ALLERGY

- **Strengths:**
  - Strongly alignment and collaboration with Pediatrics.
  - Strong foundation and history of extramurally funded research.
  - NIH funding towards human research.
  - International and national reputation of faculty.
  - Strong scholarly activities and publications.

- **Weaknesses:**
  - Lack of technical revenue from skin testing in clinic does not provide a sustainable source of funding for other missions.
  - Scheduled cFTE of 1.7 is benchmarking at the .8 cFTE level. No provider benchmarks higher than the 1<sup>st</sup> %tile of the UHC benchmark data.
  - Loss of U-19 Center grant.
  - Poor position from which to negotiate with Medical Center.
  - cFTE capacity is not conducive to adding more clinical service due to other mission responsibilities.

- **Opportunities:**
  - High market demand for clinical services.
  - Create new venues for clinical services whereby the technical revenue for skin testing can be earned.
  - Cultivate and mentor junior faculty in the clinical mission.
  - Collaboration with other subspecialties.
  - Application of new center grant for a significant shift in focus on food allergy research.
  - Collaboration with other subspecialties.
  - Leverage national reputation.
  - Outsourcing the clinical practice management.

- **Threats:**
  - Not having a sustainable funds flow from the clinical mission that can support the other missions necessary for a rounded academic Division.
  - Open market can be filled by competition.
  - Other subspecialists filling the market demand; Dermatology, ENT.
CARDIOLOGY

- **Strengths:**
  - Outstanding clinical service with well-run outpatient clinics able to provide appointments in < 24 hours;
  - Recognition by Reuters as Top 50 Cardiac Hospital, two years in a row.
  - Expanded services through Outreach in locations North, East, and West of Charlottesville
  - Heart Failure program building momentum and enhanced referral base for interventions with successful integration of additional MD.
  - Expansion of imaging to include Cardiac PET, led by energized and effective MD from our fellowship program.
  - NP-staffed private cardiology inpatient service showing anecdotal evidence of favorable impact on service quality and patient satisfaction.
  - Buchanan to Cardiology (Valve) provides some financial support for expanded percutaneous valve program.
  - Recent Vascular medicine hires (non-invasive and interventional) have positioned the division for growth with that core service line

- **Weaknesses:**
  - Procedural activities show concerning trends in volumes while complexity is increasing. The division is adjusting from a clinical mix that was financially driven by procedures to a blend that is more balanced between procedures, E&M, and grants
  - Salaries for some are below benchmarks as well.
  - Numerous areas of funds flow that require adjusting

- **Opportunities:**
  - Center of Excellence initiatives to enhance access, efficiency, and quality
  - Continued recruitment efforts in heart failure and cardiac transplantation
  - Expansion of the Hospital to Home program to combat Heart Failure readmissions
  - Develop clear metrics to assess NP-staffed services, using admission data, UHC outcomes data, and patient satisfaction data.
  - Review NP program support from the Hospital to ensure that the clinical mission is optimized but not having the financial personnel cost/burden be on the division

- **Threats:**
  - Limited market size and stagnant PSA population growth
  - Augusta Medical Center continues to expand their Heart and Vascular Center and the division needs to develop a strategy to foster collaboration.
  - Need to maintain focus on innovation and high risk activity.
  - Need to balance clinical needs with needs of faculty to maintain clinical, research and education balance.
ENDOCRINE

- **Strengths:**
  - Historical research portfolio
  - Faculty recognition and clinical reputation
  - Effective management of unfunded research risks

- **Weaknesses:**
  - Lack of Sufficient Research Funding
  - Lack of dedicated inpatient diabetes program
  - Successful Recruitment of junior clinical investigators as current physician scientists retire

- **Opportunities:**
  - Patient population will continue to grow (diabetics, obese patients)
  - Opportunities for patient care centered research increasing
  - Many quality initiatives will center around management of chronic diseases – opportunity to lead DOM and UVA in quality

- **Threats:**
  - Upcoming retirements threaten national reputation as well as clinical productivity and volume targets
  - Community hospitals threaten patient retention in chronic disease management (vs subspecialties centered around acute care)
  - Decreasing research funding
  - Less competitive salary threatens recruitment/retention of junior faculty
GASTROENTEROLOGY

- **Strengths:**
  - Skilled, productive, and International renowned Clinical Faculty
  - Highly collaborative multi-disciplinary programs
  - Differentiating Technologies/Techniques/Programs
    - EUS
    - EMR
    - Barrx
    - ESD (1st center in US)
    - Advanced ERCP
    - Liver transplantation.
    - Advanced treatment of Varices
    - IBD
    - Viral Hepatitis
    - FMT (Buchannon Grant)
  - Clinical Trials/Clinical Research (IBD, NASH, Cirrhosis, Viral Hepatitis, Liver transplantation, Artificial Liver)
  - Fellowship training programs (General GI, Advanced Endoscopy, Transplant Hepatology)
  - Teaching/Education-(UME/GME) numerous awards to faculty.

- **Weaknesses:**
  - Poor Access to outpatient services
  - Barriers to Referring Physician transfer to Inpatient service.
  - Crowded and inefficient outpatient facilities
  - Lack of state-of-the-art outpatient endoscopy facility
  - Inadequate Interventional GI facilities and Anesthesia/Nursing support impairs Interventional productivity and quality
  - Too few faculty
  - Inadequate presence in GI Motility and in Functional GI disease
  - Loss of translational and basic research base

- **Opportunities:**
  - Recruitment of new IBD Faculty (Dr. Tuskey) has resulted in increased availability of IBD appointments
  - Dr. Mann’s recruitment enabled us to attract a faculty member with strong interest in motility (no regional competitors)

- **Threats:**
  - Loss of referral base due to:
    - To few providers
    - Mandate for Care Connection (~500 new appts./year) which has drastically reduced avail of new appts for outside referring MDs.
    - Poor patient experience
    - Long waits for inpatient transfers
  - Retention of faculty
    - Erosion of academic mission
    - Below market compensation
    - Poor morale
    - Loss of engagement/collaboration with MC on Quality and Operations
  - Loss of research base/national reputation as an Academic GI division
    - Likely loss of NIH funded T32 Institutional GI Training due to inadequate research base
  - Degradation of the Fellowship program from potential loss of GME funded fellowship slots
GENERAL INTERNAL MEDICINE, GERIATRICS, PALLIATIVE CARE AND HOSPITAL MEDICINE

• **Strengths:**
  - Strong primary care clinical programs
  - Teaching excellence at all levels
  - Across-grounds & peer institution collaborations
  - Decreasing mortality index
  - Expertise in technology-based systems of learning
  - One of the largest funded palliative research programs
  - Expertise in quality improvement, patient safety and appreciative practice
  - First nationally recognized patient-centered medical home at UVa

• **Weaknesses:**
  - Challenges in retention and recruitment across specialties
  - Decreasing national profile in palliative care
  - Insufficient research funding

• **Opportunities:**
  - Expansion of Palliative Care services
  - Expanded home visits program
  - Enhanced Quality & Patient Safety education
  - Partnership with Contemplative Sciences
  - Global Health partnerships
  - Interprofessional education
  - Model for accountable care organizations
  - Inclusion of Integrative Medicine
  - Unfilled endowed chair in General Medicine
  - Unfilled endowed chair in Geriatrics

• **Threats:**
  - Non-Competitive Faculty Salaries
  - Changes in Payor Mix & Reimbursement
  - Significant Cuts in GME/UME Funding
  - Productivity Targets Impacting Faculty Job Satisfaction
HEMATOLOGY/ONCOLOGY

• **Strengths:**
  - International and national reputation of senior faculty.
  - Recruitment of excellent new faculty (GI, Thoracic, Benign Hematology, GU, Hematologic Malignancies) to strengthen subspecialties.
  - Strong relationship, alignment and collaboration with UVa Cancer Center.
  - MOUs with Medical Center.
  - Focus on Cancer as a Center of Excellence.
  - Sustained and growing clinical productivity.
  - Emily Couric Clinical Cancer Center (ECCCC) state-of-the-art space and on-site ancillary services.
  - ACGME accredited fellowship program.
  - NMDP accredited Stem Cell program.
  - Growing focus on clinical research and establishment of infrastructure.
  - Institutional acquisition of multi-site community practice (HOPE Cancer Care).

• **Weaknesses:**
  - ECCCC capacity and inefficiencies in clinic/infusion/other procedures (operational) workflow.
  - Reliance on MOUs for financial sustainability and not at a level that provide for growth and new programming.
  - Limitations of hospital inpatient design for program growth.
  - Inadequate and fragmented clinical trials infrastructure.
  - Limited institutional investment in clinical research.
  - Limited number of mid-career faculty to provide mentorship and for succession planning.

• **Opportunities:**
  - High demand for clinical services/subspecialties.
  - Expansion of inpatient capacity.
  - Quality initiatives in support of strategic plan.
  - Mentor and support (UVa Cancer Center start-up funds) new faculty in clinical research.
  - Collaboration with other subspecialties in establishing multidisciplinary teams for cancer treatment.
  - Recruitment of additional mid-career and senior faculty who will also carry leadership responsibilities in the UVa Cancer Center.
  - Growth and full accreditation of Stem Cell Transplant Program (Cellular Therapy Program).
  - Scholarly activities and publications.
  - Leverage national reputation.
  - Increase use of physician extenders.

• **Threats:**
  - Unsustainable infrastructure/financial model for clinical trials.
  - Regional competition.
  - Eroding payor mix.
INFECTIONOUS DISEASES

• **Strengths:**

  **Clinical**
  - Fourteen faculty that are board certified in ID, and a superb group of 9 fellows that are clinically excellent, academically oriented and nationally recruited.
  - Major texts originate from UVa, including *Principles and Practice of Infectious Diseases* (Dr. Mandell), *Infections of the CNS* (Dr. Scheld), *Tropical Infectious Diseases* (Dr. Guerrant), *Clinical Virology* (Dr. Hayden), and *Medical Parasitology* (Dr. Petri).
  - Goals for Clinic wait times for appointments have been consistently achieved
  - Percentage growth in RVUs is the highest for any Division
  - Robust QA/QC Program in the Division that includes M&Ms, involvement of trainees as well as faculty, monitoring of quality of care delivered and active engagement of faculty and fellows in initiatives to improve care.
  - Growth in the Outpatient Ryan White, HIV, ID, STD and Travel Medicine Clinics.
  - Recent addition of Complicated Clostridium difficile Clinic which is a collaborative effort between ID, GI and Geriatrics. This collaboration is also an opportunity for research and education.
  - Antibiotic Stewardship Program at UVa and Culpepper Hospitals that improves quality and saves pharmacy costs.
  - Hospital epidemiology programs at UVa, TCH and Culpepper Hospitals
  - Growth in the Inpatient Infectious Diseases and Transplant and HIV Services
  - Musculoskeletal Infections Program Launched
  - New HCV-HIV Co-Infection Clinic Started

**Research**
- The Division leads interdisciplinary research in infectious diseases and biodefense at the School of Medicine. Research funding for the Division ($17.6 million annually in 2014) exceeds that of the entire College of Arts and Sciences at UVa, is one half of all support to the Department of Medicine, and one tenth of all support to the School of Medicine.
- Gates Foundation grants bring robust support to the Division and provide new opportunities in nutrition, vaccinology, human genetics, immunology, microbiome, and nine international field sites, complementing an already robust level of NIH support.
- Internationally recognized faculty (2 IOM, 5 AAP, 8 ASCI members, 2 former presidents of IDSA, 2 former presidents of ASTMH, one former Editor of Infection and Immunity).
- 16 faculty are PIs on NIH grants (6 have a total of 10 RO1s; 4 U01s; recently renewed MARCE Biodefense Center; multiple small business awards; 5 K awards). Diverse research interests that span parasitology, bacteriology, virology, epidemiology, nutrition, healthcare worker safety and international health.
- Robust fellowship program with 90% of former fellows currently in academic positions, with 10 graduates having received K awards (with 3 going on to R01s to date).
- High quality research, conference and administrative space in the Carter-Harrison Research Building (occupied July 2009).
- Strong tradition of successful awards through the NIH Loan repayment program which, in part, allow for protected research time.

**Education**
- Superb faculty who have won 3 SCHEV Outstanding Faculty Awards (Hewlett, Petri, Scheld), 5 University Outstanding Teaching Awards (Dillingham, Hewlett, Petri, Scheld, Wispelwey), 2 University Outstanding Scientist Award (Guerrant, Scheld), and the Commonwealth of Virginia Outstanding Scientist Award (Guerrant).
- Infectious diseases fellowship program is highly competitive, recruiting from a national pool and placing into academics 90% of all trainees, including the chairs of infectious diseases at Stanford and Case
Western Reserve and the clinical chair at Yale University. ACGME approval was obtained for a 5 year cycle.

- T32 Infectious Diseases Training Program, T32 Biodefense Training Program, T35 Summer Research Internship Program, Global Infectious Diseases Training Program all competitively renewed in the last three years.
- Educational environment within the Division is remarkable for the strong basic science-clinical science collaboration, with 8 graduate students, with basic science joint appointments basic science courses led and taught by ID&IH faculty.
- Graduate medical education is a tremendous area of strength, with ID attendings highly evaluated by house staff for their excellence in education, and Dr. Donowitz in the Division leading GME for the Department.
- Fellowship program has 90% of graduates in academics, including the chairs of infectious diseases at Stanford and Case Western Reserve and the clinical chair at Yale University.
- Leadership in Undergraduate Medical Education for the Department is by Dr. Wispelwey of the Division who received this year’s Robley Duglison Award.
- New Farr-Hayden Lectureship in Epidemiology and Virology endowed.

**Faculty Development**

- The robust research and clinical activities of the Division provide an ideal incubator for young faculty. The high level of success of our fellows at obtaining K awards extends the protected period for clinical investigators.
- There are many opportunities for young faculty to develop their own lines of investigation under the grant support of senior faculty.
- The Division has a proactive faculty mentoring plan, with an annual formal review of each junior faculty by two senior faculty, followed by a dinner meeting attended by all senior faculty where consensus is arrived at to provide guidance to the junior faculty.
- In addition there is an active grants review program where faculty present their specific aims in advance of grant writing to get feedback from colleagues.
- Women comprise 42% (11/26) and under-represented minorities comprise 7.7% (2/26) of faculty.

**Weaknesses:**

**Clinical**

- Limited remuneration for E&M activities with no procedural billing.
- Substantial indigent care and low reimbursement per RVU.
- Lack of institutional RVU supplement to recompense for issues with poor reimbursement.
- Outpatient clinics remain in temporary space that is inadequate.
- Small community setting for UVA limits ability to grow the clinical enterprise.

**Research**

- Increasingly competitive NIH funding.
- Increasing competition in Global Health nationwide
- Lack of industry-supported and federal contract research.
- Lack of extramural funding in some core areas of ID, including antibiotic resistance, hospital epidemiology, HIV and malaria.
- Lack of funding to recruit experts in study planning/coordination (ex. biostatisticians familiar with infectious diseases, program coordinators, etc.)
- Inadequate gap funding and seed funding from the University, at a time when competing renewals require a longer time to success.
- Lack of a sustainable funding plan for Academic Investigators, not only in ID&IH but in all Clinical Departments.
- Lack of a CTSA and the opportunities it would provide especially to the clinical research infrastructure and junior investigators.
- Lack of funding to invest in recruitment of investigators in AIDS, TB and/or malaria (the so-called ATM diseases), and in influenza and other respiratory viruses (a historic area of strength at UVa).

**Education**
- Recruitment of fellows remains a highly competitive undertaking, with a small pool of potential fellows interested in academics.
- The internal medicine residency program could be deeper in academically-oriented individuals with more emphasis on academics and short-tracking into UVa fellowships for MD-PhDs.

**Faculty Development**
- The many demands on senior faculty time limits their ability to mentor, thus necessitating a formal mentoring program.
- Support through tenure and promotion to full professor is needed for all, but perhaps especially for women and underrepresented minorities that are not well represented in tenured faculty.

**Opportunities:**

**Clinical**
- Build the HCV-HIV co-infection clinic
- Advertise/promote the different specialty clinics—traveler’s, msk, hepc-hiv, C. difficile, etc.
- Obtain permanent outpatient clinical space for the Division, with adequate office space for the staff.
- Recruit a leader for research and clinical care in transplant ID, including an increased outpatient presence.
- Advocate for greater support for hospital epidemiology program from the Medical Center.
- Continue to make the case for an RVU supplement for E&M to make clinical work self-sustaining (ID outpatients are disproportionately impoverished [AIDS, TB, parasitic diseases, hepatitis] and thus are poorly reimbursed). Recognition of downstream revenue created by E&M is essential for viability of the clinical enterprise.
- Continue quality initiatives and the metrics to measure performance.

**Research**
- Gates Foundation grants provide the opportunity for additional “Discovery” grants in infection, immunity and diagnostics.
- Global Health Institute initiative at UVA
- Extraordinary ties with the basic science departments that increase our competitiveness. • Opportunity to interact with immunology through joint seminar and RIP series.

**Education**
- Expanding educational and research opportunities for fellows, housestaff, and students at international sites.
- New educational effort on antibiotic stewardship.

**Faculty Development**
- Clinical and educational service activities need to be increasingly borne by senior faculty to provide protected time to junior faculty.
- The key opportunity to build and recruit junior faculty is recruiting the best and brightest to our fellowship (and residency) program.
**Threats:**

**Clinical**
- Lack of State participation in expansion of Medicare in the Affordable Care Act threatens support for indigent care.
- Reduction in Ryan White HIV Clinic support as a potential consequence of the ACA.
- ID outpatients are disproportionately impoverished (AIDS, TB, parasitic diseases, hepatitis) and thus are poorly reimbursed.
- Lack of procedures and reliance solely on E&M billing
- Support for non-billable activities in the musculoskeletal infectious diseases program.

**Research**
- Flat NIH budget requires us to be ever more competitive and interdisciplinary, and also look beyond NIH for research support (Gates, DTRA, World Bank).
- Foundation grants bring in less F&A than Federal grants

**Education**
- Educational effort is always difficult to support financially, with more limited cross-subsidies from research and clinical.
- We are fortunate that both the Infectious Diseases and Biodefense T32s have recently been competitively renewed (through 2017 and 2018 respectively); however there is the constant risk of loss of these T32s without constant pro-active efforts to recruit and train the very best fellows. • In addition the increasingly competitive grants application situation, along with increased clinical service, can be distractions from teaching. We must continue to emphasize “doing the right thing” by excelling in teaching regardless of financial constraints.

**Faculty Development**
- Junior faculty require prolonged start-up plans in light of the fact that the average age of a first-time R01 Principal Investigator is approaching middle age.
- Increasing competitiveness for grants will make the transition from K to R level support more difficult.
- We have many more assistant than full professors, and increasing attention must be spent on making them a success.
Strengths:

Clinical Care
- Innovative extracorporeal services
- Apheresis, short daily, nocturnal hemodialysis, ABO incompatible Tx and Paired Donation.
- Strong geographical footprint for outpatient subspecialty programs.
- We care for ~850 dialysis patients in Central Virginia.
- Specialty services: Stone clinic at AMC, polycystic disease clinic at UVA
- Strong "move as one’ relationship with the Health System.
- The Division has a very good funds flow model with the Medical Center that is called the "Academic Fund" via an MOU. On a yearly basis, the division earns funds from a sharing arrangement tied to the performance of all satellite dialysis facilities on the basis of net patient care revenue and operating margin.

Research
- Diversity and breadth of research that is vibrantly collaborative in select areas: includes kidney function and disease, lupus GN, immune cells and immune cell response to infection / disease in model systems, immunogenetics of immune responsiveness in kidney disease and lupus GN, pathogenesis of kidney disease in SLE, immune response and pathogenesis in salivary gland disease.
- Clinical and Basic Science divisions provide the opportunity for translational research.
- The leadership in clinical and basic areas of research is quite strong and positive.
- T-32 Program
- Faculty
  - Outstanding senior faculty with varied areas of expertise including, nephrology, rheumatology, and immunology.
  - Nationally and internationally recognized faculty for productivity and scholarship
  - The faculty has been very productive, research support has been well utilized, and a very strong training record in combination with the T32, demonstrate that there are educational as well as research rewards for research efforts within the Division/CIIR.
  - Combined interests and experience of rheumatology and nephrology faculty and the potential for applicability in a wide array of inflammation-related research.
  - Solid, creative investigators with strong research projects, excellent publications and significant research support (outside awards).
  - The national recognition and reputation of the investigators is strong; individual faculty members participate on various national and international committees.
  - Researchers in Division are approachable and interactive. This is useful and helpful to less public and more infrequent discussions among individual PIs. A positive outcome is the exchange of information, opinions, and suggestions for potential collaboration(s).

Weaknesses:

Clinical Care
- Martha Jefferson program is small.
- Transplantation numbers are down.
- Current transplant care model needs redesign.
- Minimal home dialysis in units other than Lynchburg. As we move into the bundling era, home dialysis is not only a financial advantage but also likely to be a better mode of treatment for appropriate individuals.
- Institution is not facile enough to be proactive or respond to the implementation of strategy.

Research
- Loss of faculty.
- Investigator initiated Clinical Research
- Depth of Clinical Investigators (physician scientist).
- There is a need for more CIs within the Division which extrapolates to the need for greater clinical activities and clinical support since the division CIs are currently already stretched a bit thin by satellite clinical activities. These are quite time consuming with very minimal, if any, financial return.
- External Funding opportunity remains tenuous. The landscape has changed and we will have to be even more competitive for less funding available.
- What is the future for the AI track?

**Opportunities:**
- Leveraging the resource rich experience of our faculty in partnership for opportunities and concepts.
- Novel programs such as Contrast Enhanced Ultrasonography (CEUS) program that provides translational kidney care.
- Expand practice at Zion XR.
- Expand outreach transplant activities.
- Increase clinical activity at Martha Jefferson Hospital.
- Expanded footprint for dialysis to the west and south.
- Expand Acute Kidney Injury (AKI) Risk Reduction Program.
- Expanded modality of Peritoneal Dialysis (PD) to decompress pressure on In-Center HD volumes in the effort to retain patients in our system of care at AMC.

**Threats:**
- General attrition of faculty to completive environments and retirement.
- Reduction in reimbursements.
- Changes in the competitive health-care environment.
- Uncertainty in the landscape of extramural research funding.
- Uncertainly in the landscape of education funding.
- Instability of partners in the Lynchburg Nephrology Physicians (LNP).
- Sentara Healthcare merger has made it difficult to expand practice at MJH.
- Effect of bundling on dialysis revenue. With new CMS regulation regarding payment to dialysis units we will be challenged with reducing our expenses in order to maintain profit margin.
PULMONARY

• **Strengths:**
  - Robust critical care program;
  - Robust development of advanced bronchoscopy procedures:
    - Navigational bronchoscopy
    - EBUS
    - Thermoplasty
  - Enhanced outpatient subspecialty programs:
    - Interstitial Lung Disease Clinic (directed by B. Mehrad);
    - Cystic Fibrosis program (V. Indihar and C. Brown);
    - Multidisciplinary Pulmonary Hypertension Clinic (E. Gay and J. Kennedy);
    - COPD Clinic (M. Shim)

• **Weaknesses:**
  - Borderline staffing for MICU
    - Need urgent development of NPs for MICU to expand number of critical care beds on service;
  - Need additional lung transplant physicians;
  - Recruitment of another sleep physician (P. Suratt retiring or going to 50% effort 7/14);
  - Need critical mass of research faculty in order to develop:
    - Project Program Grant
    - T32 Training Grant

• **Opportunities:**
  - Development of a procedure service:
    - Any inpatient procedure on any ward (thoracentesis, paracentesis, central venous line placement);
    - Coverage of MICU urgent MICU procedures while MICU team rounding;
    - PICC catheter insertions for outpatient antibiotics;
  - With adequate staffing, enhance MICU bed capacity to 34 beds (three team model)

• **Threats:**
  - Reputation for Quality of Patient Care with Referring Providers
  - Patient Access Issues
  - Sentara/MJH:
    - Established Reputable Pulmonary Rehab Program
    - Increased competition for Sleep Service Program
  - Augusta Medical Center
  - Increased competition for General Pulmonary Services (Dr. Robbins + 1 new Pulmonologist)
  - Effects of Health Care Reform
**RHEUMATOLOGY**

- **Strengths:**
  - Abundant patient population
  - Limited competition from surrounding rheumatology practices
  - Experienced core faculty and relatively low turnover of clinical staff
  - New providers have been added for FY14

- **Weaknesses:**
  - Historically patient access & patient satisfaction have been problematic. The clinic currently has a large waiting list of patients seeking appointments. Access has been limited by the small number of faculty which has been compounded by both regional and national shortages of rheumatologists.
  - Small # of experienced faculty (3) to carry out educational and administrative missions. Two junior faculty have been added to the division in 2013, but it will take time before they are ready to assume teaching and administrative responsibilities.
  - Even with the addition of Drs. D'Souza and Potter, we project that the current clinicians will not be able to meet the clinical demands for care.
  - 2 of the faculty (Drs. Giuliano and Fu) are >70 years and likely to retire in the next few years.
  - In the current academic climate, it is not certain if we will be able to retain the newly recruited faculty.
  - It remains challenging to recruit providers for academic rheumatology faculty positions.

- **Opportunities:**
  - New providers will allow for a substantial increase in clinic volumes and will improve patient access and satisfaction deficiencies.
    - Will allow for development of specialized clinics
    - Enhance procedural side of practice (ultrasound)
    - Time to plan the future of the division before existing faculty retire

- **Threats:**
  - Patient referral base has not been secured
  - Need to be able to offer services to distinguish UVA from private practice rheumatologists
  - Ultrasound is not yet established. The Division does not have ultrasound equipment.
  - Not enough space to effectively grow the practice.
  - Current clinic management of the practice at Fontaine has made clinical improvements and attempts at improving patient satisfaction difficult.
  - Acquisition of Albemarle Arthritis Associates (not UVA Rheumatology at Pantops) threatens the payer mix at the existing practice.