HSG | PHYSICIAN MANPOWER PLANNING

# 12 CORE QUESTIONS TO CONSIDER IN THE AGE OF EMPLOYMENT

# PHYSICIAN MANPOWER PLANNING

## MOVING BEYOND COMMUNITY NEED

Over the past 20 years, the **"Community Need Assessment"** has been at the core of health system physician recruitment planning. Defining whether a given market was "undersupplied" or "oversupplied" with a particular specialty became one of the core considerations when deciding whether to add a physician FTE to the recruitment plan. Between 2005-2010, when employment had not become a priority for provider alignment in a majority of markets, this approach made sense. Stark made physician recruitment largely an effort in justification of community need, and health systems analyzed markets with that objective in mind.

In today's environment, manpower planning should be the tool with which health systems answer the question **"How do we execute our strategy through our providers"** and not just **"How do we meet the needs of the community?"**

Today's healthcare environment forces health systems to ask a different set of questions when considering physician manpower need and recruitment strategy. The rise of employment has changed the dynamics around physician recruitment as well as the requirements for legal validation needed to justify health system support for recruitment. Under employment, health systems are largely free to determine their own recruitment needs without the need to address Stark exemptions or find private practice partners to facilitate their recruitment. In addition, the vast majority of newly graduated residents in the last five years prefer to seek employment arrangements. These dynamics have resulted in health systems having greater flexibility available to them in their approach to recruitment.

# THE IMPERATIVE FOR A DIFFERENT APPROACH

In our work across the country, we still see health systems approaching manpower planning with the "community need" mindset which includes some or all of the following behaviors:

- Evaluating provider need through the lens of one question: "Does our market have an under/over supply of a specific specialty?" An alarming number of health systems ask this (and only this) question when considering physician needs. 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 manpower planning decisions.
- Tasking decision making to a non-strategic "manpower 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.
- Assessing physician need on a three-year (or longer) timeframe, and not being responsive to changing market conditions and/or health system needs

After years of helping organizations through strategic planning and manpower planning, HSG believes a different approach to manpower planning is required for health systems to execute their strategy and maximize their ROI on physician recruitment decisions. The "community need" mindset must evolve if manpower plans are going to create the right recruitment priorities.

# ACKNOWLEDGING THE IMPACT OF EMPLOYMENT

For health systems looking to evolve their manpower planning to be a strategic effort that is in sync with the organization's goals, different questions must be asked. More significant effort and resources must be applied to the process. Hospitals and health systems must embrace the concept that the multimillion dollar investment it will make in physicians (and advanced practitioners) must be defined explicitly within the context of the organization's strategy and done so with the realization of how employment has changed the dynamics of developing manpower recruitment plans. Failure to do so will result in the recruitment of providers who do not fit the organization's strategic goals, or even worse, failure to recruit the providers the organization ultimately needs to be successful.

## GETTING THE RIGHT TEAM AT THE TABLE

To build a different, more impactful approach to manpower 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 at 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.

# 12 CORE QUESTIONS TO CONSIDER IN THE AGE OF EMPLOYMENT

## HEALTH SYSTEM STRATEGY CONSIDERATIONS

**1. Revenue Goals. How many physicians must we employ (or align with) to meet a revenue target?**

This may relate to a specific service line, the employed provider network or the hospital/health system overall. It often takes the form of what primary care base do we need to capture patients in our system that will drive needed volume to core specialties. HSG often sees health systems take the approach of figuring out what they need to recruit, and then projecting the revenue those providers will generate for the health system – however, revenue should be an objective, not a by-product, of a well-executed physician manpower plan.

**2. Service Line Capabilities. What providers do we need to recruit to create an excellent service line?**

This question goes beyond FTEs of providers, although having a supply that creates superior access is important. The important consideration is what array of capabilities are needed to be the market leader in a given service line and whether the volume exists with the health system's current market strategy to keep that provider busy.

**3. Geographic Reach. What ambulatory access points and what providers do we need to create the geographic reach required for the hospital to be a success?**

A health system's recruitment plan must reflect its ambition for growth – new markets cannot be penetrated without a provider presence. This often takes the form of primary care access points, but can also include hospital-based-and-ambulatory specialties. Proactively defining growth goals ensures the health system does not have empty office suites in new markets awaiting providers to be recruited and credentialed.

**4. Referral Capture. Are there physician splitters that the hospital should target for employment with the physician network?**

Beyond simple numbers, are there physicians who could add volume if they are acquired? Or alternatively, if a competitor were to acquire the physician, would it cause the hospital damage? While altering referral patterns is not simple, newly employed physicians generally understand that they need to refer within the network.

# EMPLOYED PHYSICIAN NETWORK CONSIDERATIONS

**5. Employed Subsidy Tolerance. How comfortable are we with increased employed provider subsidies?**

Only a handful of employed networks across the country operate without subsidies from the health system. Recruiting a physician, even one who is successful and grows volume quickly, is likely to cause an increased subsidy at the employed group level. How comfortable is the health system with this dynamic? Are we comfortable with an additional $1MM in losses if we recruit and employ 6 providers this year? How about $10MM if we recruit 60? Is there room for improved performance and reduced subsidies to employed providers through better management/operations?

**6. Practice Capacity. What volume growth objectives can be met by expanding capacity in the existing practices rather than recruiting additional providers?**

From a "community need" perspective, a 1.0 FTE physician is a 1.0 FTE physician. In reality, physicians working the same hours in the same specialties may have very different levels of productivity and excess capacity in their practices. Measuring this capacity and evaluating opportunities to improve its usage is much cheaper than recruiting incremental providers. The process for expanding capacity is multifaceted. Are schedules not being well managed? Are physician or staff incentives a barrier to driving volume? Is office staffing so lean that throughput is difficult? Is promotion of the practices adequate? Understanding this opportunity starts with practice benchmarking, while strong accountability is required to leverage those opportunities.

**7. Primary Care/Specialty Ratios. What size primary care base do we need to keep our employed specialists busy?**

There are a number of issues around this question. One is mitigating risk of specialty employment. Having a specialty base that is not largely supported by your employed primary care network puts your specialists at risk of having their referral volume cut off. A second issue is network integrity – the ability of the network to keep appropriate referrals within the network. If the primary care base does not have specialists in your network to refer to, how will the hospital keep the volume? Creating the right ratio is often something that will conflict with community need – which is why its just as important to ask "what does our health system need?"

**8. Compensation Model Impact. How does our physician compensation model affect the demand for physicians?**

Compensation models tend to incent volume, through wRVUs. The advent of higher pay tied to quality metrics may change that incentive. Some systems are limiting compensation for productivity if quality metrics are not met, which may reduce productivity as doctors focus on thoroughness and documentation. This, in turn, will drive up provider demand – **finding the right balance is key.**

# OTHER MANPOWER PLANNING CONSIDERATIONS

**9. Advanced Practitioner Usage. Are we thoughtfully including Advanced Practitioners in our recruitment plan and using them appropriately?**

To obtain the providers needed, we must think beyond just physicians. Advanced Practitioners must be a part of the plan and be a core part of satisfying the strategic provider need. The key to this is making sure Advanced Practitioners are used at top-of-license – understanding the model that maximizes benefit by specialty is key to success. Building a culture of acceptance by physicians is likewise essential. Effective use of APPs is not preordained, and working closely with physician leaders is required to ensure the desired benefits are captured.

**10.** **Succession Planning. Which practitioners need succession planning and how should the recruitment plan reflect this need for transition?**

As the baby boomer population starts to hit retirement age, a greater percentage of medical staffs are reaching the 62-65 age mark. With an employment mindset, two considerations should be top of mind:

1. As our employed providers age out, and how do we strategically employ and locate providers to make that transition as seamless as possible?
2. What community physicians are at risk of retirement? Should the health system consider employing those providers to have more control over the transition of the practice?

**11.** **Care Models. Has our employed network adopted (or does it plan to adopt) new care models in response to the need to manage populations? How are those models impacting the need for providers?**

New models often expand staffing for counselors, psychologists, care coordinators, dieticians, and other staff. The impact of these models on physician staffing requirements are relevant to the overall staffing plan. Recruiting nothing but physicians when your Patient-Centered Medical Home (PCMH) Level 3 Primary Care practices want to evolve to a 1:3 Physician to Advanced Practitioner ratio is a recipe for disaster.

**12.** **Population Health Management. What mix of physicians and supporting staff is required to best manage populations?**

This imperative may change your perception of needs for physicians who manage chronic conditions. HSG sees many organizations focused on recruiting physicians such as endocrinologists or psychiatrists, recognizing that they may help keep patients healthy. The interest is generally greater than if the hospital were to solely focus on the revenue generated by these physicians in a fee-for-service market.

## THE BOTTOM LINE

**The growth of a physician employment network creates a strategic opportunity which health systems must seize. The dominance of the employment model requires these systems ask new questions in their provider manpower and recruitment planning. Those that do it well will more effectively drive strategic advantage in both the fee-for-volume and fee-for-value worlds.**

## GETTING STARTED

We want to help your physician network evolve through your Physician Manpower Planning and Recruitment Strategy in order to maximize your health system's performance.

Please feel free to reach out to us to schedule a discussion about an improvement initiative for your Physician Network.

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**We Build High-Performing Physician Networks** so Health Systems can Address Complex Changes with Confidence.

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