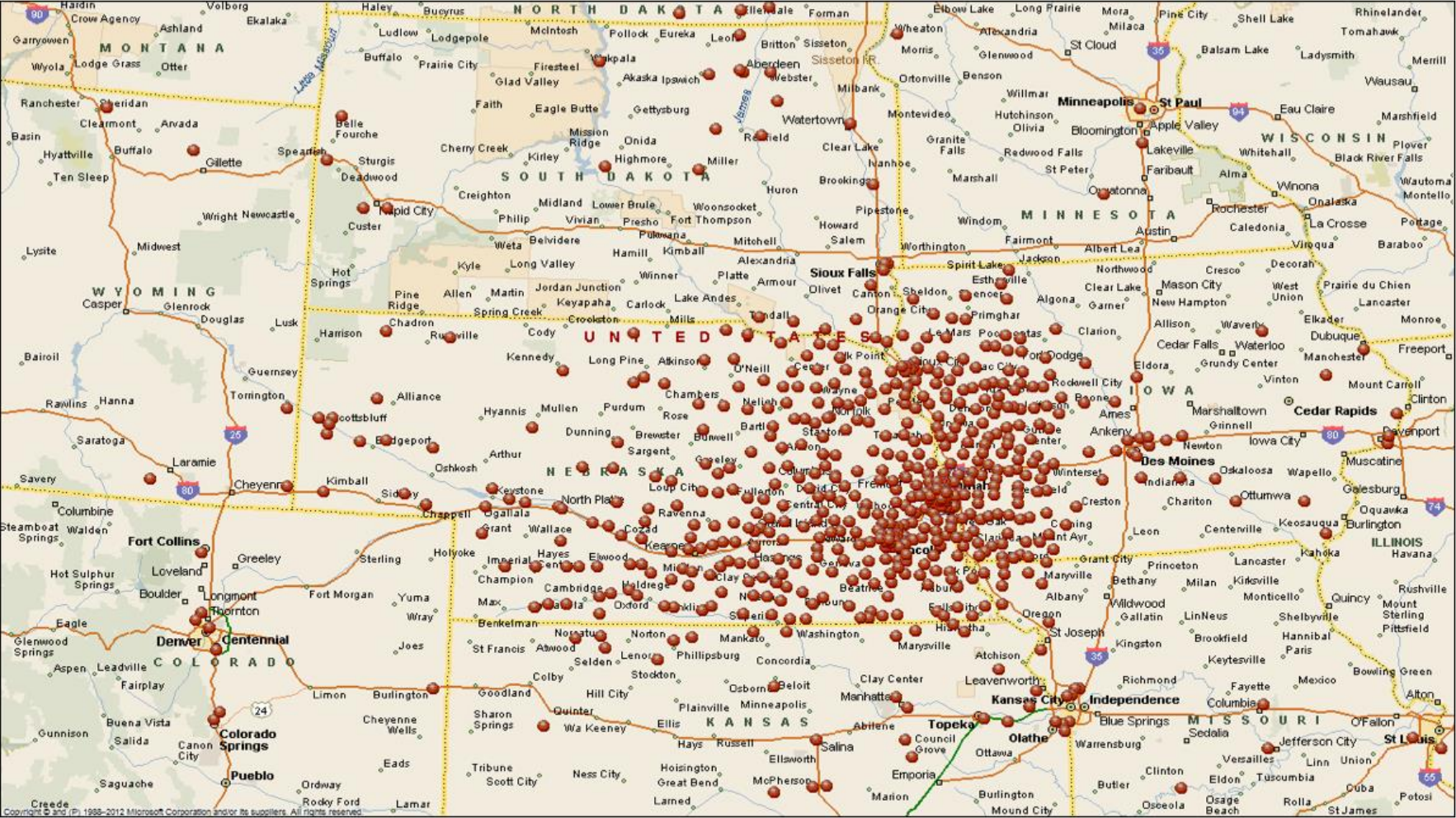


# New Cancer Patients-Methodist

## Head & Neck Oncology New Cancer Cases 1995-2012



# Patient Origin Region



# Patient Origin Country



# Strategic Plan Building A Team

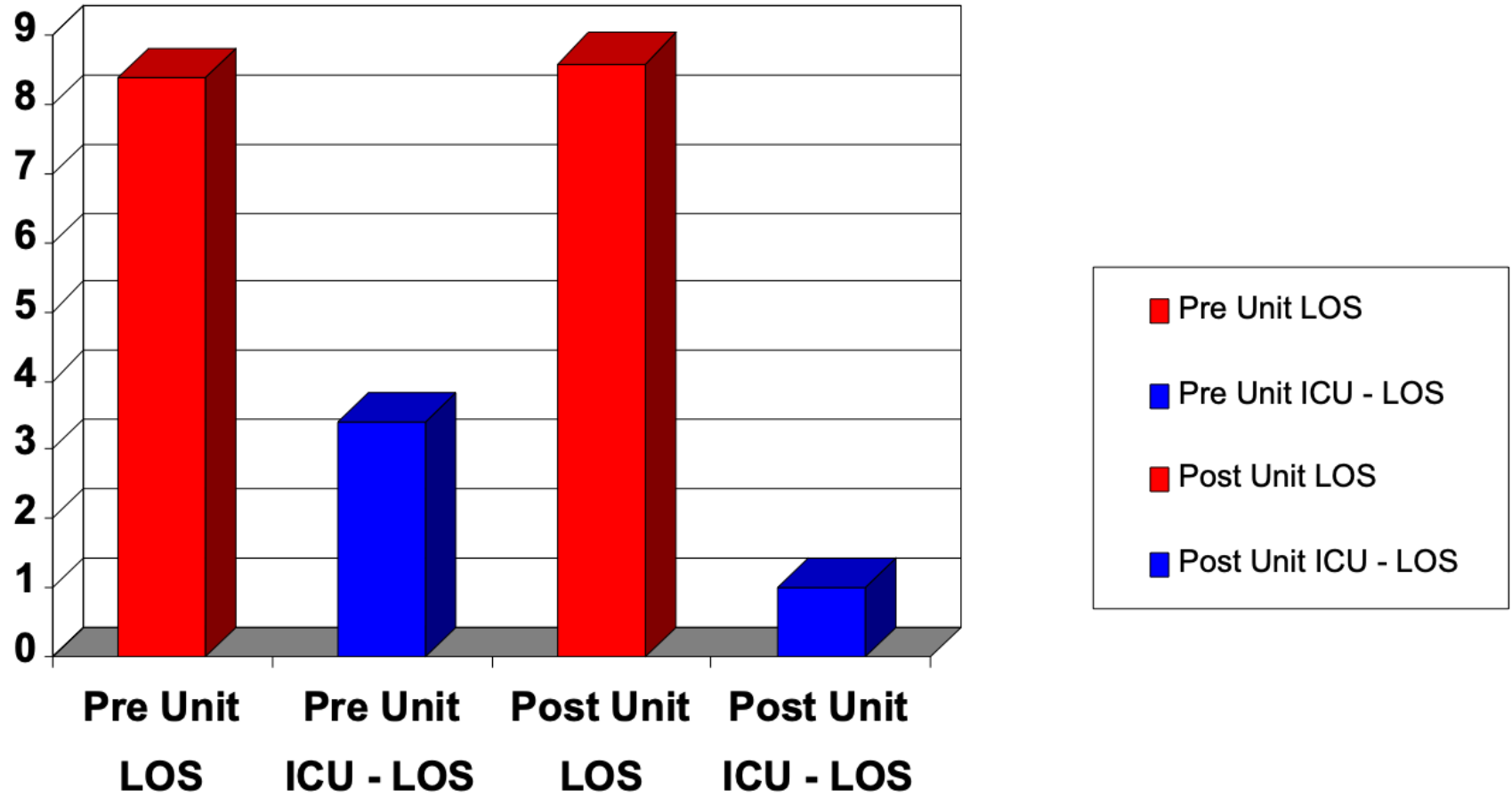
- » Social work
- » Dietician
- » Speech swallowing
- » Hereditary risk and prevention
- » Head and neck oncology
- » Radiation oncology
- » Pathology/Radiology
- » Medical Oncology
- » Psycho-oncology
- » Dental oncology
- » Midlevels, Nurses
- » Survivorship/ Harper's Hope

## Rationale for Head and Neck Oncology Unit

- Sent to the ICU because of a fresh tracheostomy or airway concerns without the need for a vent
- Sent to the ICU for monitoring of a free flap
- Sent to the ICU because of a need for higher nursing acuity
- Ultimately go to a floor with a different level of care

## Inpatient H&N Unit (continued)

- Protocol treatment algorithms/printed orders
- Inpatient unit something unique to Methodist
- Improved continuity of care for patients re-hospitalized
- Nurses established part of the team
- Cost savings



## Head and Neck Surgical Oncologists

- » Alan Richards
- » Aaron Wieland
- » Russ Smith
- » Oleg Militsakh
- » Rob Lindau
- » Aru Panwar
- » Andrew Coughlin
- » Angela Osmolak
- » Andrew Holcomb
- » David Guo

## Vision

Methodist Head and Neck Surgical Oncology will be recognized as an internationally pre-eminent clinical and educational program and the most prominent Midwestern referral destination

## Mission

- Our fundamental mission that drives all others is to **provide the most advanced multi-disciplinary care available to patients** with neoplastic diseases of the head and neck.
- Our supporting missions also of critical importance and derived from #1 are:
  - To deliver a **comprehensive educational experience** for fellows, residents, students and practicing clinicians to meet societal needs for future medical care.
  - To conduct **clinical and translational research** that will have a positive impact on the quality of life, functionality, and survival of patients
  - To be the **resource** for the medical and lay community on all aspects of head and neck oncology through community and regional lectures, screenings and media participation.

Physician commitment is critical

Culture is the soil from which excellence grows

Administrative support is vital to success

Team work

Put the patient first

Thank you to all that are and have been part of  
the head and neck team!