Washington Healthcare News®

wahcnews.com | Articles, Interviews and Statistics for the Healthcare Executive

Five Considerations for Right-Sizing Physician Supply

By Sandy Champion, CMSR
President
The Champion Group, LLC

It is no secret that the nation is facing a dire physician shortage. A recent article from the *Annals of Family Medicine* determined the country will need about 52,000 more primary care physicians by 2025, and some hospitals and health systems are already feeling the pinch – and doing something about it.

Additionally, the total number of office visits to primary care physicians is projected to grow from 462 million in 2008 to 565 million in 2025 — an increase driven by population growth and aging, according to the study.

The PPACA and other shifts in healthcare delivery have increased the number of physicians looking for employment. More physicians view employment as a "safe harbor" from reduced reimbursement and other uncertainties brought on by reform. These uncertainties have changed the way physicians look at their work and employment opportunities.

Hospitals are again pursuing employment of physicians as a core strategy: especially primary care, hospital based specialists, and hard to recruit specialists.

The greater challenge is ensuring the overall *right-sized supply*. How we get there is complicated based on many considerations but not limited to the following:

1. Community Need

Physician demand based on a community need model is often a beginning step to look at shortages by specialty in any hospital's geographic service area. While this methodology has been workable for many hospitals as a process to comply with federal rules for recruiting physicians, it generally represents an ideal physician supply assuming a 100% market share.

A best next step would be to "market share-adjust" that 100% Market Share Need on the facility's estimated current market share for each specialty in Primary Care, Medical Specialities, and Surgical Specialties.

By drilling down to a market share-adjusted need, a hospital can determine the right number of physicians (FTEs) needed going forward (usually a three to five year horizon) in order to:

1. Project physician need that would protect the current market share;
2. Project physician need based on a return to a "best year" market share;
3. Project physician need to GROW a specialty as part of a strategic growth plan by understanding the number of FTE

physicians needed to support that growth.

Such an exercise should be done annually to adjust for departures or new physicians coming to the service area. For recruitment documentation, it is best to have an “objective party” validate that need prior to recruiting.

Adjustments can be made to consider midlevel and hospitalist use, as well as qualitative factors affecting community need like new patient wait times for an appointment with a physician, limited Medicare or Medicaid access by practice or specialty, practice capacity to see more patients, physician productivity, and physician succession factors.

2. Workload

Demand based on workload is generally reserved for hospital-based specialties like anesthesia, pathology, emergency medicine, radiology, hospital medicine, etc. Each specialty understands the staffing methodology needed to staff their departments appropriately. However, when the department workload increases or decreases, then physician supply may also need to be adjusted.

3. Degree of Hospital/Physician Integration/Alignment

The words, “integration and alignment” have become part of our everyday healthcare conversation especially with increased consolidation. Integration of physicians and hospitals is achieved through various alignment models ranging in complexity from limited to moderate to full depending on what is perceived as the best fit for all parties. The current and future needs, strategic goals and market environment all play an important role. Hospitals and physicians have many reasons to collaborate, each bringing capabilities while interdependent.

Alignment models can include:

Limited

- Managed Care Networks, IPAs, PHOs
- Call coverage stipends
- Medical directorships
- Physician recruitment assistance

Moderate

- Managed Services Organization (MSO)
- Equity Model
- Shared savings through cost savings objectives
- Provider equity, Joint Ventures
- Clinical Co-Management, Service Line Management

Full

- Employment – traditional or Group Practice
- Professional Services Agreements

Regardless of affiliation, employed, independent physicians, multi-specialty and single specialty groups alike will likely need some form of alignment with hospitals in the future to stay viable.

4. Planning

The purpose of the planning effort is to best position the hospital or medical group for a strong future and for health care reform. This requires a laser focus on “the Triple Aim”– outcomes, the patient experience and cost. Service mix, access to physicians, physician supply, physician alignment, efficiency and market position are also key elements.

5. Sustainability

The healthcare industry saw a wave of physician employment by hospitals back in the 1990s, and hospitals are again pursuing employment of physicians as a core strategy. Employing physicians tends to work in a fee-for-service environment and should also work as hospitals move forward into an ACO managed-care type of environment. The downside to a physician employment strategy is that it is expensive for the hospital, and there are increasing anecdotal discussions about the losses per physician that systems suffer as they employ physicians in larger numbers.

Additionally, in some areas, the average productivity of the employed physicians seems to be declining. Initially, as hospitals began to employ physicians, there had been focus on hiring the most productive physicians. With a competitive fever for recruiting and attracting physicians now, it seems hospitals have an "all in" strategy. Thus, the average productivity per physician has regressed to a more average level. This means the losses on professional fees are more significant, and it is harder to "make up the numbers" on the technical side.

We are experiencing the most significant economic downturn since the Great Depression and organizations

are looking to squeeze every non-essential cost out of their business operations…including physician labor. While physicians are often an expensive venture, they represent a hospital's or medical group's essential and "most important asset."

Conclusion: Balancing community physician demand, competition, and growth, with cost for the long term is a critical challenge. Caught between a cost benefit balance recognizes the challenges ahead for ensuring the right-sized physician staff.

Sandy Champion, CMSR is the president of the Champion Group, LLC. Since founding the firm, she has worked with healthcare organizations across the country to provide a full spectrum of physician development and planning services, and has earned a reputation as an expert in community needs analysis, physician development planning, and strategic program development. Champion has been nationally recognized for her successful approach to the recruitment process and received the National Achievement Award by The American Academy of Medical Management. Sandy also works with the National Centers for Workforce Planning in Washington D.C. and other healthcare planning leaders to better integrate provider supply.

The Champion Group is a healthcare consulting firm specializing in community needs analysis, medical staff planning and development. The Champion Group works with hospitals, health systems, medical groups, government entities, and managed care organizations to produce strategic plans that identify provider needs. Additionally, they offer the "Demand Tool" for inhouse physician planning to manage documentation for physician recruiting.

She can be reached at 206-567-7737 or championgroup42@msn.com.

Reprinted with permission from the Washingon Healthcare News. To learn more about the Washington Healthcare News visit wahcnews.com.