Medical Staff Development Planning in 2021

Physician Relations and Recruiting Track

June 8, 2021

11:30AM-12:30 PM

Company **Overview**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy

Driving a common strategic focus with engaged physicians.

Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement

Improving the performance of employed physician networks.

Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation

Aligning physician compensation with health system and employed network goals.

HSG Thought Leadership
Medical Staff Development Planning

Incorporating Service Line Strategy

Improving Patient Access to Care

Leveraging Claims Data

Incorporating APPs

Find these materials and more at: https://hsgadvisors.com/physician-strategy/physician-manpower-plans/

Medical Staff Development Planning in 2021
Objectives for Today's Discussion

- How Medical Staff Development Planning is Evolving for Health Systems in Today's Environment
- Key Components of an Effective Medical Staff Development Plan
- Questions and Answers

Medical Staff Development Planning in 2021

Description

Medical Staff Development Planning in 2021 will provide perspective on how health systems are approaching medical staff development planning as well as best practices for medical staff development for health systems in the current healthcare environment.

Behavioral Outcomes

1. How Medical Staff Development planning is evolving for health systems
2. Key components of an effective medical staff development plan

Behavioral Outcomes Supporting Points

1. Identify how provider need intersects with health system strategic plan objectives
2. Implications for physician recruitment activity
3. Implications for C-team physician strategy activity.

Medical Staff Development Planning in 2021

Medical Staff Development Planning in 2021
Background and Overview

- 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 strategy will support the health system's overall strategic vision, **particularly in the area of Medical Staff Development Planning.**
- 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 Medical Staff Development 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.**

The Problems with Focusing on Community Need Alone

Sample 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

The Problems with Focusing on Community Need Alone

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.

Critical Components of Effective Medical Staff Development Plans

Critical Components of Effective Medical Staff Development Plans in 2021

Effective Strategic Medical Staff Development Planning encompasses the following elements:

1. **Tailoring Market Definitions for Making Strategic Decisions**
2. **Understanding Utilization of the Care Continuum by Patients within the Market**
3. **Identifying Supply, Capacity, and Capability Gaps by Specialty.**
4. **Identifying Succession Planning Dynamics by Specialty**
5. **Defining Existing Capacity Within the Health System's Current Network of Practices and Providers**
6. **Defining Ideal mix of Physicians and Advanced Practice Professionals**

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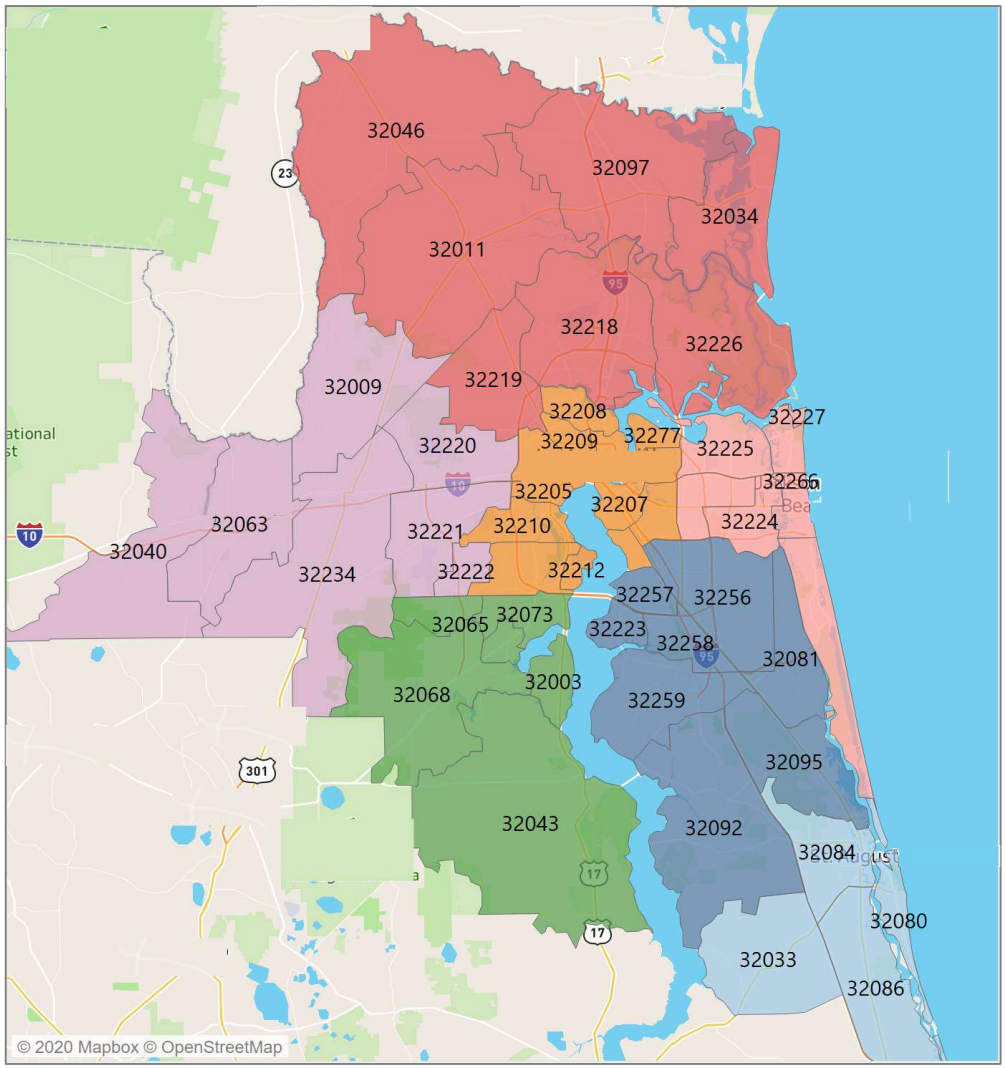
Market Definitions for Strategic Decision Making

- Many organizations rely on historic "Primary/Secondary/Tertiary" market definitions for evaluating provider recruitment and deployment needs

- As care becomes more local, health systems need to focus on more granular markets to target care delivery – not just for primary care but for specialty care as well.

- Creating more granular market "clusters" and thinking about provider strategy at a more local level can inform recruitment needs

Market Definitions for Strategic Decision Making
Example



Central
North
West
East
Southwest
Southeast
Far South

Market Definitions should be based on:

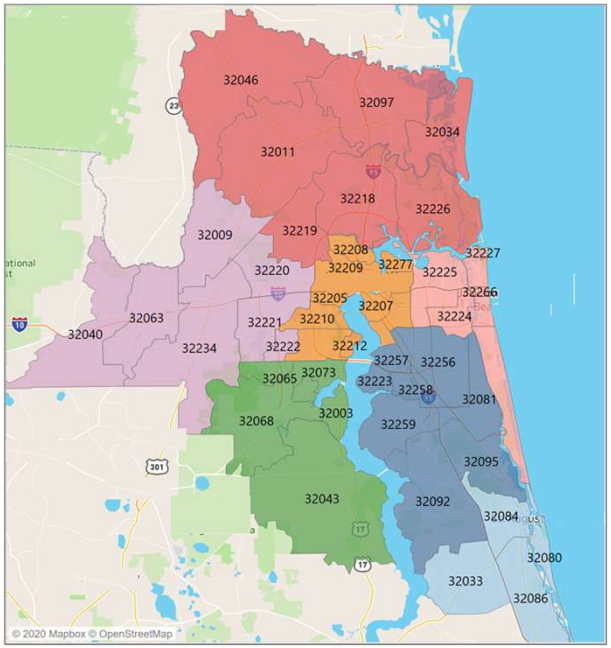
- Common Routes of Travel
- Historic Penetration
- Demographically-similar groups
- Common Competitive Threats
- Strategic Priority

This allows for:

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

Market Definitions for Strategic Decision Making

A health system's market should be looked at on a more granular basis than a "primary, secondary and/or tertiary" market perspective.



Sample Market w. Cluster Rollups

The rubric below identifies different strategies based on an aggregation of quantitative factors:

	"Cluster" Development Strategy	Employed Primary Care Penetration	System Market Share	Competitor Penetration	Access to System Specialty Care and Acute Care	Market Demographics
1	**Reinforce and Defend**	Moderate-to-High	High	Low-to-Moderate	Reasonable	Moderate-to-Favorable
2	**Strategic Growth Opportunities**	Low-to-Moderate	Low-to-Moderate	Low-to-Moderate	Reasonable	Moderate-to-Favorable
3	**Broaden Network for Referral & Lives Capture**	Low	Low-to-Moderate	Low	Limited	Unfavorable-to-Moderate
4	**Penetrate Highly Competitive Market**	Low	Low	High	Reasonable	Favorable
5	**No Recommendation**	Variable	Variable	Variable	Variable	Variable

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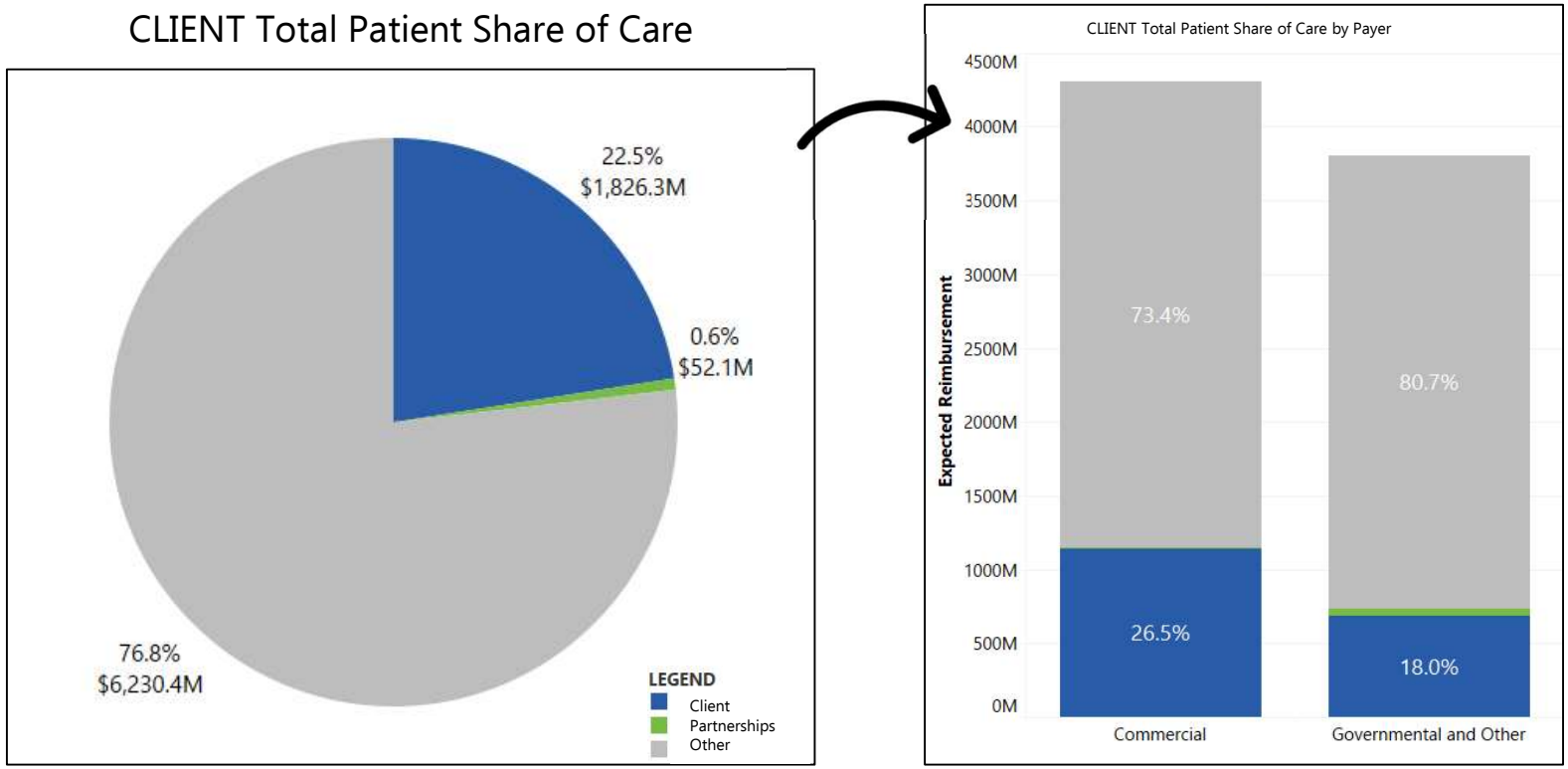
Understanding Utilization of the Care Continuum

- Many organizations are limited to evaluating market share on an inpatient-only basis – creating blind spots in the areas of outpatient and ambulatory that are critical to consider when developing a provider recruitment or development strategy
- Understanding overall Patient Share of Care - the Health System's capture of a patient's total healthcare dollar - is critical to identifying gaps in the Health System's delivery of overall care, especially as it relates to provider access.
- Provider manpower plans should support the increased, incremental capture of the total patient dollar.

Understanding Utilization of the Care Continuum
Patient Share of Care: System – Overall Example

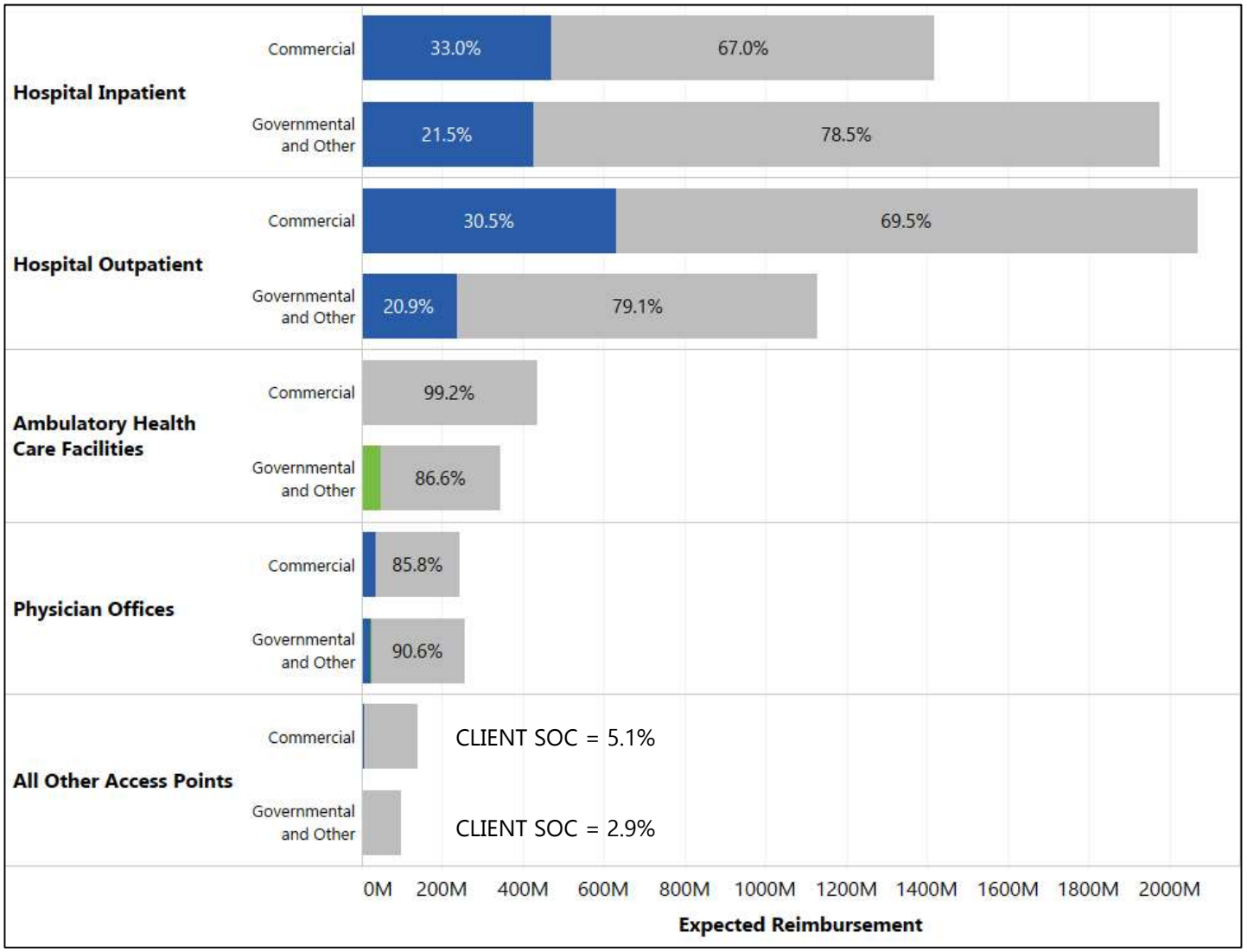


	FY19
CLIENT Owned	22.5%
CLIENT Partnerships	0.6%
Total BLINDED CLIENT	**23.1%**

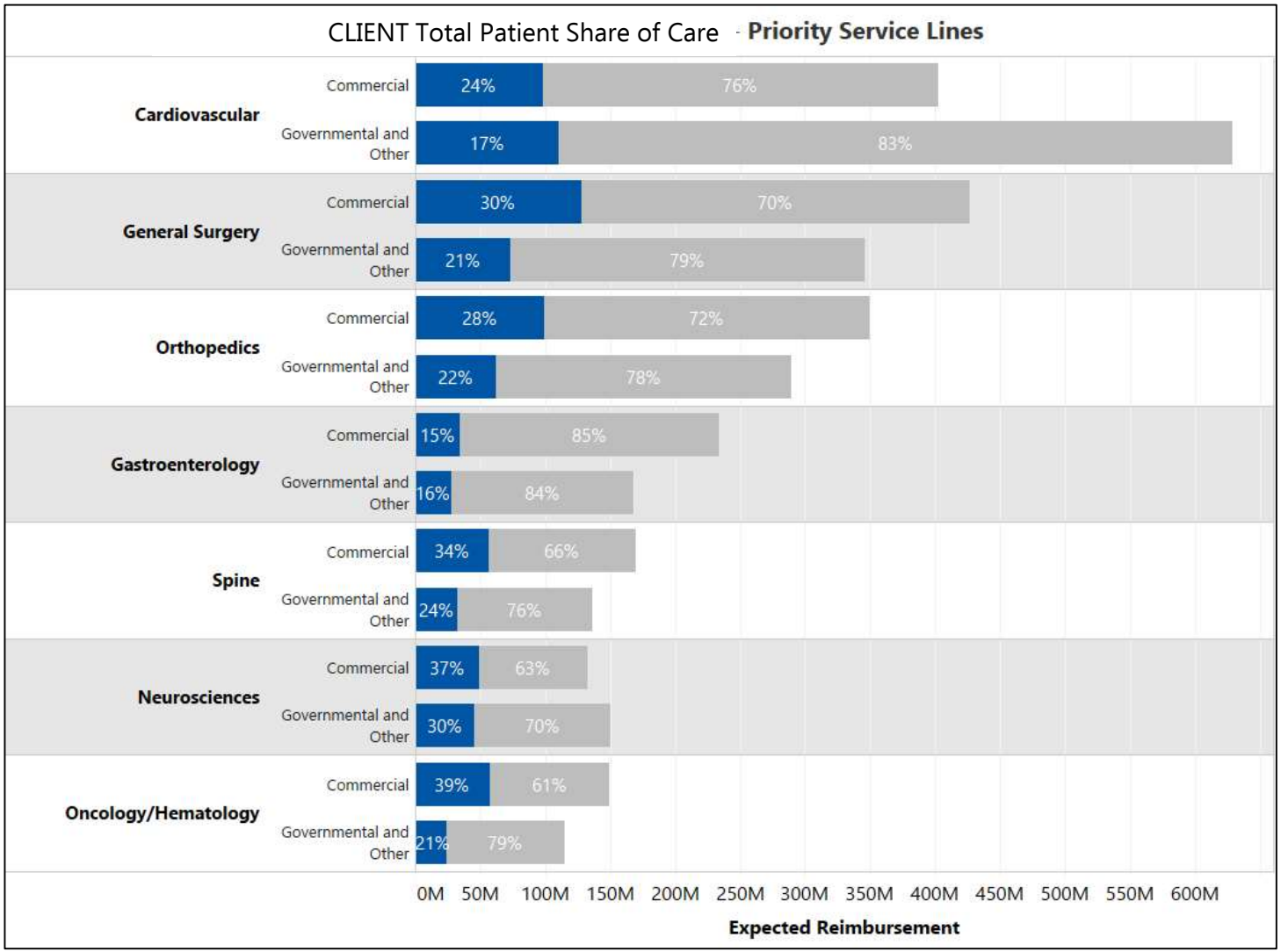
- BLINDED CLIENT is **capturing 22.5% of the total expected healthcare spend ($8.1B)** for healthcare entities providing services in the 5-county service.
- This ranges from 18.0% for Governmental and Other Payers* to 26.5% for Commercially Insured Patients.

*Governmental and Other Payers includes:
FFS Medicare, Medicaid, Managed Medicare, Worker's Compensation, Other State & Local Govt. Payers

Understanding Utilization of the Care Continuum
Patient Share of Care: System – Site of Care Example



Understanding Utilization of the Care Continuum
Patient Share of Care: System – Service Line Example

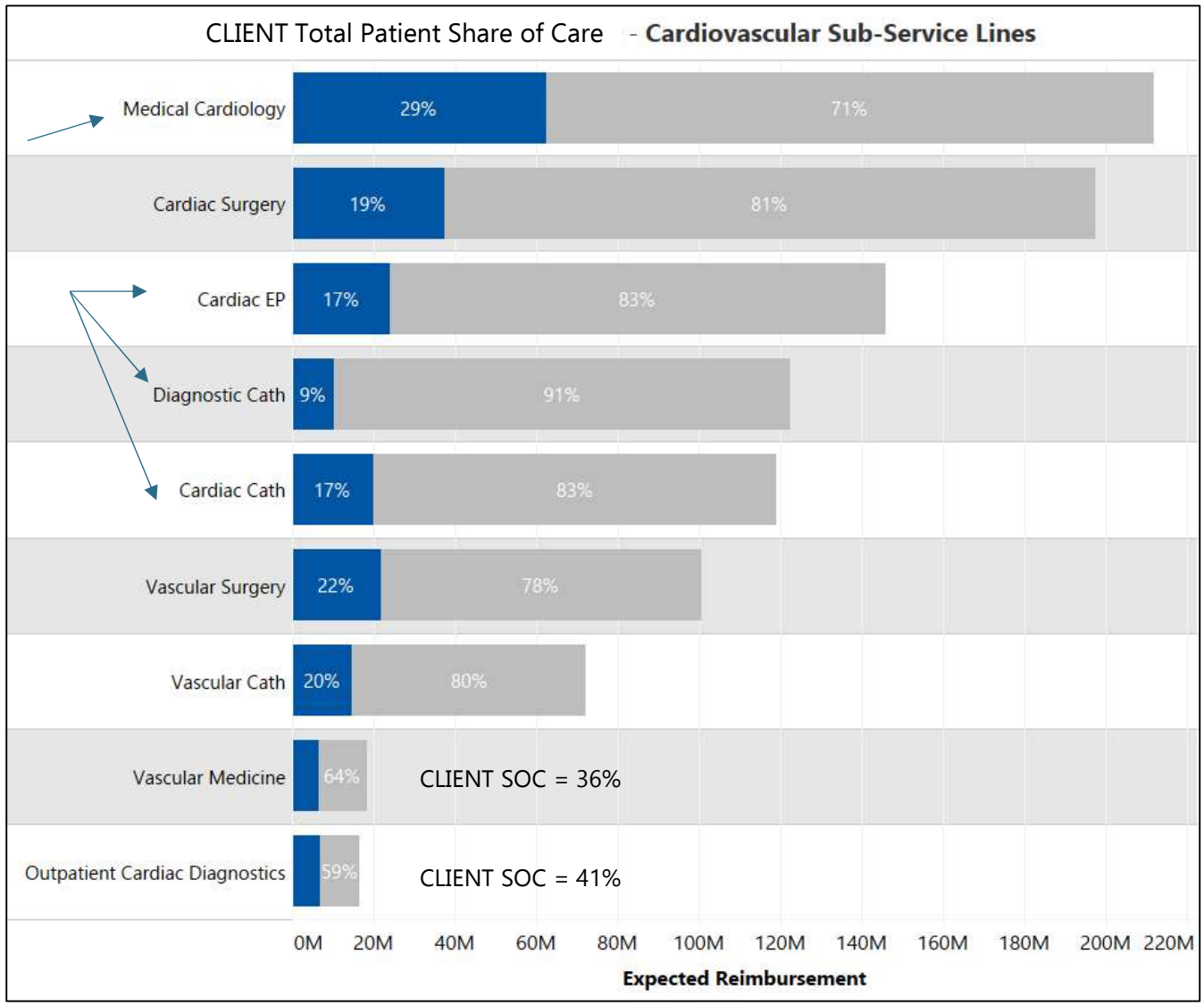


Understanding Utilization of the Care Continuum
Patient Share of Care: Priority Sub-Service Lines

		Share of Care	Expected Reimbursement
Cardiovascular	Medical Cardiology	29.4%	$211.9M
	Cardiac Surgery	18.9%	$197.4M
	Cardiac EP	16.6%	$146.0M
	Diagnostic Cath	8.5%	$122.6M
	Cardiac Cath	16.8%	$119.2M
	Vascular Surgery	21.7%	$100.7M
	Vascular Cath	20.3%	$72.3M
	Vascular Medicine	36.5%	$18.3M
	Outpatient Cardiac Diagnostics	41.5%	$16.5M
	Vascular Outpatient Diagnostics	53.9%	$3.7M
General Surgery	Other General Surgery	25.7%	$227.7M
	Tracheostomy	24.2%	$125.5M
	Colorectal/Lower GI	28.2%	$88.7M
	Hernia	28.7%	$57.8M
	Bariatric/Obesity	15.1%	$43.2M
	Breast	33.8%	$41.9M
	Cholecystectomy	24.6%	$31.4M
	Upper GI	17.1%	$27.1M
	Appendectomy	41.9%	$24.2M
	Skin	36.7%	$21.9M
	Endocrine	36.8%	$18.3M
	Trauma (General Surgical)	20.1%	$17.0M
	Hepatobiliary/Pancreatic	20.5%	$17.0M
	Other GI	21.0%	$15.9M
	Adhesions	25.9%	$9.6M
	Splenectomy	16.8%	$1.0M

		Share of Care	Expected Reimbursement
Orthopedics	Joint Replacement	24.3%	$217.5M
	Sports Medicine	28.5%	$138.7M
	Surgical Trauma (Orthopedics)	22.1%	$113.9M
	Other Surgical Orthopedics	26.4%	$64.7M
	Hand	28.6%	$29.0M
	Orthopedic Diagnostics	38.4%	$28.7M
	General Medical Orthopedics	17.4%	$17.9M
	Medical Trauma (Orthopedics)	20.9%	$7.8M
	Foot	7.0%	$2.5M
Spine	Fusion	33.2%	$151.2M
	Other Surgical Spine	26.1%	$95.3M
	Spine Outpatient Diagnostics	30.5%	$34.4M
	Medical Spine	15.5%	$16.4M
Neurosciences	Brain	42.2%	$87.9M
	Stroke and Transient Ischemic Att..	33.4%	$58.0M
	Outpatient Neurology	31.7%	$31.1M
	Other Neurology	33.6%	$29.0M
	Seizure/Epilepsy	25.6%	$20.6M
	Other Neurosurgery	16.9%	$13.5M
	Peripheral and Cranial Diseases	28.4%	$12.7M
	Degenerative Disorders	14.0%	$12.2M
	Nervous System Infection	45.7%	$6.9M
	Multiple Sclerosis	36.3%	$3.1M
	Trauma (Neurosurgery)	27.6%	$2.2M
Oncology/ Hematology	Chemotherapy	45.3%	$77.3M
	Inpatient Oncology (Medical)	28.6%	$59.6M
	Radiation Oncology	31.9%	$48.7M
	Inpatient Hematology (Medical)	26.9%	$29.5M
	Diagnostics	40.7%	$12.8M

Understanding Utilization of the Care Continuum
Patient Share of Care: Sub-Service Line Example



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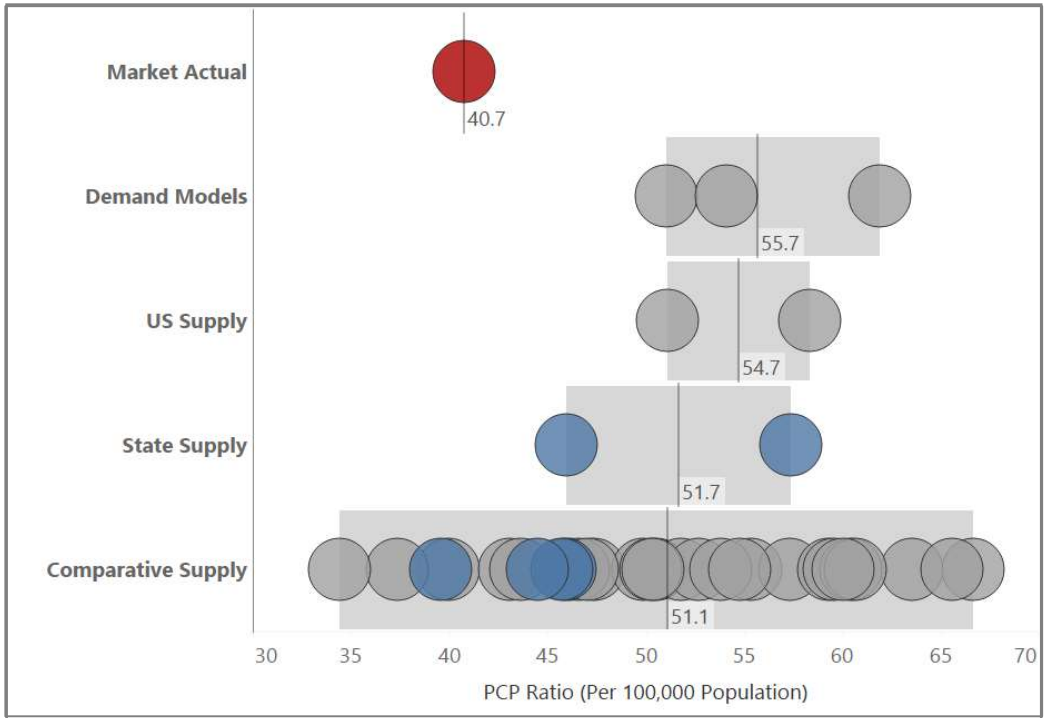
Identifying Supply and Demand Gaps by Specialty

- "Community Need" can be a useful data point to consider when building a Strategic Medical Staff Development plan.
- Community Need often provides context to other data points to help make decisions about future recruitment needs
- However (as a reminder) it should not be used to justify strategic need
- The more granular the market its applied to, the more useful it becomes in evaluating community need.

Identifying supply and demand gaps by specialty
Adult Primary Care Example

Understanding PCP Need: Comparison of PCP/Population Ratios



All numbers expressed as Primary Care Physicians per 100,000 Population
Market Actual: Based on Inventory completed by HSG
Demand Models: Published Population-Based Models
US and State Supply: AMA Masterfile and CMS Physician Compare
Comparative Supply: Physician Compare - 30 metropolitan regions with populations between 1M and 2M.

CLIENT market is significantly undersupplied compared to established population-based demand models and supply benchmarks.

The table below shows the number of incremental PCPs required to match differing model and benchmark ratios.

Number of PCPs Required to Match Differing Ratios

Model	PCPs Needed
Demand Model Average	220
US Supply Average	205
State Supply Average	161
Lowest Demand Model	151

Identifying supply and demand gaps by specialty
Adult Primary Care Example

Specialty Roll-Up
Adult Primary Care

Supply and Demand Details

Current Supply and Projected Demand Summary (Based on Projected Population)

Cluster	Demand	Supply (Total)	Net Need	Supply Breakdown: On Staff	Supply Breakdown: Employed
Central	253.7	236.6	17.2	61.4	38.4
South-West	113.3	69.8	43.5	7.9	7.9
East	142.8	132.0	10.8	36.5	21.5
North	99.9	49.1	50.8	20.0	16.0
South	165.7	100.0	65.7	56.1	45.1
West	50.4	10.1	40.4	2.0	2.0

Succession Planning Details

Physician FTEs older than 65 by 2023

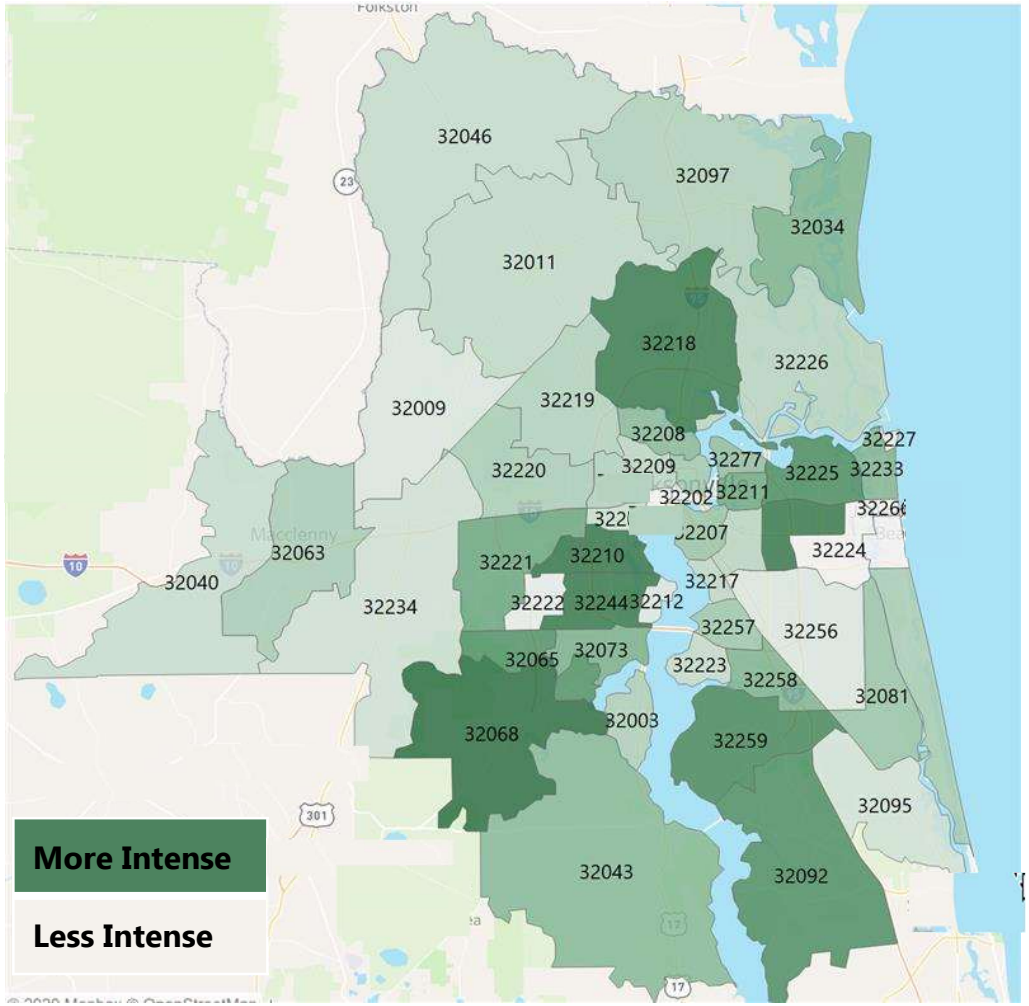
Cluster	Employed	On Staff Non-Employed	Grand Total
Central	8.2	5.0	13.2
South-West	2.1		2.1
East	1.0	4.0	5.0
North	3.0	4.0	7.0
South	8.0	5.0	13.0
West			
Grand Total	22.3	18.0	40.3

Medical Staff and Employed Locations

Is there sufficient need to justify recruitment into private practice?
Yes/No By Hospital

Facility #1	**Yes**
Facility #2	**Yes**
Facility #3	**Yes**

Identifying supply and demand gaps by specialty
Adult Primary Care Example



- Intensity of Primary Care Need is relatively high throughout market
- Dark Green Core Areas Lacking Intensity of Primary Care Resources

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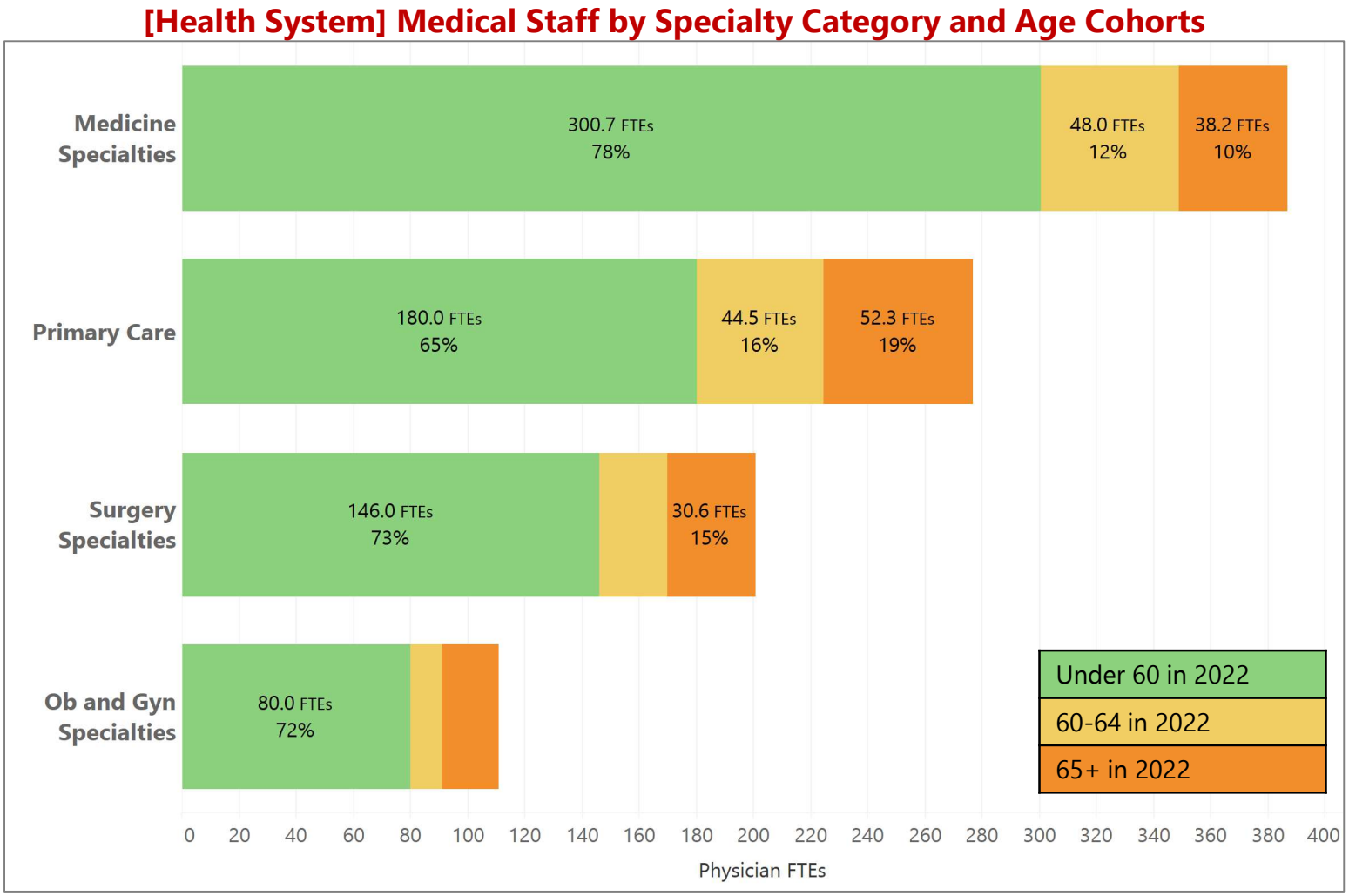
Identifying Succession Planning Concerns by Specialty

- Age dynamics within the overall US physician supply are creating a challenge for maintaining supply
- Generally, 20-30% of a health system's medical staff may be at risk of retirement within a 5-8 year timeframe, necessitating a forward-thinking plan for supplementing the recruitment process.

Medical Staff Age Analysis



Based on Medical Staff Rosters provided by [Health System]. Includes physicians on staff at any [Health System] facility (all staff categories)

Medical Staff Age Analysis

[Health System] Age Analysis Details
FTE Counts by Specialty and Age Cohort (Above 60)

Grouping	Specialty Roll-Up	Age 60-64	Age 65 or Greater
Primary Care	Adult Primary Care	26.40	32.65
	Pediatric Primary Care	18.10	19.60
	Infectious Diseases	6.00	3.00
	Endocrinology	1.00	
	Rheumatology		1.00
Cardiology	General Cardiology	8.00	7.60
Orthopedics	Orthopedics General	4.00	3.00
	Sports Medicine	2.00	1.00
	Orthopedics Hand	2.00	
	Physical Medicine & Rehabiliation	1.00	
Neurosciences	Neurology	2.00	2.00
	Neurological Surgery	1.00	1.00
Otolaryngology	Otolaryngology	6.00	4.00
Pulmonary	Pulmonary and Critical Care	9.00	9.00
Urology	Urology	2.00	8.60
Cancer	Hematology/Oncology	5.00	5.00
	Radiation Oncology	2.00	
	Gynecological Oncology	1.00	
	Surgical Oncology	1.00	
Psychiatry	Psychiatry		2.60

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Defining Existing Capacity Within the Health System's Current Network of Practices and Providers

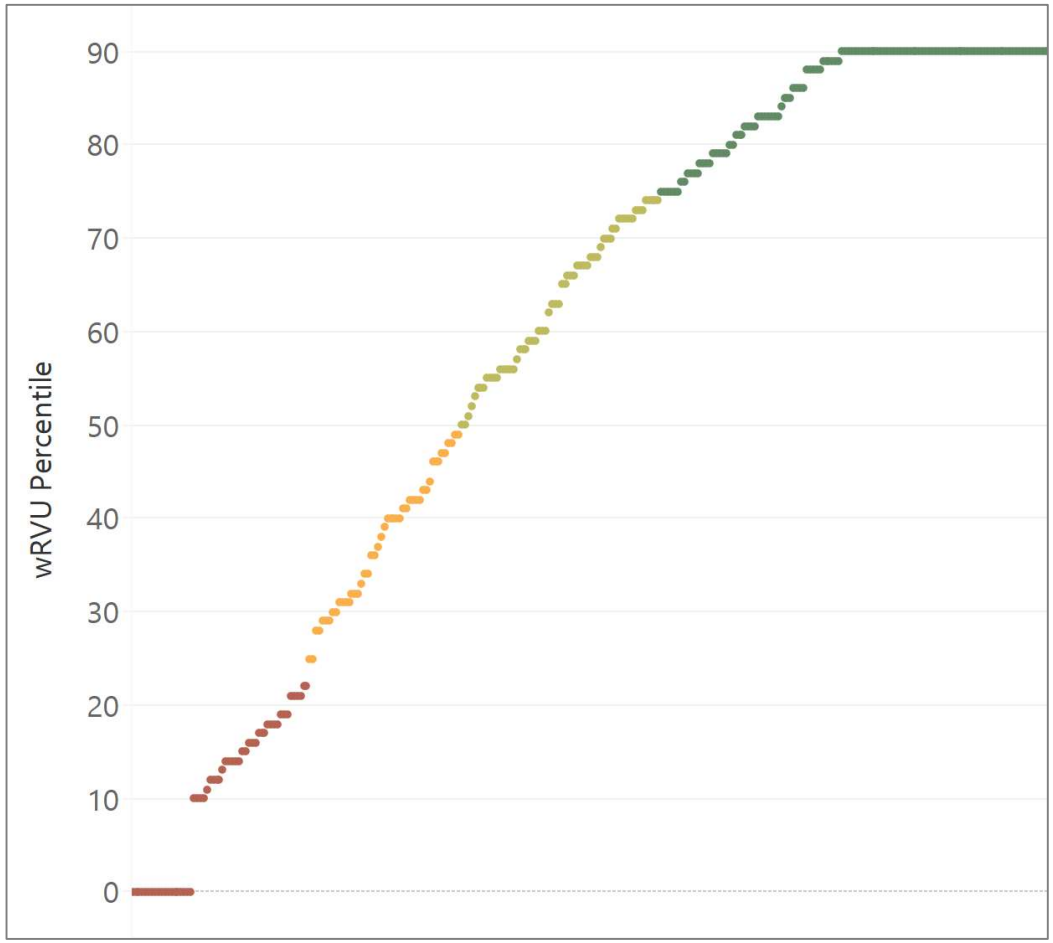
- Many organizations have disconnects in available measuring provider capacity (usually owned by the employed network leadership) and evaluating incremental provider need (usually owned by planning or recruitment).
- Needs for incremental access should start with "how can we better use existing resources" before moving to "how many provider resources should we incrementally add?"
- Measures of productivity, time to 3rd next available appointment, and other measures should be evaluated from the current group of providers before considering incremental recruitment.
- Developing Access Plans for specialties with a preponderance of 75th+ percentile productivity providers is critical as well.

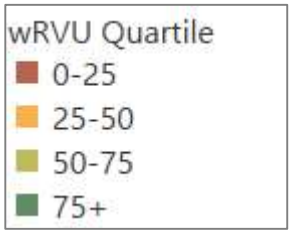
[Health System] Productivity Summary – All Physicians

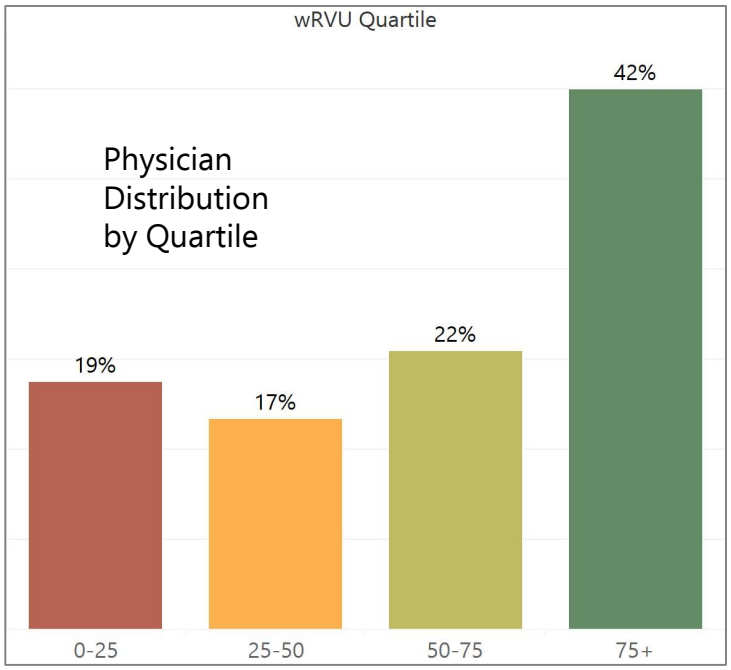
Productivity Percentile by Physician

Based on wRVUs and MGMA National Benchmarks

Each dot represents one physician. Position along Y axis corresponds to wRVU Percentile. Color Coded by Quartile. EM and Hospitalists Excluded





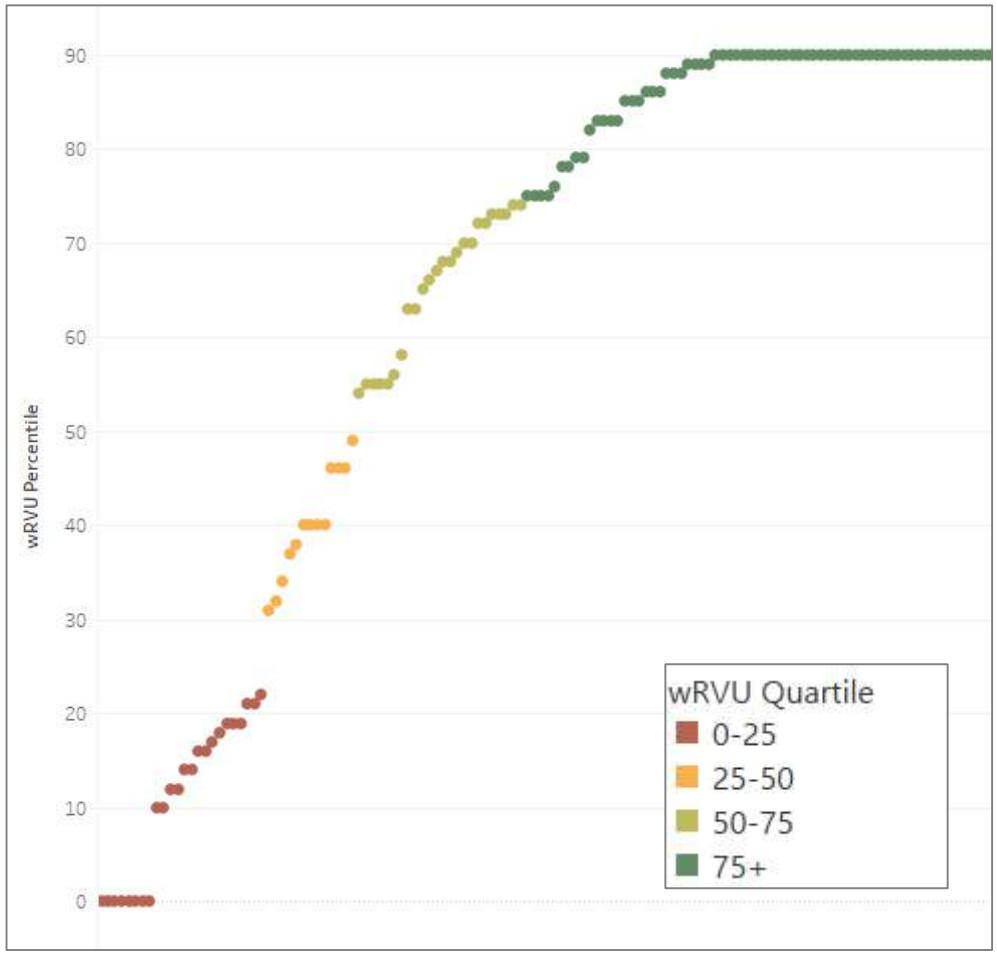


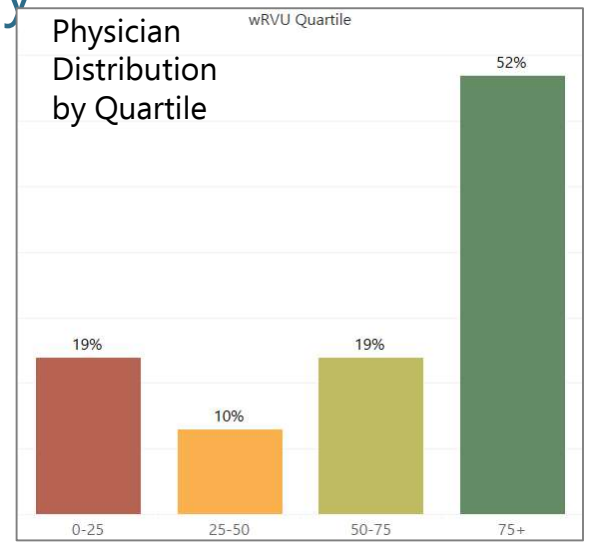
[Health System] Productivity Summary
Adult Primary Care Only

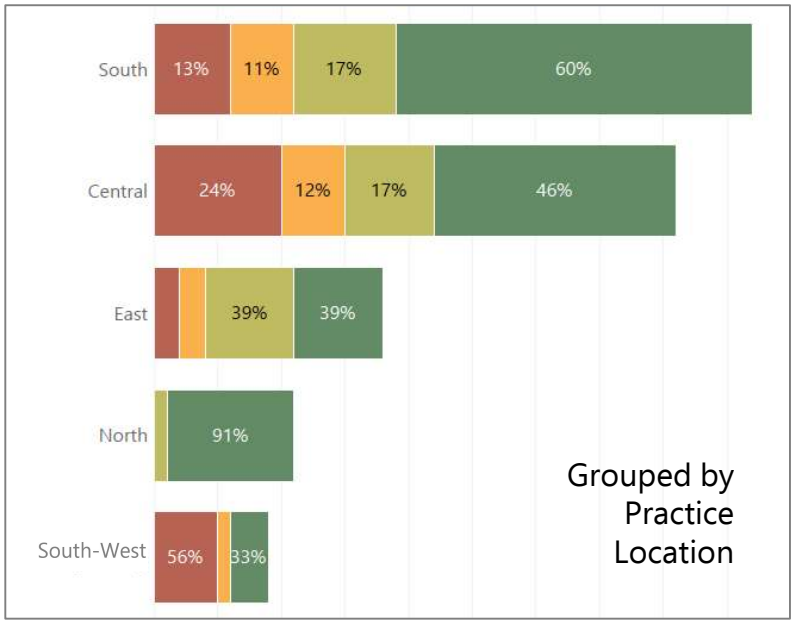
Productivity Percentile by Physician

Based on wRVUs and MGMA National Benchmarks

[Health System] Primary Care Only. Each dot represents one physician. Position along Y axis corresponds to wRVU Percentile. Color Coded by Quartile.





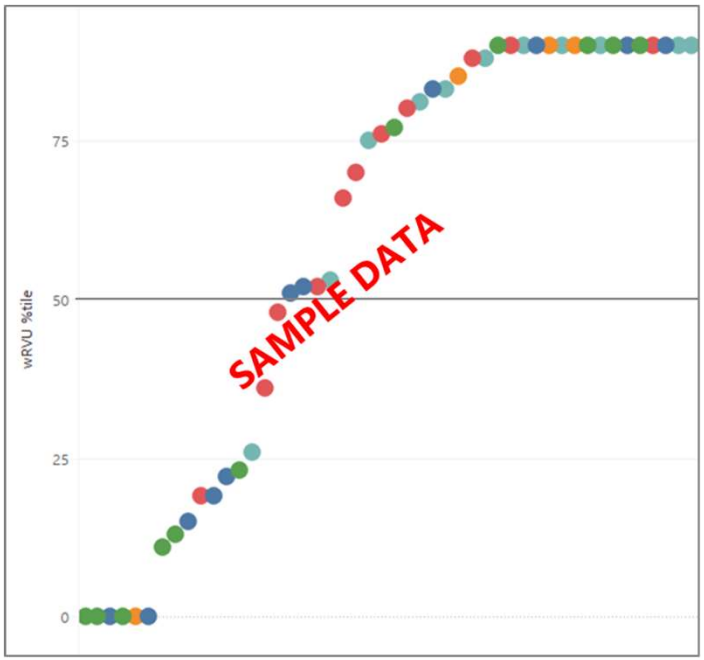


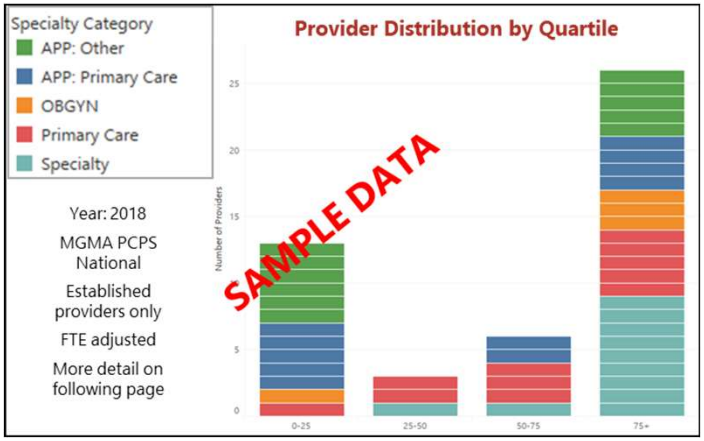
Defining Existing Capacity Within the Health System's Current Network of Practices and Providers

Employed Providers – wRVU Production Potential

Total incremental wRVUs if every employed provider produced at the following percentiles in your network:	40th	50th	60th	70th
Primary Care	86,521	93,574	102,080	116,539
Orthopedics	27,531	30,843	33,768	39,411
Cardiovascular	38,356	42,747	47,278	55,463
General Surgery	23,420	26,280	29,318	34,786
Total	**175,828**	**193,084**	**212,444**	**246,199**

wRVU Percentile by Provider





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Effective Strategic Medical Staff Development Planning encompasses the following elements:

1. Tailoring Market Definitions for Making Strategic Decisions
2. Understanding Utilization of the Care Continuum by Patients within the Market
3. Identifying Supply, Capacity, and Capability Gaps by Specialty.
4. Identifying Succession Planning Dynamics by Specialty
5. Defining Existing Capacity Within the Health System's Current Network of Practices and Providers
6. **Defining Ideal mix of Physicians and Advanced Practice Professionals**

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.

Physicians and Advanced Practice Professionals
Barriers to APP Utilization

Barrier	Potential Issues
Patient Acceptance	• **Quality of Training/Care -** APPs who deliver empathetic, compassionate, "quality" care are readily accepted and embraced – and quickly develop a loyal following • **Practice Cultural Adoption -** When physicians and office staff speak highly of APPs, patients are more likely to accept them
Care Delivery Model	• Physicians and support staff must fully support concept of APPs as key members of the practice's/system's patient care delivery team

Compensation Model	• **Revenue Minus Expense Model**
	  • Allocation of APP expense to physician that may or may not be ultimately offset by revenues in a revenue minus expense model, creating disincentive to adopt
	  • Allocation of APP revenues to physician that brush up against Stark compliance safe harbor (personal inurement for services not personally rendered)
	• **wRVU/Productivity-Based Model**
	  • Competition between physicians and APPs for wRVUs
	  • Lack of stipend or other compensation consideration for collaboration requirements

Physician Culture	• Lack a positive personal frame of reference - many physicians have never worked with an APP • Have a negative personal frame of reference - Often a mismatch between expectations and realities, whether general expectations or relative experience or relative autonomy • Perception of Education and Training

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

Specialty	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 a Medical Staff Development Plan Together

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.

What Should It Look Like When Its Done?

		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 FY2023, the MSDP recommends the recruitment of 115 physicians and 53 advanced practitioners.
- Assumptions for demand for support from independent specialties, "Other", were made based on total need.


HSG | Thank You


HSG | Questions

Conflict of Interest

I have no real or perceived conflicts of interest that relate to this presentation.

About HSG

Company **Overview**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy

Driving a common strategic focus with engaged physicians.

Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement

Improving the performance of employed physician networks.

Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation

Aligning physician compensation with health system and employed network goals.

OUR MISSION

HSG builds high-performing physician networks so health systems can address complex changes with confidence.