HSG advisors

Building an Organization-Wide Provider Recruitment Plan: Strategies and Analytics to Support Strategic Development

HSG **Speakers**

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Strategic Healthcare Executive experienced in system- and organizational-level management and planning for Physician Alignment Strategy, Employed Physician Network Strategy, and Accountable Care Strategy.

EXPERTISE

- Employed Physician Network Growth
- Physician Network Strategy
- Market Development Strategy
- Operational and Financial Performance
- Management Infrastructure

PROFESSIONAL EXPERIENCE

- Chief Executive Officer at HSG Advisors
- Multi-year enterprise-wide physician strategy planning for large, multi-hospital systems
- Physician Network management team development of long-term alignment and growth plans

EDUCATION

- MBA, Vanderbilt University
- Dual BS in Finance and Business Management, UT Knoxville
- Member, American College of Healthcare Executives *(ACHE)*

Presentation Overview

- **Definitions and Overview**
- **Common Challenges with Recruitment Planning**
- **Critical Data Elements to Support Recruitment Planning**
- **Bringing Organizational Stakeholders into the Process**
- **Finalizing and Refreshing Recruitment Plans**
- **Baby Steps Towards Organizational-Level Planning**

Definitions and Overview

Organization-Wide Provider Recruitment Plan
Definitions

Differing Nomenclature by Health System

- "Physician/Provider Workforce Plan"
- "Physician/Provider Development Plan"
- "Physician/Provider Recruitment Plan"
- "Medical Staff Development Plan"

Core Characteristics - Centralized Plan Defining:

- Recruitment Needs by Specialty
  - Physicians (and ideally APPs)
- Timeframe for Recruitment
- Rationale for Recruitment
- Recruitment Model (employment, support for independent practice, other)

- Ideally, with organizational agreement across stakeholder groups (health system leadership, hospital leadership, employed provider network leadership, service line leadership) on what the recruitment priorities are.

Organization-Wide Health System Provider Recruitment Planning in 2024

- Health System strategic objectives are increasingly focused on improving access and overall customer experience. However, many Health Systems are finding gaps in their deployment of their provider resources that are creating barriers which are hard to surmount - **access to the right provider, in the right location, at the right time, and with the right provider capability.**

- To address this, Health Systems must greatly **enhance the way they evaluate how their provider recruitment strategy will support the health system's overall strategic vision.**

- Many organizations still focus on physician and advanced practitioner recruitment as a disconnected process that is the end result of multiple service line and employed physician network strategies. Instead, Health Systems should focus on their recruitment planning as an opportunity to centralize their growth and access strategies, with a **focus on proactively identifying the provider complement that will enable the execution of the Health System's overall strategy.**

Common Challenges with Organization-Wide Recruitment Planning in Health Systems

These common challenges result in recruitment plans disconnected from the strategy of the organization – resulting in unavailable provider resources to effectively serve strategic need (or recruiting too many providers who do not serve strategic need.

Challenge	Description
Myopic Community Need-Focused Planning	Evaluating provider need through the lens of one question: "Does our market have an under/over supply of (insert specialty)." An alarming number of Health Systems ask this, and only this, question when considering provider need. The answer becomes the basis by which recruitment decisions are made – completely absent of the strategic context that Health Systems should be layering around their recruitment decision making.
Not Tying in Geographic Ambulatory Growth Strategy	Building new or existing growth strategies that require provider recruitment support in a vacuum; disconnected from recruitment planning activity
Not Involving Organizational Stakeholders	Tasking decision making to a non-strategic "Medical Staff Development Planning" or "recruitment" committee that is not directly involved with the Health System's strategic planning or integrated with the employed network's management infrastructure.
Building a Plan, but Ignoring It or Not Updating It	Building a three-year or longer plan but then not updating it and/or constantly finding "exceptions" to why recruitment outside of the plan is needed based on anecdotal criteria
Not Considering Existing Capacity for Internal Growth	Making recruitment decisions based on the desire for "growth" with the assumption that more FTEs are needed; rather than focusing on how to grow volumes within existing array of providers within a specialty
Focusing on Physicians Only	Assessing only physician need and not considering the role of the Advanced Practitioner as a strategic resource whose addition must be forecasted to drive access

Framework for Medical Staff Development Planning

Framework for Organization-Wide Recruitment Planning

What strategic and market dynamics should the Medical Staff Development Plan consider?

- Health System Strategy
- Service Line Strategy
- Ambulatory Footprint Growth
- Outpatient Service Growth
- Market Velocity Towards Value
- Competitor Strategy & Activity

What data points should be aggregated to provide a comprehensive overview of provider need?

- Patient Attraction & Retention
- Provider Supply & Alignment
- Provider Demand
- Existing Provider Capacity & Access
- Provider Workforce Age Dynamics
- Provider Opinion

What Health System stakeholders should be involved in building the Plan?

- Executive Leadership
- Hospital Leadership
- Employed Network Leadership
- Service Line Leadership
- Planning Leadership
- Recruitment Leadership

What recruitment considerations should the final Plan consider?

- Strategic Growth Priorities
- Critical Succession Needs
- Future Strategic Needs
- Long-Term Succession Needs
- Provider Mix Dynamics
- Geographic Placement

- Consideration of Strategic Dynamics impacting system recruitment needs
- Aggregation of key quantitative and qualitative data, tied to strategic market areas
- Synthetization of data with representative leadership of health system
- Development of Comprehensive Plan that is consistently updated and appropriately reconsidered on a recurring basis

Critical Data Elements to Support Recruitment Planning

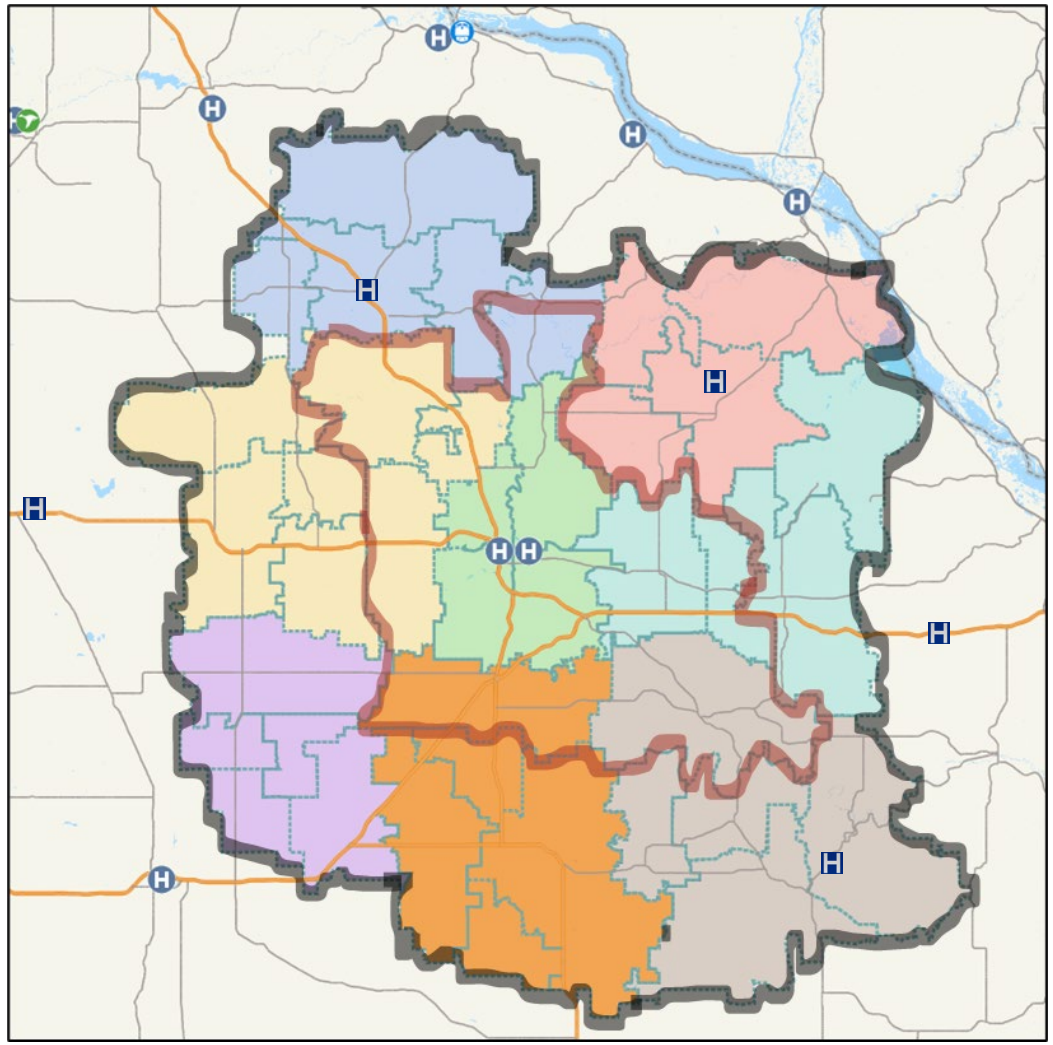
Critical Data Elements to Support Recruitment Planning

- Developing **Strategic Market Definitions** to Evaluate Provider Supply, Provider Need and Competitive Performance
- Evaluating **Provider Supply and Demand** by Specialty and Geography
- Evaluating **Succession Planning** Issues
- Evaluating **Access and Capacity** within Current Array of Specialties, Practices and Providers
- Defining Ideal Mix of **Physicians and Advanced Practitioners** by Specialty

Critical Data Elements to Support Recruitment Planning

Strategic Market Definitions

Developing Strategic Market Definitions



Historic Primary Market

Historic Secondary Market

Subdivision into Strategic Market Clusters

Central
North
West
Southwest
South
Southeast
East
Northeast

Submarket Definitions should be based on:

- Common Routes of Travel
- Historic Penetration
- Demographically-similar groups
- Common Competitive Threats
- Strategic Priority

This allows for:

- Targeted geographic footprint decision-making for access points and competitive action plans
- Prioritization of opportunities

Developing Market-Level Recruitment Strategies

A health system's market should be looked at on a more granular basis than a "primary, secondary and/or tertiary" market perspective. The Submarket Development framework below identifies different strategies based on an aggregation of quantitative factors:

Submarket Development Strategy	OUR Primary Care Resource Allocation	OUR Primary Care Market Share	OUR Overall Market Share	Competitor Resource Penetration	Incremental Primary Care Need	Market Demographics	Ease of Access to OUR Services
Reinforce and Defend • Ensure Sufficient Primary Care Access • Balance Productivity Growth with Incremental Recruitment • Recruit Proactively to Address Succession Need	Moderate-to-High	Moderate-to-High	Moderate-to-High	Low	Low	Moderate-to-High	Moderate-to-High
Growth Opportunity in Non-Competitive Market Near OUR Resources • Aggressively Expand Primary Care Resources • Incorporate Other Outpatient/Ambulatory Resources as warranted	Low-to-Moderate	Low-to-Moderate	Low-to-Moderate	Low	Moderate-to-High	Moderate-to-High	Moderate-to-High
Growth Opportunity in Non-Competitive Market Not Near OUR Resources • Aggressively Expand Primary Care Resources • Incorporate Other Outpatient/Ambulatory Resources Aggressively to Ensure Patient Retention • Consider integrated Primary Care, Ancillary Services, Specialty Clinic, Freestanding ED/Urgent Care	Low-to-Moderate	Low-to-Moderate	Low-to-Moderate	Low	Moderate-to-High	Moderate-to-High	Low
Compete in Highly Competitive Market Near OUR Resources • Evaluate whether significant and rapid expansion of resources within market is feasible, or if resources should be prioritized elsewhere	Low-to-Moderate	Low-to-Moderate	Low-to-Moderate	Moderate-to-High	Low	Moderate-to-High	Moderate-to-High
Compete in Highly Competitive Market Not Near OUR Resources • Evaluate whether significant and rapid expansion of resources within market is feasible, or if resources should be prioritized elsewhere	Low-to-Moderate	Low-to-Moderate	Low-to-Moderate	Moderate-to-High	Low	Moderate-to-High	Low
Not A Strategic Imperative • Evaluate whether it is strategically valuable to allocate incremental resources to market or whether existing resources should be reallocated	Variable	Variable	Variable	Variable	Variable	Low	Low

Critical Data Elements to Support Recruitment Planning

Evaluating Strategic Provider Supply and Demand

Community Need is Not Strategic Recruitment Need

Sample Stark III Community Need Data – Primary Care – *Need/(Oversupply)*

Category	Specialty Roll-Up	Net Need (Including AP)	Net Need (Physician Only)
Primary Care	Adult Primary Care	17.23	41.83
	Pediatric Primary Care	18.29	19.79
Ob and Gyn Specialties	Maternal and Fetal Medicine	0.29	0.29
	Neonatal-Perinatal Medicine	1.60	1.60
	OB/GYN	11.76	12.96
	Reproductive Endocrinology	0.33	0.33
Medicine Specialties	Allergy and Immunology	2.09	2.09
	Dermatology	4.56	4.56
	Endocrinology	3.05	3.05
	Gastroenterology	4.00	4.00
	Infectious Diseases	2.01	2.01
	Nephrology	1.88	2.88
	Neurology	6.30	6.30
	Pain Medicine	(0.79)	(0.79)
	Physical Medicine & Rehabiliation	2.66	2.66
	Psychiatry	17.65	18.25
	Pulmonary and Critical Care	1.54	2.74
	Rheumatology	1.80	1.80
Surgery Specialties	General Surgery	4.39	5.59
	Head & Neck Surgery	0.11	0.11
	Neurological Surgery	2.87	2.87
	Ophthalmology	7.54	7.54
	Oral & Maxillofacial Surgery	(1.06)	(1.06)
	Otolaryngology	1.63	2.83
	Plastic Surgery	2.48	2.48
	Surgical Critical Care	0.39	0.39
	Trauma Surgery	(0.84)	(0.84)
	Urology	2.17	2.77

Useful for:

- High-Level Education About Provider Supply Dynamics for Health System Stakeholders
- Directionally Understanding Deficits of Provider Availability for Community
- **Stark III Compliance Regarding Supporting Recruitment to Independent Practices**

Not Useful For:

- Building a Provider Manpower Strategy That Ties to Achievement of Health System Strategic Goals

Community Need is Not Strategic Recruitment Need

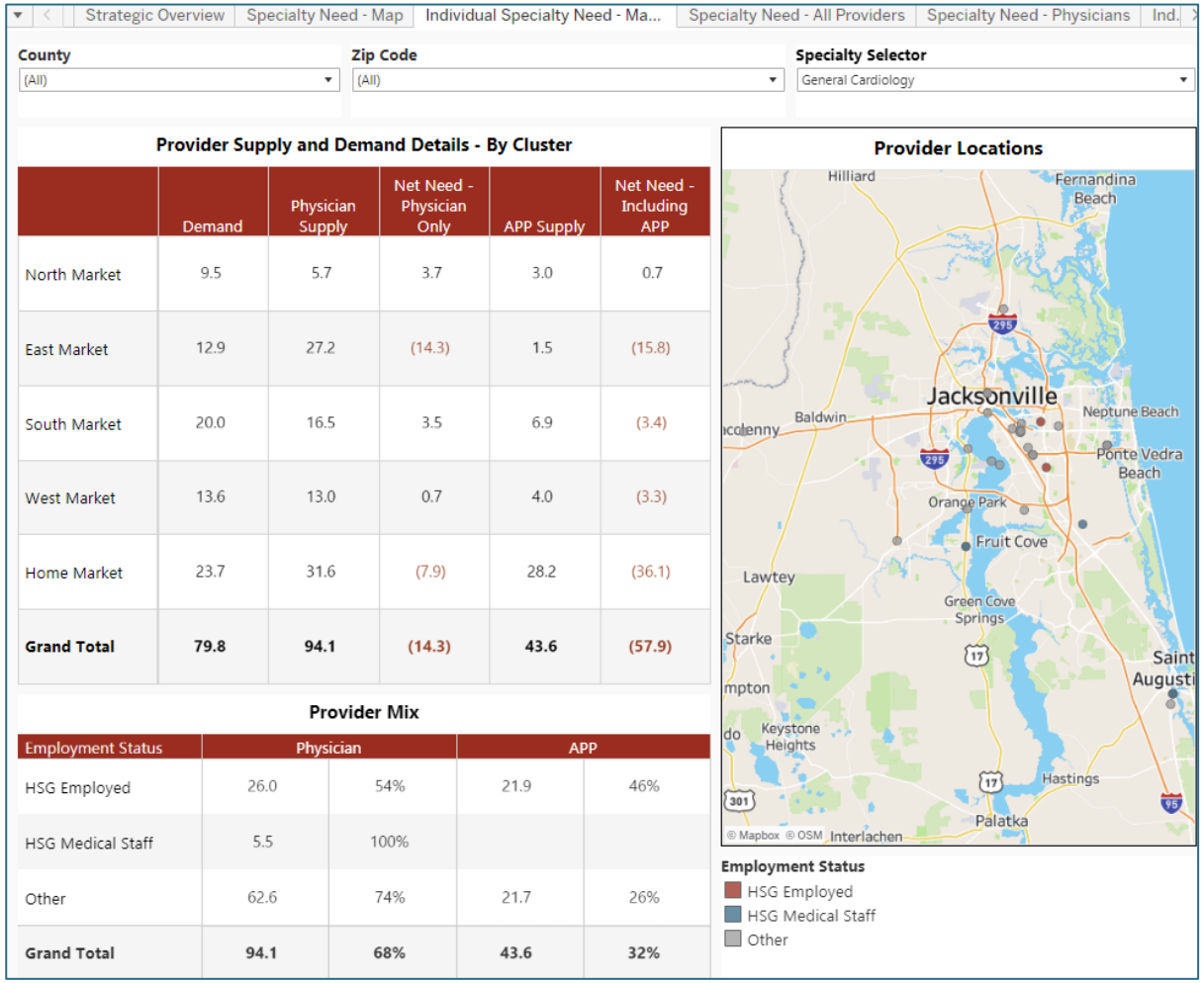
Community Need is NOT useful for building a Provider Manpower Strategy that ties to achievement of health system strategic goals.

- Is a component of access, but not a driver of access
- Does not help address competitive concerns
- Does not consider organization's strategy
- Does not fully consider the market the health system strategically serves
- Does not acknowledge that physician employment has changed organizational decision making in the last decade+ - just because providers are in the market does not mean our organization's (or patient's) needs are met

Summary:
In terms of planning for provider manpower, Community Need informs what we CAN do (related to independent practice support), not what we strategically SHOULD do or NEED to do to achieve organizational goals or provide the access that our SYSTEM needs to be able to deliver, especially in the context of employment being the dominant recruitment/alignment model.

Strategic Provider Supply and Demand
Regionalizing Specialty Data to Determine Gaps in Supply

- Provider Supply and Demand data **should be evaluated at the submarket level to identify gaps in care**
- Variation in need may be warranted, or may define incremental opportunity
- Has implications for **Access Point Development, Specialty Clinic strategies, and other facility placement decisions**



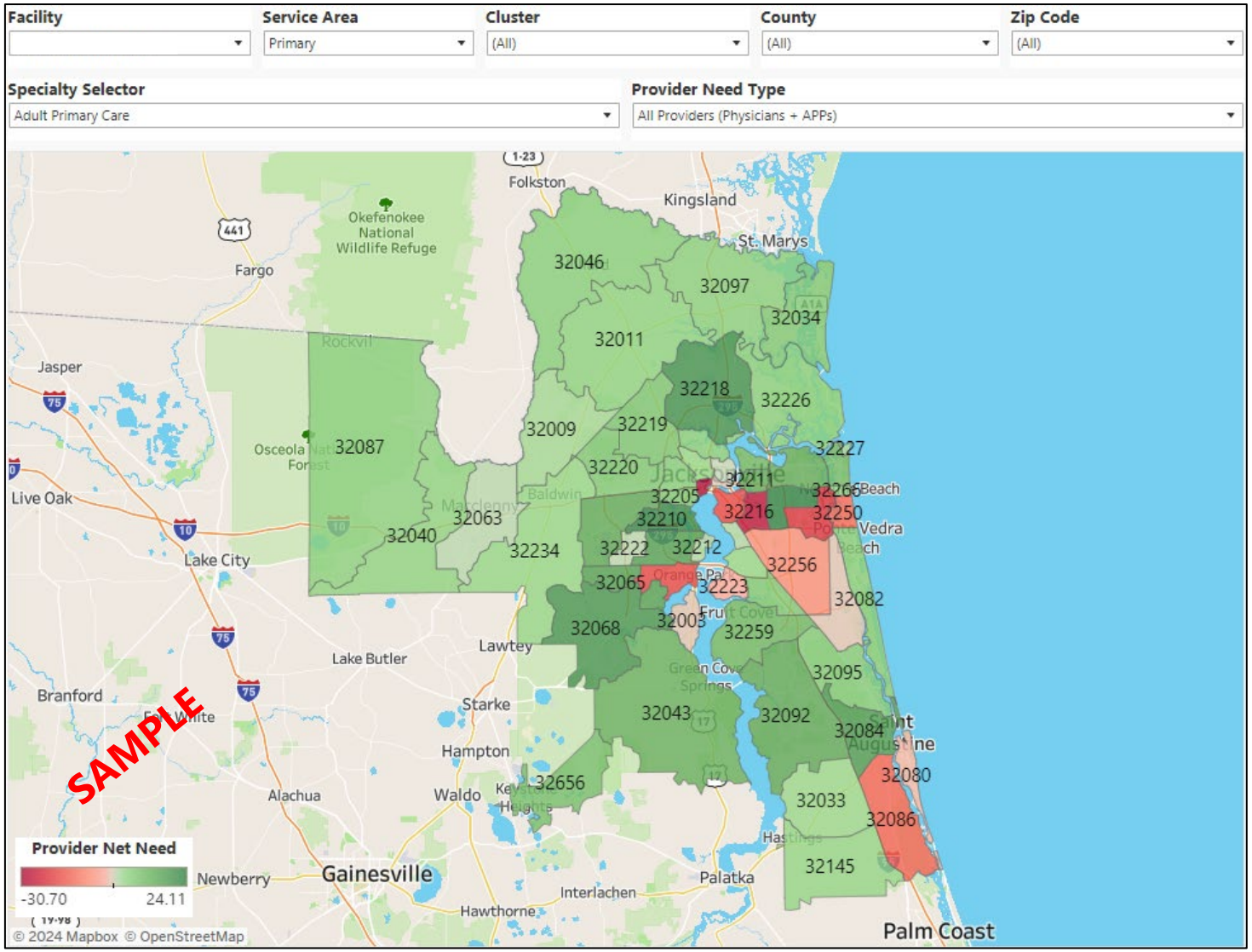
	Demand	Physician Supply	Net Need - Physician Only	APP Supply	Net Need - Including APP
North Market	9.5	5.7	3.7	3.0	0.7
East Market	12.9	27.2	(14.3)	1.5	(15.8)
South Market	20.0	16.5	3.5	6.9	(3.4)
West Market	13.6	13.0	0.7	4.0	(3.3)
Home Market	23.7	31.6	(7.9)	28.2	(36.1)
Grand Total	**79.8**	**94.1**	**(14.3)**	**43.6**	**(57.9)**

Employment Status	Physician		APP	
HSG Employed	26.0	54%	21.9	46%
HSG Medical Staff	5.5	100%		
Other	62.6	74%	21.7	26%
Grand Total	**94.1**	**68%**	**43.6**	**32%**

Strategic Provider Supply and Demand
Regionalizing Supply and Demand Data

- Intensity of Adult Primary Care Need is **relatively high throughout market**

- However need varies by geography – historic concentrations of providers near hospital campuses creates opportunity for regionalizing geographic footprint



Strategic Provider Supply and Demand
Evaluating Needs by Specialty within Geography

Medical Staff Aging by Specialty | Medical Staff Aging | Specialty Roll-Up By Geography | By Geography (1 of 2) | By Geography (2 of 2) | Appendix

County: (All)

Zip Code: (All)

Provider Supply & Demand by Specialty

		Demand	Physician Supply	Net Need - Physician Only	APP Supply	Net Need - Including APP
Primary Care	Adult Primary Care	908.3	589.3	319.1	109.6	209.5
	Pediatric Primary Care	232.9	156.9	76.0	23.4	52.6
Women's Health	Maternal and Fetal Medicine	5.8	9.0	(3.1)	0.0	(3.1)
	OB/GYN	160.1	135.4	24.7	22.9	1.8
	Reproductive Endocrinology	2.3	7.5	(5.2)	1.8	(7.0)
	Urogynecology	2.2	1.0	1.2	1.2	0.0
Behavioral Health	Mental Health	136.7	42.9	93.8	2.4	91.4
	Substance Use Disorders	3.8	4.2	(0.4)	0.0	(0.4)
Cardiovascular	Cardiovascular and Thoracic Surgery	19.1	9.8	9.3	0.0	9.3
	Electrophysiology	9.3	23.3	(14.0)	0.9	(14.9)
	General Cardiology	79.8	94.1	(14.3)	43.6	(57.9)
	Interventional Cardiology	17.9	32.6	(14.7)	0.6	(15.3)
	Vascular Surgery	19.2	10.6	8.5	2.4	6.1
Orthopedics	Orthopedic Sports Medicine	10.4	18.5	(8.1)	0.0	(8.1)
	Orthopedics Foot and Ankle	1.7	4.0	(2.3)	0.0	(2.3)
	Orthopedics General	76.4	62.9	13.5	24.3	(10.9)
	Orthopedics Hand	10.8	10.0	0.9	0.0	0.9
	Orthopedics Spine	5.2	2.0	3.2	0.0	3.2
Cancer	Gynecological Oncology	4.0	9.1	(5.1)	0.6	(5.7)
	Hematology/Oncology	53.4	93.1	(39.7)	30.9	(70.6)
	Radiation Oncology	21.9	35.6	(13.7)	0.0	(13.7)
	Surgical Oncology	4.2	10.7	(6.4)	0.0	(6.4)
Neuroscience	Neurological Surgery	21.6	26.1	(4.5)	11.5	(16.0)
	Neurology	59.0	68.1	(9.1)	14.7	(23.8)

Specialty Detail Notes
Demand: Calculated by applying the demand rate (based on an adjusted average of four population-based models) to the market population.
Physician Supply: Total physician FTEs in the market
Net Need – Physician Only : Is calculated as demand minus physician supply
APP Supply: Total advanced practice provider FTEs in the market. 0.6 FTE adjustment per 1.0 FTE based on practice patterns
Net Need – Including APP: Is calculated as demand minus physician supply minus APP supply
Negative Numbers denoted with () indicates an oversupply

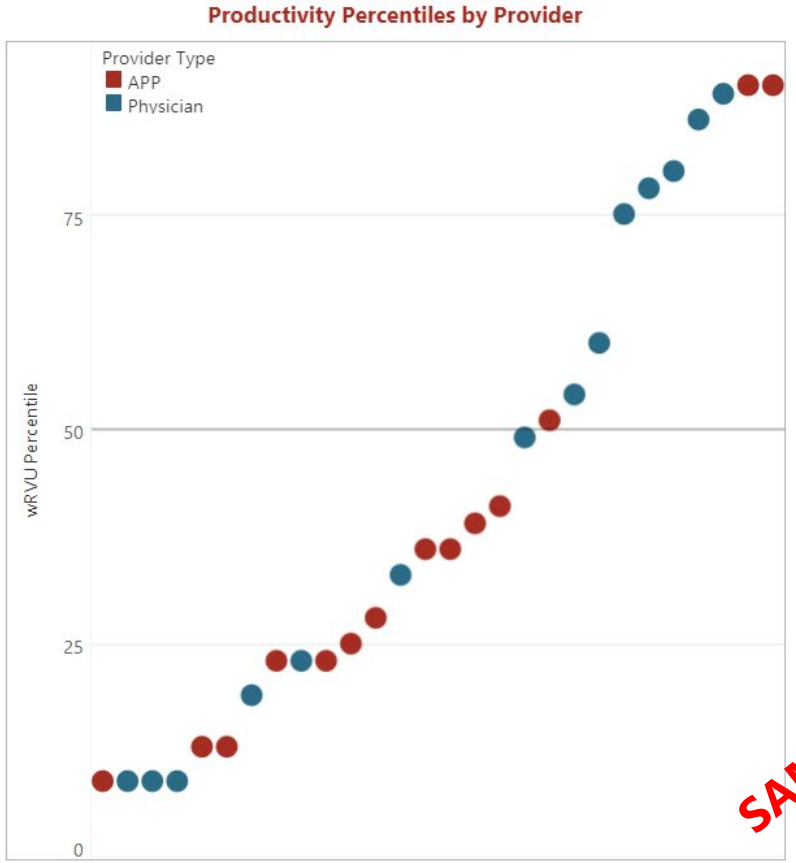
- Provider Supply and Demand data **should also be evaluated for each specialty when considering strategy for a specific geography**
- Variation in need may be warranted, or may define incremental opportunity
- Has implications for **Access Point Development, Specialty Clinic strategies, and other facility placement decisions**

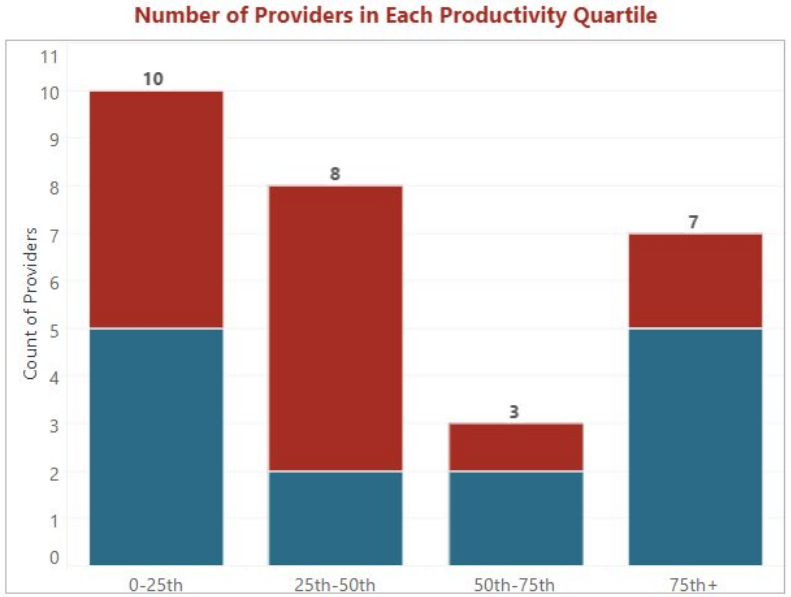
Critical Data Elements to Support Recruitment Planning

Evaluating Access and Capacity in Existing Specialty and Practice Array

Demand and Capacity
Integrating Practice Capacity and Access

- Provider productivity is a reasonable proxy for evaluating existing capacity within the service line being evaluated.
- Providers achieving 75th percentile productivity will likely have difficulty increasing access/capacity versus those below the 50th percentile
- This sample analysis indicates potential additional capacity for more than half of the listed providers – especially the APPs.



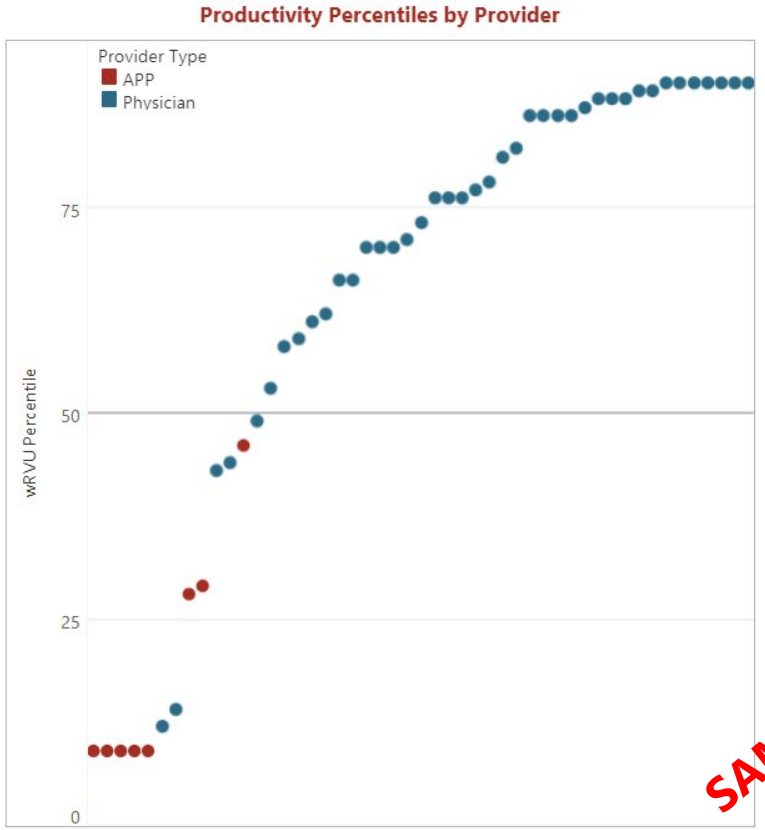


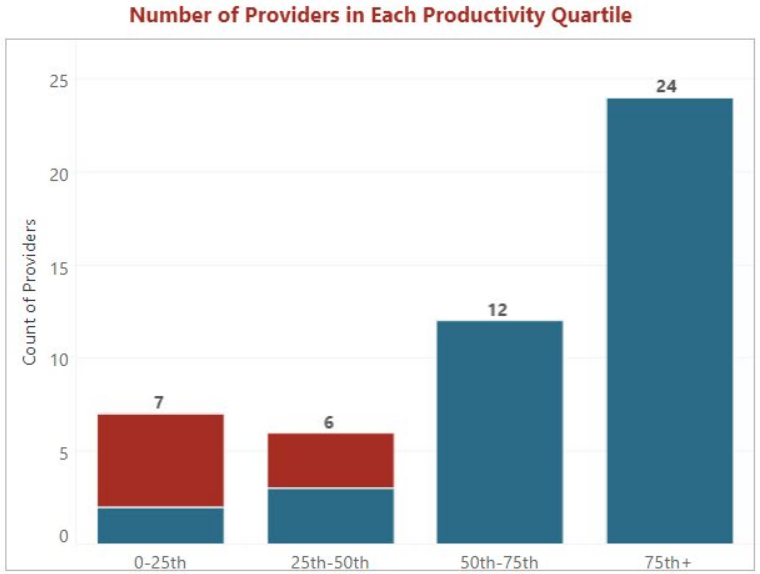
SAMPLE

Provider Type	0-25th	25th-50th	50th-75th	75th+	Total
Physician	5	2	2	5	**14**
APP	5	6	1	2	**14**
Grand Total	**10**	**8**	**3**	**7**	**28**

Demand and Capacity
Integrating Practice Capacity and Access

- … whereas this sample analysis indicates little additional capacity for existing providers and likely predicts access challenges – except for the APPs.
- … although reviewing APP utilization may be an opportunity for this group.





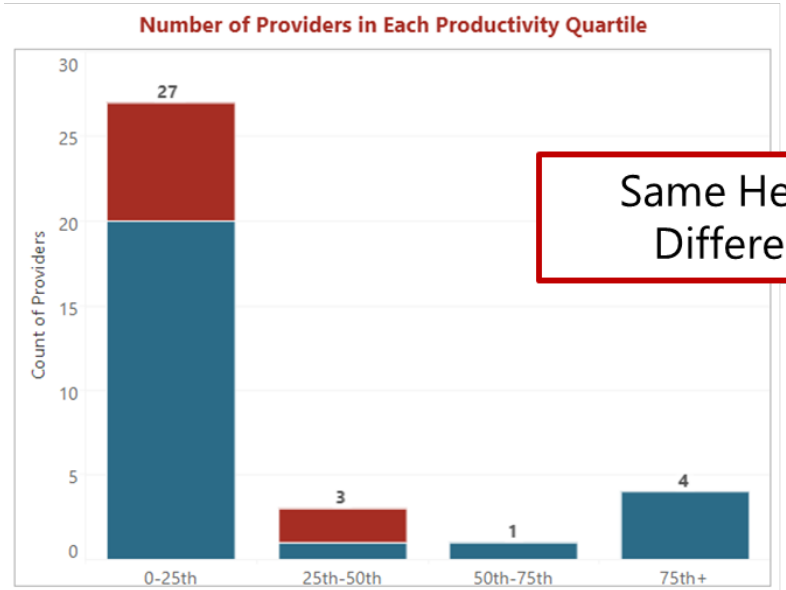
Provider Type	0-25th	25th-50th	50th-75th	75th+	Total
Physician	2	3	12	24	**41**
APP	5	3			**8**
Grand Total	**7**	**6**	**12**	**24**	**49**

SAMPLE

Demand and Capacity
Integrating Practice Capacity and Access

- Frequently, opportunities to balance regional investment exist within an employed network.
- This network may be able to reallocate resources to more effectively meet demand.

Market A Primary Care

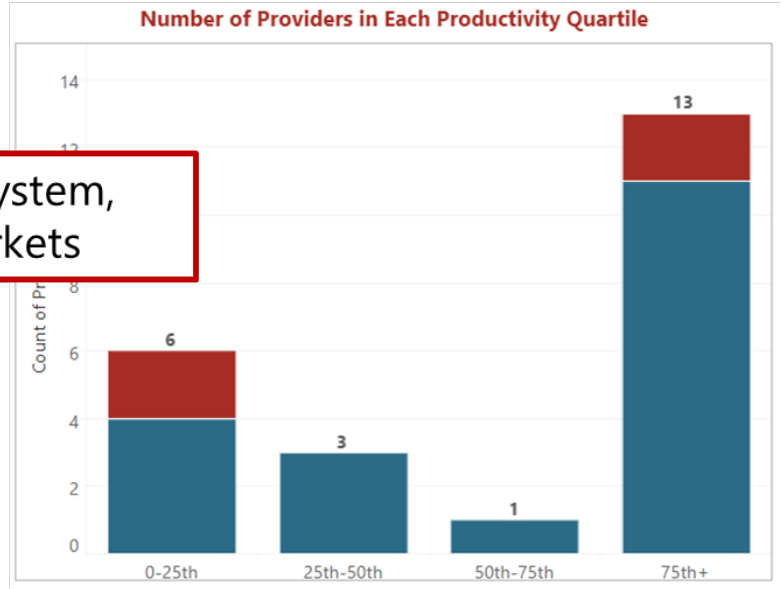


Provider Type	0-25th	25th-50th	50th-75th	75th+	Total
Physician	20	1	1	4	**26**
APP	7	2			**9**
Grand Total	**27**	**3**	**1**	**4**	**35**

Same Health System, Different Markets

SAMPLE

Market B Primary Care

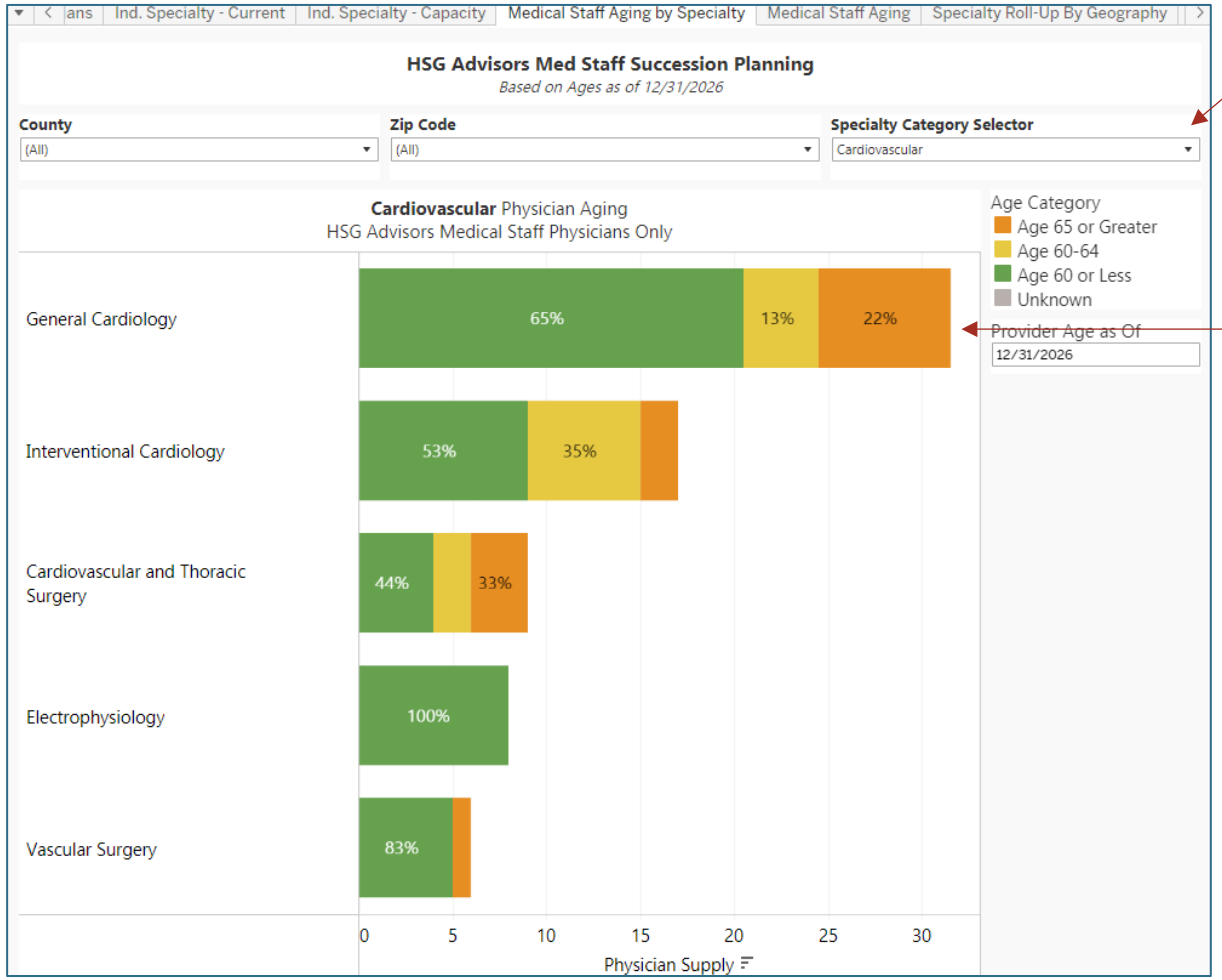


Provider Type	0-25th	25th-50th	50th-75th	75th+	Total
Physician	4	3	1	11	**19**
APP	2			2	**4**
Grand Total	**6**	**3**	**1**	**13**	**23**

Critical Data Elements to Support Recruitment Planning

Evaluating Succession Planning Issues

Succession Planning
Medical Staff Aging by Specialty

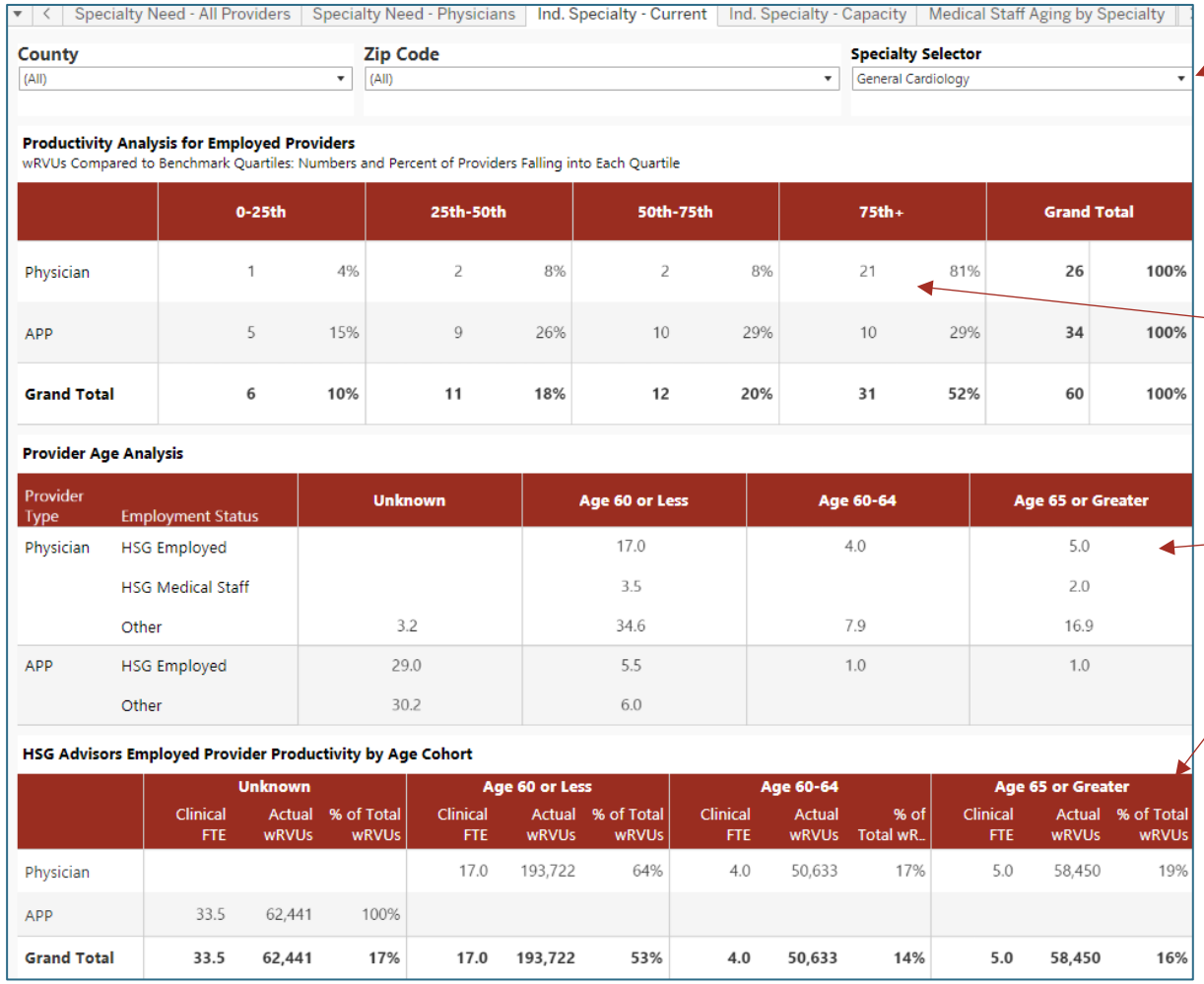


Dropdowns:
- Geography (County or Zip)
- Specialty (all specialties)

Data Shown:
- Age Cohort Distribution by Specialty and Subspecialty

Purpose
- Visualization of Service Line-Level Succession Planning Challenges

Individual Specialty
Current Productivity and Age



Specialty Need - All Providers | Specialty Need - Physicians | Ind. Specialty - Current | Ind. Specialty - Capacity | Medical Staff Aging by Specialty

County: (All) | Zip Code: (All) | Specialty Selector: General Cardiology

Productivity Analysis for Employed Providers

wRVUs Compared to Benchmark Quartiles: Numbers and Percent of Providers Falling into Each Quartile

	0-25th		25th-50th		50th-75th		75th+		Grand Total	
Physician	1	4%	2	8%	2	8%	21	81%	26	100%
APP	5	15%	9	26%	10	29%	10	29%	34	100%
Grand Total	**6**	**10%**	**11**	**18%**	**12**	**20%**	**31**	**52%**	**60**	**100%**

Provider Age Analysis

Provider Type	Employment Status	Unknown	Age 60 or Less	Age 60-64	Age 65 or Greater
Physician	HSG Employed		17.0	4.0	5.0
	HSG Medical Staff		3.5		2.0
	Other	3.2	34.6	7.9	16.9
APP	HSG Employed	29.0	5.5	1.0	1.0
	Other	30.2	6.0		

HSG Advisors Employed Provider Productivity by Age Cohort

	Unknown			Age 60 or Less			Age 60-64			Age 65 or Greater		
	Clinical FTE	Actual wRVUs	% of Total wRVUs	Clinical FTE	Actual wRVUs	% of Total wRVUs	Clinical FTE	Actual wRVUs	% of Total wR..	Clinical FTE	Actual wRVUs	% of Total wRVUs
Physician				17.0	193,722	64%	4.0	50,633	17%	5.0	58,450	19%
APP	33.5	62,441	100%									
Grand Total	**33.5**	**62,441**	**17%**	**17.0**	**193,722**	**53%**	**4.0**	**50,633**	**14%**	**5.0**	**58,450**	**16%**

Dropdowns:

- Geography (County or Zip)
- Specialty (all specialties)

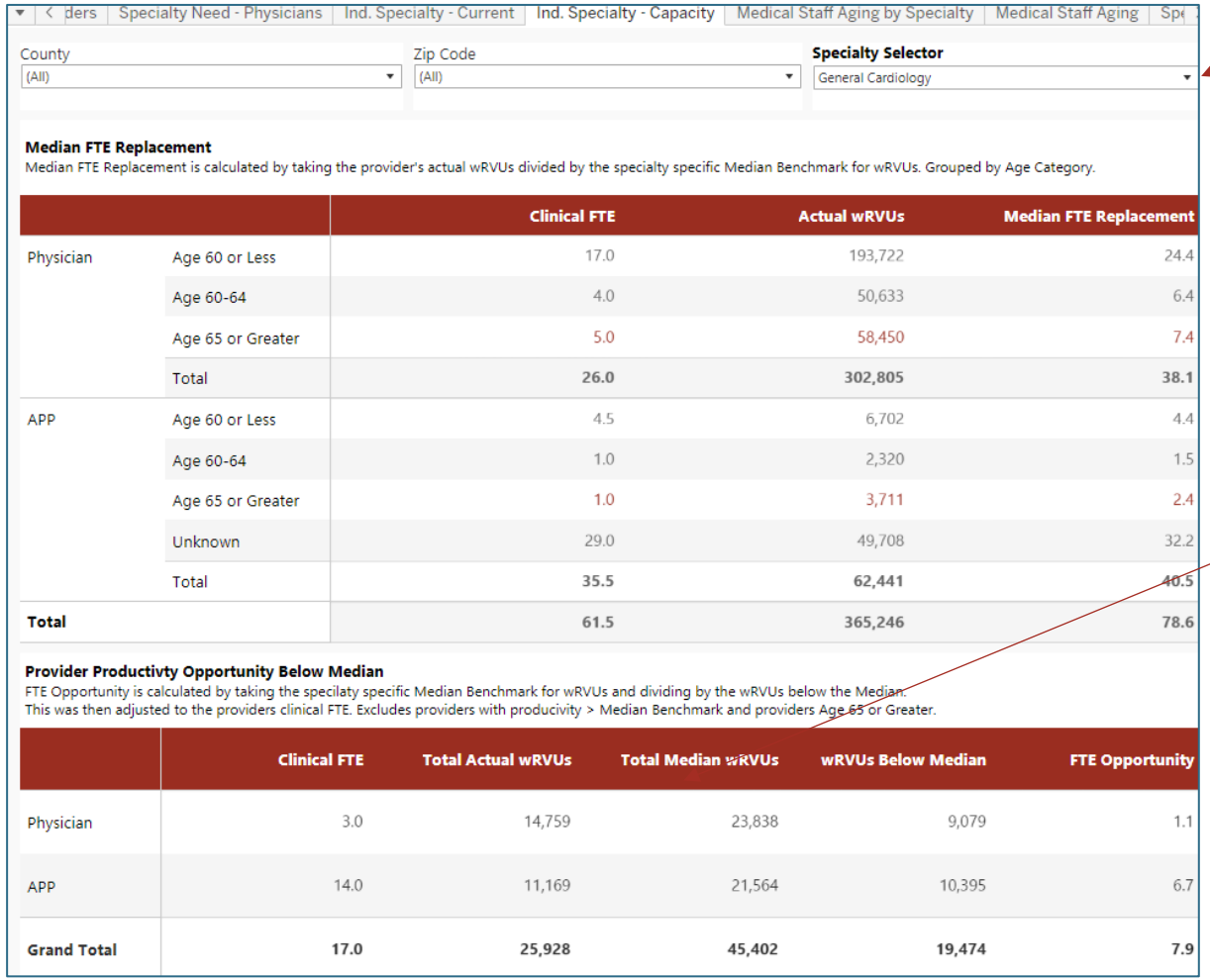
Data Shown:

- Stratification of Employed Providers by Productivity Quartile
  - Physicians
  - APPs
- Stratification of Employed and Medical Staff Provider Age by Cohort
- Productivity Data Stratified by Age Cohort

Purpose:

- Evaluate capacity and succession planning issues within a given specialty

Individual Specialty
Succession Impact on Capacity



ders | Specialty Need - Physicians | Ind. Specialty - Current | Ind. Specialty - Capacity | Medical Staff Aging by Specialty | Medical Staff Aging | Spe

County: (All)

Zip Code: (All)

Specialty Selector: General Cardiology

Median FTE Replacement

Median FTE Replacement is calculated by taking the provider's actual wRVUs divided by the specialty specific Median Benchmark for wRVUs. Grouped by Age Category.

		Clinical FTE	Actual wRVUs	Median FTE Replacement
Physician	Age 60 or Less	17.0	193,722	24.4
	Age 60-64	4.0	50,633	6.4
	Age 65 or Greater	5.0	58,450	7.4
	Total	**26.0**	**302,805**	**38.1**
APP	Age 60 or Less	4.5	6,702	4.4
	Age 60-64	1.0	2,320	1.5
	Age 65 or Greater	1.0	3,711	2.4
	Unknown	29.0	49,708	32.2
	Total	**35.5**	**62,441**	**40.5**
Total		**61.5**	**365,246**	**78.6**

Provider Productivty Opportunity Below Median

FTE Opportunity is calculated by taking the specialty specific Median Benchmark for wRVUs and dividing by the wRVUs below the Median.
This was then adjusted to the providers clinical FTE. Excludes providers with producivity > Median Benchmark and providers Age 65 or Greater.

	Clinical FTE	Total Actual wRVUs	Total Median wRVUs	wRVUs Below Median	FTE Opportunity
Physician	3.0	14,759	23,838	9,079	1.1
APP	14.0	11,169	21,564	10,395	6.7
Grand Total	**17.0**	**25,928**	**45,402**	**19,474**	**7.9**

Dropdowns:

- Geography (County or Zip)
- Specialty (all specialties)

Data Shown:

- # of Median-Level Specialty FTEs to Replace Providers per Age Cohort
  - FTEs to Replace 65+ Particularly Important
- FTEs of Capacity within Existing Provider Complement, Assuming Goal is to Move All Providers Below Median Productivity to Median Productivity

Purpose:

- Determine Impact of Succession Planning Issues to What Extent Existing Capacity Can Absorb Shortfalls

Critical Data Elements to Support Recruitment Planning

Defining Ideal Mix of Physicians and Advanced Practitioners

Defining Ideal Mix of Physicians and Advanced Practice Professionals

- Many organizations still view Advanced Practice Professional recruitment as an "operational" activity, rather than a strategic one.
  - i.e. Dr. Smith is getting close to capacity – we're going to add an APP to her practice to supplement their productivity

- Given projected shortages in most key physician specialties, maximizing APP recruitment and utilization is and will continue to be a major strategic driver of care delivery and patient access.

- **Major Challenges:**
  - Variation in utilization by specialty (or by practice…or by provider)
  - Culture and History
  - Clinical Practice Model

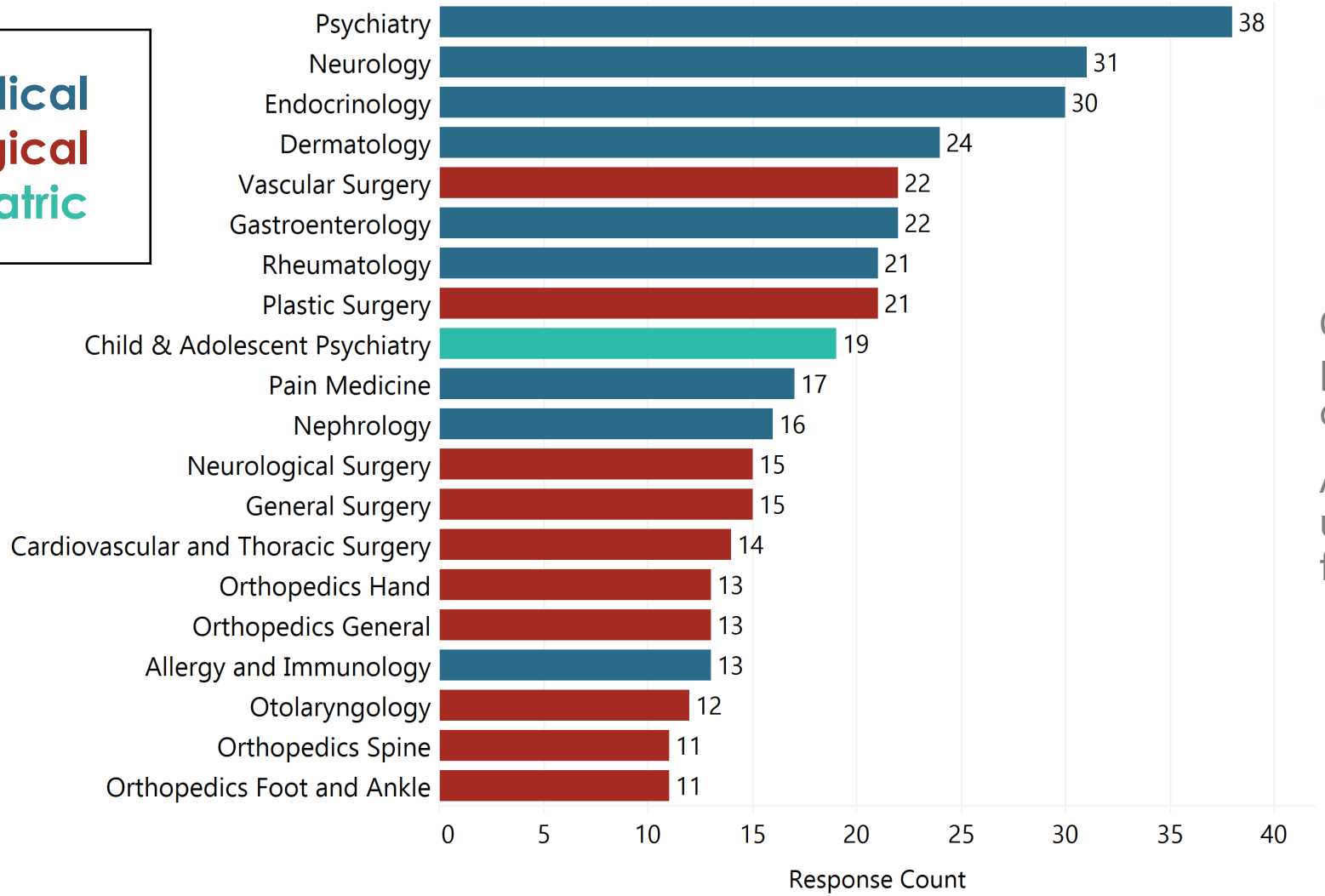
Physicians and Advanced Practice Professionals
Common Service Lines for APP Utilization/Expansion

Specialty Examples	Ideal Utilization
Primary Care	• Initial - Same day access; preventative/wellness services • Expanded – Chronic Stable patients; proactive population health • Practice delivery model consistent with PCMH principles for clinical practice transformation • Models promoting 1:2 to 1:4 physician to APP ratios abound
Behavioral Health	• In-Office – Medication Management • Inpatient – Admission H&Ps, discharge summaries, chronic medical management • Psychiatrist:APP ratios of 1:2 or more can safely and effectively increase access
Orthopedics	• Initial Evaluation, Completion of Visit, Patient Education • Splinting/casting • Perioperative assessment; post-operative interval • Orthopedist:APP ratios of 1:2 can be highly efficient
Cardiology	• In-office - Testing; Patient education; Secondary/tertiary prevention efforts • Inpatient and Outpatient - Initial patient evaluation; patient follow-up • Current rate of 1.5:1 may be adequate for general cardiology but may be able to move closer to 1:1
Neurology	• In-Office - Intake assessments; Monitoring established plan of care; Same day access for new or established patients • Subject matter expert (e.g., concussion management; headache syndromes) • Inpatient - Admission H&Ps, initial consultations, daily rounding assistance, discharge summaries • General neurology rate can approach 2:1 or even 1:1

Bringing Organizational Stakeholders into the Process

Collecting Provider Opinion on Need

Medical
Surgical
Pediatric



Qualitative input from providers incredibly useful in compliance support

Also extremely useful in understanding pain points for referral access

Getting the Right Team to the Table

- To build a different, more impactful approach to Medical Staff Development Planning, a health system must start by getting the right people involved in decision making.
- Recruitment planning should not be driven by a non-executive committee, nor should it be driven by the executive team alone. The right people need to be around the table, reviewing the same data, asking and answering the same questions, and making decisions as a team.
- Failure to do this results in multiple executives executing their own individual strategies, which will likely be incongruous and much less successful than an aligned strategy.

Finalizing and Refreshing Recruitment Plans

Summary-Level Three-Year Recruitment Planning

		Total by Cluster						Total by Provider Type	
Grouping	Specialty Roll-Up	Central	South-West	East	North	South	Grand Total	Physician	APP
Cancer	Hematology/Oncology		1		1	2	4	2	2
	Radiation Oncology		1			2	3	3	
	Surgical Oncology	1					1	1	
Cardiology	Cardiovascular and Thoracic Surgery	2					2	2	
	Electrophysiology	1				2	3	3	
	General Cardiology	2	1	2	2	2	9	5	4
	Interventional Cardiology		2			2	4	4	
Neurosciences	Neurological Surgery	3				2	5	2	3
	Neurology	1	1	2		2	6	4	2
Orthopedics	Orthopedics (General or Joint)	2	1	1	1	3	8	6	2
	Orthopedics Hand					1	1	1	
	Physical Medicine & Rehabiliation		1			1	2	2	
	Sports Medicine	1			1		2	2	
Otolaryngology	Otolaryngology	1	1	2	1		5	3	2
Primary Care	Adult Primary Care	13	5	5	13	25	61	31	30
	Endocrinology		1		1		2	2	
	Infectious Diseases		1		1	1	3	3	
	Rheumatology	1				1	2	2	
Psychiatry	Psychiatry	4		1	2	1	8	4	4
Pulmonary	Pulmonary and Critical Care	4	1	2	3	1	11	7	4
Urology	Urology	1	1		2	1	5	5	
Other	General Surgery	3		3	3	4	13	13	
	OB/GYN	2		1	1	1	5	5	
	Vascular Surgery	2				1	3	3	
Grand Total		44	18	19	32	55	168	115	53

- By end of the planning period, the MSDP recommends the recruitment of 115 physicians and 53 advanced practitioners.

Critical Considerations

- Provider Mix
- Location
- Timing

Baby Steps Towards Organizational-Level Planning

Baby Steps Towards Organizational-Level Planning

- "Our organization isn't (culturally/operationally/mentally) ready for a comprehensive planning process with this much stakeholder engagement and/or ready to adopt a centralized plan"

- **A centralized final recruitment plan isn't needed to get organizational benefit** – centralized data; tied to strategy and looked at through the lens of recruitment can highlight the need for integrated recruitment decision making

- **Initial Steps:**
  - Build integrated data sets from silos across the health system
    - Market definitions
    - Provider Supply and Demand
    - Market Share
    - Succession Planning
    - Access and Capacity
    - Provider Mix (Phys:APP) by specialty
  - Tie data to strategic planning objectives
  - Circulate data sets to decision makers across organization; use to facilitate discussion

About HSG Advisors

About HSG

HSG Advisors (HSG) partners with health systems to transform their approach to their markets, services, and providers for improved growth and operational and financial sustainability.

Headquarters: Louisville, KY
Formed: 1999

HSG CLAIMS DATA ANALYTICS

Evaluate competitive dynamics within markets, service lines, providers and patients based on all-player healthcare claims data analysis and HSG insights and expertise.

HSG STRATEGY

Define strategic goals and direction for your health systems' long-term growth plans that allows for the simultaneous pursuit of immediate market opportunities, focused on growth strategies and Medical Staff Development Planning.

HSG EMPLOYED PROVIDER NETWORKS

Improve your financial and quality performance and overall Operational Excellence by building a Shared Vision and developing strong organizational, leadership, and governance support structures.

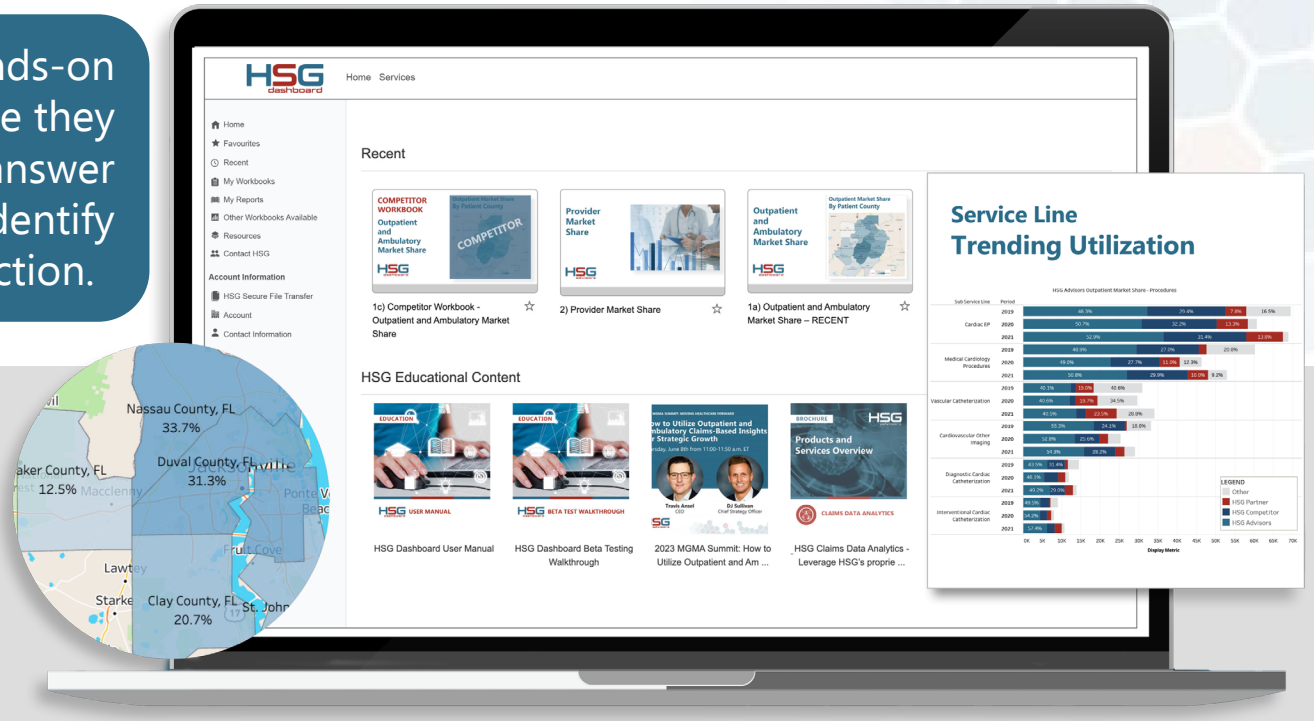
HSG COMPENSATION AND COMPLIANCE

Develop sustainable provider compensation solutions to achieve market competitiveness, financial sustainability, and regulatory compliance through compensation model development and implementation.

HSG Dashboard
Overview

HSG Dashboard is HSG's Tableau-based client data visualization environment that blends **HSG's proprietary All-Payer Claims Database, State-Level Inpatient Market Share, Outpatient Market Share, and Emergency Department and internal client health system data** to create unique, easily-interpretable reports, all housed in **one** central location, for utilization by **Health System Executive, Planning, and Employed Network Leadership** and other stakeholders focused on understanding the market and making strategic decisions.

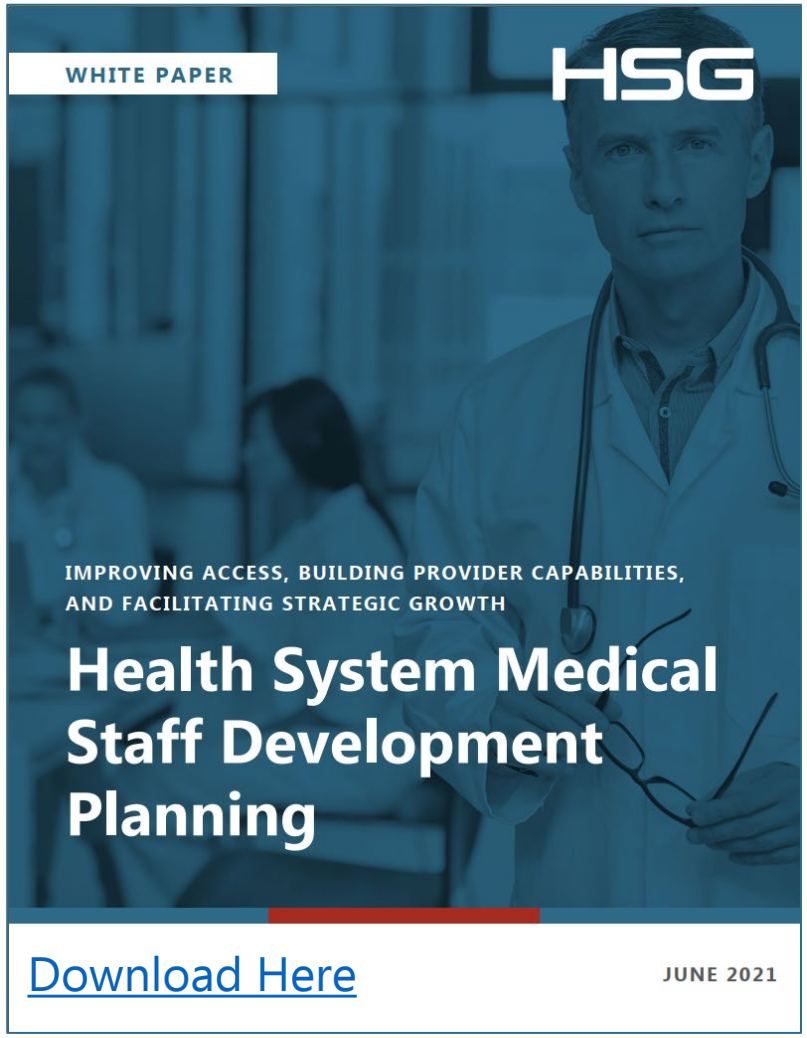
HSG's Strategic Advisory Team employs a hands-on approach to ensure health system clients get the value they are seeking - helping health system clients answer questions about their markets and providers and identify incremental opportunities, turning information into action.



Core HSG Dashboard Solutions:

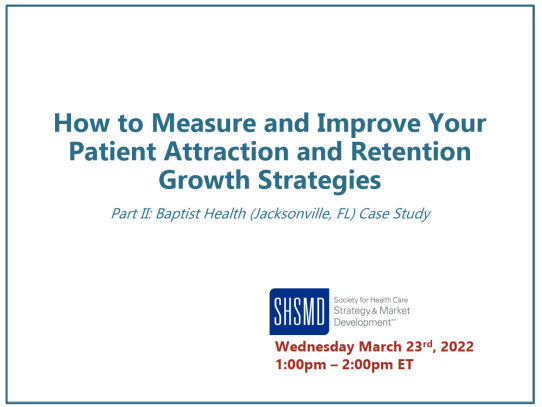
- HSG Outpatient and Ambulatory Market Share™
- HSG State-Level Inpatient Market Share™
- HSG Patient Flow™
- HSG Patient Share of Care™
- HSG Provider Market Share™
- HSG Provider Need Analytics™
- HSG Market Demographics™

Additional Resources



[Download Here]

SHSMD
[Patient Share of Care: Measuring Patient Brand Loyalty]



SHSMD
[How to Measure and Improve Your Patient Attraction and Retention Growth Strategies]

Find these materials and more at: https://hsgadvisors.com/hsg-strategy/medical-staff-development-planning/

HSG Provider Manpower Planning

Our Depth of Manpower Planning Expertise. HSG has performed 300+ Manpower Development Plans in the last decade, for hospitals of all sizes, from critical access hospitals to some of the largest health systems in the country. For many of these clients, HSG has developed a multi-year partnership focused on helping the client optimize their physician network – getting the right manpower, deploying it strategically to achieve health system goals, and ensuring the financial performance of closely aligned or employed practices are sustainable for the health system.

Our Thought Leadership. HSG consultants publish a tremendous amount of thought leadership about the elements of physician manpower planning that drive optimal performance. Most recently, HSG published *"Health System Provider Workforce Development Planning: Improving Access, Building Provider Capabilities, and Facilitating Strategic Growth"* which advocates for comprehensively developing Health System Provider Workforce Plans with a focus on system strategic needs, growth strategies, service line strategies and an overall focus on improving patient market share capture.

Our Team. As an industry leader in Manpower Planning/Provider Workforce Development HSG's team members have a deep knowledge and understanding of the challenges that health systems face in this area. Our engagement teams heavily utilize our thought leaders, our physician leaders and a consulting staff that is intimately familiar with the data needs of our health system partners related to Provider Workforce Planning efforts.