

## Strategic Medical Staff Development Planning Building Your Medical Staff from the Ground Up



Live teleseminar with  
Marc Halley, President and CEO of Halley Consulting Group  
and author of  
*Owning Medical Practices: Best Practices for Sustainable Results*  
and  
Ashleigh Finley, Director of Business Analytics  
and Resident Strategic Medical Staff Development Planning Expert

### KEY POINTS

- 1) Crucial differences between *strategic* medical staff development planning and traditional medical staff development planning.
- 2) Critical questions that every medical staff development plan should answer.
- 3) Basic tenets of effective medical staff development planning and how to use this process to build your owned medical practice network.

*Strategic medical staff development planning ensures the proper mix of physician specialties and locations at the right time to meet the needs, wants, and priorities of referring physicians and the local community.*



**Ralph Harding:**

Good afternoon, everyone. This is Ralph Harding, your host for our fifth semiannual Halley Consulting Group Teleseminar. Our guests today are Marc Halley, who is one of the leading authorities in the nation on strategy and performance improvement for physician networks, and Ashleigh Finley, who is the Director of Business Analytics and resident strategic medical staff development planning expert at Halley Consulting Group.

Today we will be visiting with Marc and Ashleigh about strategic medical staff development planning. As a result of attending this seminar, you will learn:

- the crucial differences between strategic medical staff development planning and traditional medical staff development planning.
- the critical questions that every medical staff development plan should answer.
- the basic tenets of effective medical staff development planning and how to use this process to build your owned medical practice network so you are making significant strides toward market leadership in the next 12 months.

The content of our discussion today is driven by the dozens of thoughtful questions that you, as healthcare professionals, posed to Marc and Ashleigh during our Ask Campaign. We have selected a number of those questions to answer during this 60-minute broadcast.

Please note that we have carefully reviewed all of the questions submitted during our Ask Campaign, and any that we are not able to answer during today's broadcast will be answered by Marc or Ashleigh, either by phone or email.



Before we dive into the content of the seminar, I'd like to turn your attention to the blue handout link in the upper left-hand corner of your screen just below the "Ask Marc Halley" heading. Please print the handout and be prepared to take copious notes on the clear counsel that we will be receiving from Marc and Ashleigh today on this most important topic.

Before we begin the interview, let me provide you with a view of Marc's rich background in healthcare, and then I will ask Marc to introduce Ashleigh Finley.

Marc D. Halley is President and Chief Executive Officer of Halley Consulting. Marc has provided management and consulting services to medical practices for more than 25 years, and has worked with a variety of specialties, including hospital-owned practice networks across the United States.

He has negotiated numerous contracts to acquire medical practices on behalf of hospitals in highly competitive environments, served as senior operating officer of primary care and multi-specialty networks, facilitated the financial turnarounds of hospital-owned medical practice networks, and worked with physicians to take primary care networks into risk-sharing arrangements, including payer contract negotiations for a 100-physician primary care panel.

He also developed and implemented numerous models and tools to assist physicians and managers to track and improve medical practice operations. His supervisory training program has been taught to medical office managers around the country.

Marc is a frequently-requested speaker, addressing governing boards, senior executives, physician groups and management teams, as well as national organizations.



Marc's first book, *The Primary Care - Market Share Connection: How Hospitals Achieve Competitive Advantage*, was released by Health Administration Press in March 2007.

In December 2007, Marc contributed to a three-volume set titled *The Business of Healthcare*. Marc was also a contributor and co-editor of *The Medical Practice Start-Up Guide*, released by Greenbranch Publishing in August 2008.

His newest book, *Owning Medical Practices: Best Practices for Sustainable Results*, was released by The American Hospital Association's AHA Press in January 2011.

Marc received his Bachelor of Science degree from Weber State University in Business Administration Management and his Master of Business Administration degree from Utah State University.

Marc, we are delighted to have you and Ashleigh on the call. Will you please help our listeners to know more about Ashleigh's education and experience?

**Marc Halley:**

Thank you, Ralph. Yes, I'd be happy to share a bit about Ashleigh. As you mentioned, Ashleigh Finley is the Director of Business Analytics for Halley Consulting Group. Ashleigh's work is focused on developing and implementing strategic growth initiatives at hospitals and health systems across the country. Her expertise includes what we call strategic medical staff development planning, primary and secondary market analysis, the development of primary care retail strategies, specialty and service line strategy planning, garnering competitive intelligence, medical practice site selection, physician recruitment, and practice start-ups.



Ashleigh conducts market analyses focused on referral patterns and adapting specialty mix and service lines to meet market demand in light of hospital and health system strategic objectives. She has facilitated the development of detailed plans for medical practice acquisition and start-ups with hospitals and health systems all over the country.

Ashleigh has also been actively involved in medical practice network mergers and in practice acquisition. She has significant experience in healthcare financial analysis, in budgeting, and in cash flow management.

She has developed both cost management and revenue enhancement strategies for medical practices and for medical practice networks. She has also developed long- and short-term financial plans and built statistical tools and models designed to measure and improve provider productivity.

She majored in finance and earned a Bachelor of Science in Business Administration from the Fisher College of Business at Ohio State University and a Master of Business Administration degree at the Schulich School of Business at York University in Toronto, Canada, with her focus of study being marketing and strategy.

**Ralph:** Thank you, Marc, for that excellent introduction. Ashleigh, we'd like to welcome you to the call, and thank you for joining us today.

**Ashleigh Finley:** Thanks, Ralph. It's my pleasure to be here.



**Ralph:**

Marc and Ashleigh, you will be interested to know that we have healthcare professionals representing numerous health systems and hospitals from literally every region of the United States in attendance for our seminar today, so we're delighted to welcome our listeners with us.

Let's begin by talking for just a few minutes about your perspective as it relates to assisting hospitals through the process of strategic medical staff development planning by presenting the first question from one of our listening hospital executives. He makes this statement and then asks two related questions:

**“We do conduct medical staff development planning. What exactly is strategic medical staff development planning and how is it different?”**

Ashleigh, would you like to address this question?

**Ashleigh:**

Yes, absolutely.

Many of the medical staff plans that we see out there focus exclusively on two numbers: demand and supply. Fundamentally, this type of plan looks at specialist utilization, commonly referred to as demand, and offsets it with the number of physicians practicing each specialty in the market. The resulting figures, therefore, represent your plan.

*Strategic* medical staff development plans are different in both composition and process. You certainly can't ignore supply and demand - those are key components - but relying on that information exclusively leaves out a lot of important data. So strategic medical staff development plans include more qualitative data, which we obtain in part from physician surveys, both web based and in person, and administrator feedback.



To give you an example on what it is that gets us beyond the numbers, we'll oftentimes see that a need for a certain specialty exists, not because of shortage per se, but because referring physicians aren't satisfied with their options, or more specifically, with the way they and their patients are treated by the specialist.

I'd say we actually run into this with at least one specialty with every medical staff development plan that we do, where the needs of the specialty is not so much proven by quantitative need, but by the feedback we're getting from the physicians. And maybe that justifies a new recruitment, or maybe it just says we need to spend some time training this physician on some demand chain principles - demand chain, of course, representing the relationships between service lines, hospital-based physicians, specialty physicians, and primary care physicians.

Merging this qualitative feedback with a robust quantitative analysis allows us to not just offer up numbers of physicians to add to your ranks, but more specific recommendations and implementation tactics around the who, what, where, and when.

In terms of the process of the strategic medical staff development planning, the key point I would drive home is that strategic medical staff planning cannot be done in a silo. We as consultants cannot go into a market, collect data, and then disappear for a few weeks to come back with a completed plan. It just doesn't work that way.

To foster a collaborative process, we form a work group at the start of the project, which is typically composed of specific management team members and other key players, including hospital and practice leadership. This ensures that the hospital's specific strategic initiatives, as well as the local market realities (which obviously vary from market to market) are given adequate consideration in the analysis.



This group meets frequently throughout the project so that at the end, it's not the consultant's plan, but rather "our" plan.

**Ralph:**

Very excellent. Thank you, Ashleigh. That's exactly the type of information our listeners need to receive from this interview, especially like the examples you just presented, so thank you very much.

Listeners, let's turn to page two of the handout and review the answers there. The blanks in the box should be filled in with "specific recommendations" and "implementation tactics." So that box will read, "The strategic medical staff development planning process provides more than just numbers of physicians to add to your ranks. It provides specific recommendations and implementation tactics."

Marc, this next question is one that you will enjoy answering:

**"Can you guide us in our thinking as we define primary service area, both now and in the future?"**

**Marc:**

This is a good question, Ralph. As we all know, the regulatory definition of a hospital's primary service area includes those contiguous zip codes that provide at least 75 percent of hospital admissions. Now, this measure is usually a good starting point for analysis, but it should not determine a hospital's strategy.

Strategy should be based on a variety of factors: on market share target, on payer mix objectives, the competitive alternatives and competitive strategies being employed,



current and future service offerings, migration patterns for retail services and more.

Too often, we see clients restrict their thinking to where they are today, as defined by their current admissions, rather than where they need to be strategically or from a payer mix standpoint, and where they can be based on a solid primary care retail strategy.

**Ralph:**

Wonderful information, Marc. Thank you.

Listeners, please note that the information Marc provided for you is summarized at the top of page three on your handout.

Ashleigh, this next question is perfect for you:

**“What are the outputs or actionable deliverables we should be seeking for as a result of our medical staff development planning process?”**

**Ashleigh:**

Perhaps the best way to answer this question would be to discuss the deliverables that we provide when we’re conducting the strategic medical staff development plan.

To begin, or lay the foundation of the plan, we’ll typically have two to three on site strategic planning meetings. That’s obviously a bit more of a process than a deliverable, but certainly a key part of laying that foundation.

At the end, the strategic medical staff development plan includes a summary of physician survey results; a demographic market analysis; a market share analysis; a market goals analysis; typically it will include referral



and demand chain analysis, provided that there is referral data available for us to analyze, keeping in mind that not all hospitals are there yet with the tracking; a physician manpower analysis (that's the demand minus supply that we talked about earlier); and a physician life stage analysis, which is where we look at the distribution of ages of physicians by specialty to determine how imminent the need is based on predicted retirement.

Then we populate our priority determinant matrices, and from that we get prioritized recommendations, and I think that's really a key part of what we do. We actually rank the recommendations and basically say to you, "If we were you and we were spending your capital, here's the order in which we would execute these priorities." So our client, or you the listeners, would go just as far down the list as your capital will allow.

We also detail implementation tactics and associated budget, another key part that's oftentimes missing from those traditional medical staff plans. At the end of our process, you will be able to know - through your conversations with physicians via the web survey and the in-person surveys - those physicians who are looking to expand their practices and those physicians who are looking to retire.

So when we see that there is a demand for another general surgeon, we can also say, "This practice would like to add a provider. Let's see if we can make something work there," and both parties win. I think most people would agree that this is a lot more useful and a lot more actionable than just saying, "Okay, add 1.3 general surgeons."

Finally, we recommend developing a communication matrix, which is very helpful as you move into the implementation stage in keeping stakeholders apprised of what's going on and why you're doing it and all of that. So we have a tool to facilitate that as well.



**Ralph:**

Thank you, Ashleigh. Very impressive.

Listeners, the deliverables that Ashleigh just described for us are listed on page three of the handout.

Marc, our next listener asks a very perceptive question:

**“What is the formula or process we should use to determine how many employed or independent affiliated primary care physicians we will need to achieve our current and future market share objectives, assuming each primary care physician will have about 3,000 patients?”**

**Marc:**

Thank you for this question. This is certainly a foundation of every solid strategic medical staff development plan.

A few years ago, one of our clients had built a new hospital in a competitive territory. They started thinking about medical staff composition just a bit late, and approached us in a rush to determine how many of the various specialties they would need to capture one-third of the admissions in their new market.

We suggested that they should instead be thinking about how many lives they would need to capture in what we call “neighborhoods” to attract one-third of the admission. We define a neighborhood as that geographic area where at least 50 percent of a primary care practice’s patients live, usually within three to seven miles or about a ten-minute drive around a primary care practice in an urban or suburban area; much wider, obviously, in a rural setting.

As it turns out, that new hospital’s target market area included about 600,000 people. So with this perspective, management’s attention turned to the number of affiliated or employed primary care physicians located in the right



neighborhoods that would be needed to capture the 200,000 lives. With 200,000 lives as the focus, then it became much easier to determine, and in fact, to attract the right physician specialties to support those primary care physicians and their patients.

**Ralph:** Thank you, Marc.

Turning to page four on the handout, listeners, the answer for the box at the top of the page is “50 percent.” “A neighborhood is defined as the geographic area where at least 50 percent of a primary care practice’s patients live.”

Ashleigh, our next listener posed a two-pronged question that you are well qualified to answer:

**“How often should we do medical staff development planning, and are there particular situations that should trigger this process?”**

**Ashleigh:** Sure, another great question.

We recommend that a medical staff development plan be redone every three years; however, we also recommend that you, the hospital, survey your physicians annually on some of those same questions that come up during these medical staff planning processes. Then you can ask those important questions and get updated answers on those.

To the second part of the question, the answer is yes. There are events that often do trigger this process. To be honest, and this is not a good thing, but our experience is that many health systems actually have



the cart before the horse. They may have a pending recruitment that they need to justify with the findings of a medical staff development plan and as our listeners know, because of Stark Guidelines, certain types of recruitment situations require documented need in the community. So the hospital wants us to help them feel comfortable saying, “Okay, for the next two, three, four years, we’re going to guarantee this provider \$200,000-\$300,000 a year.”

That actually happens a lot where hospitals will call us and they will want a quick, or rapid analysis: “Can you tell us that we’re okay to bring on this cardiovascular surgeon?” That’s really not the approach we believe is in the hospital’s best interest. Certainly we’re capable of doing that, those quick analyses, but those clients, unless we can convince them to look at the broader picture, aren’t generally good candidates for our strategic medical staff development plans. But I think oftentimes that actually is what leads most hospitals to pursue a new plan.

**Ralph:**

Thank you, Ashleigh.

Listeners, Ashleigh has provided the information you need for the box at the bottom of page four on the handout: “We recommend that a strategic medical staff development plan be redone every three years and that hospitals survey their physicians annually.”

Marc, here is another excellent question from one of our listeners who asks:

**“How do we make certain that our affiliated or employed primary care physicians are in the right locations to capture the patient populations that will allow us to achieve our mission objectives, our competitive strategies, and our target payer mix?”**



**Marc:**

Yes, Ralph, this is a good question, and it's a great question especially for hospitals that are not ideally located, where the campus may be on the wrong side of town, or whatever the case may be.

We have seen even central city hospitals enhance their payer mix by placing affiliated primary care practices in selected neighborhoods based on measures like average household income or home values.

We have seen others more effectively locate and staff practices to serve the uninsured or underinsured. Those practices we call "mission-based." For example, a mission practice might be located along a public transportation line to improve its access. In addition to a physician on location it may be staffed by nurse practitioners, who tend to do a better job of educating. The practice may include a social worker or other specific services to better meet the needs of the neighborhood.

Alternatively, being first in a brand new neighborhood potentially gives primary care physicians and their affiliated specialists and hospitals a competitive advantage since Mrs. Smith, who makes the majority of healthcare decisions for the family, is loath to change doctors once relationships are established.

**Ralph:**

Thank you, Marc, for that very detailed answer.

Listeners, on page five of the handout, we have listed for you some of Marc's suggestions that can help you reach that proper balance in your payer mix.



Ashleigh, here's another very interesting question from one of our listeners that I think is particularly suited to your experience. She asks:

**“What advancements or new innovations do you bring to this process that we may not be aware of or that some other consulting company we’re considering working with does not know about?”**

**Ashleigh:**

Sure. Another great question.

The first would be our priority determinant matrices. We've got two of them, actually, which help us bring a very structured approach to the development and prioritization of our medical staff initiatives.

There's one for primary care practices which focuses and prioritizes the target, if you will, based on geography, and then there's one for specialists and surgeons which prioritizes based on the specialty that is most needed in both the health systems and for the patients it serves.

Each of these models has about 25 factors that we look at, and then we can vary the weightings for each market that we're in based on the feedback we hear from our work group members. So what it ultimately produces is a report ranking the most critical specialist recruitments or realignments needed for your particular health system.

To give you some examples of the types of factors that we're looking at in this model, we would look at the change in the service line market share, we would look at indexing the competition, we would look at the risk posed by an aging group of specialists on the medical staff; so all of those and more feed into this model and then allow us to generate this very structured, consistent - which is key - approach to evaluating each specialty.



The other innovation where I think we've made some really great advances in recent years is our physician complement ratio work. As I mentioned earlier, the typical medical staff plan looks at the number of people living in a market and then what the projected utilization is of that specialty based on the market's demographic composition.

While that's certainly appropriate and needed in the analysis, it does ignore a key component, which is how many referrals, or how much volume are health-system-employed physicians or health-system-loyal physicians sending to the various specialties? You can recruit ten cardiovascular surgeons, but if you don't have the affiliated physicians to refer to them, your efforts are really futile.

To expand on that, in more markets than not, employed physicians are the increasing majority, and health systems are getting bolder and bolder and bolder in directing their physicians to refer domestic. So if you don't have the base to support your specialist recruits, then the whole service line strategy will likely fall apart.

To this end, we've been tracking outgoing referrals from primary care physicians to specialists. As a result, we now know, for example, that ten percent of the referrals that your average primary care physician is sending out are going to cardiologists, and 15 percent of those referrals are going to orthopedists.

Therefore, not only do we address the general community need, but we can also pinpoint the specific client health system need based on their referral base that's currently in place and that might be projected to be in place.

You may not always walk into your average market and find that the health system or hospital knows how many cardiology referrals they're getting from Dr. Smith, family practitioner, so what we've tried to do over the years is convince clients to start tracking this type of information. It's always a recommendation that we will make, and to



us it's a very, very key part of knowing your market and your demand chain and executing effective physician integration strategy in general. It's always something we ask clients to do.

**Ralph:**

Excellent information, Ashleigh. Thank you.

Listeners, let's look at the box on page six of the handout and review the answers there. The first bullet should read, "Change in service line market share," the second bullet should read, "Indexing the competition," and the last bullet should read, "Risk posed by aging medical staff."

Then turning over to page seven, the answer to the box at the top of the page is "referral base." "Having a solid referral base to support your specialist recruits is essential to keep the service line strategy intact."

Marc, this next question is definitely complex.

**"What are the critical success factors we should deploy when considering the timing of engaging independent primary care physicians, adding primary care physician capacity, replacing retiring physicians, acquiring existing practices, adding employed physicians to independent practices or to implementing other strategies to capture our targeted neighborhoods?"**

**Marc:**

Ralph, let's not give away all our secrets here! Seriously, this is a great tactical question.

The answer starts again with an understanding of a particular targeted neighborhood, asking questions like: Who lives there? What are their needs? What are their wants? What are their priorities?



Consider, for example, an upscale neighborhood with many two-income households. Let's say there's a strep outbreak at the local elementary school, and Junior shows up at the school nurse's office one morning with a sore throat. The nurse is not even going to bother calling Dad, at least if she wants something done. She will call Mom!

Increasingly today, Mom is likely to be in an office downtown. Mom gets the call at 11:30. Now, she's the only presenter at a 12:15 meeting that will go until 1:00. She can move a couple of early afternoon commitments and perhaps get away at about 1:15 to go pick Junior up. It's a 30-minute commute to the school; it's 10 minutes from there to the doctor's office. Bear in mind, she is also the soccer mom and responsible to pick up four other children between 4:30 and 4:45 for a 5:00 p.m. practice.

We lay out this scenario for moms in our audiences all the time and they just chuckle because those are the lives they live, trying to balance both work and family.

So, now what does this mom need? Well, she needs an appointment; she needs a strep test for Junior and a note from the doctor saying whether or not he can return to school the next day. She wants to see her own doctor whom she trusts and who is familiar with Junior. She also wants a prescription to knock out Junior's illness. She hates being told that the virus will just have to run its course.

What are her priorities? Well, that's pretty simple. The appointment has to be between 2:00 p.m. and 4:00 p.m. If you're not available as a medical practice, she may have to settle for the nurse practitioner at a local drugstore. Knowing the needs, wants, and priorities of our targeted neighborhoods is the starting point. Then we can begin to identify who is meeting those needs, wants, and priorities and how well.



As we come to understand those medical providers that are already in the market, we can look at their affiliations, at the services they offer, at their hours of operation, and look for ways to either engage them, to add to their capacity, to perhaps acquire their practices, or if necessary, to compete with them.

The timing of these tactics flows from the particular tactics selected, the riskiest of which, of course, is adding provider capacity to a market that is already saturated with physicians who are wearing our competitors' jerseys.

**Ralph:**

Most excellent information, Marc. Thank you.

Listeners, please look at the bottom of page seven on your handout and fill in the blanks there with “needs, wants, and priorities.” “Understanding the needs, wants, and priorities of our targeted neighborhoods is the starting point.”

On the top of page eight, we have listed the important questions that Marc has just taught us we should ask in order to understand which providers are the best candidates for us to affiliate with.

Ashleigh, here is a great question for you to address. Our listener asks:

**“What do you find that hospitals take for granted in the development of their medical staff plans?”**

**Ashleigh:**

A couple of things, really. The first would be that they know everything there is to know about their medical staff. We hear often something like, “Oh, we don't need



to survey our medical staff. Let's cut that part out of this process. We talk to them; we know what's going on." But I can tell you unequivocally that we have never stood up in front of a client, reviewed the survey results, and had the client not learn something from the survey about their market or their physicians. So that would certainly be one thing that's taken for granted.

The other, and this is really a more detail or tactical issue, is the accuracy of the physician supply or the physician inventory that's provided for these analyses. We get lists of physicians practicing in the market in the various specialties, which obviously turns into the supply component of the need calculation. Sometimes the client will send us their medical staff list and assume that that pretty much covers everyone who is practicing in their market area. Or they buy a list from someone like the AMA or a similar source and just assume it's correct.

With respect to these purchased lists, we find at least a 20 percent error rate, sometimes as high as 30 or 40. Twenty percent of the physicians on the list aren't even in the market anymore and then another 10 to 15 percent of the physicians aren't practicing where the AMA or whomever has them listed. Or sometimes we've seen this, where they've got the home address listed on there, which may or may not be the same area where the physician works.

We know this because in many markets we provide a physician list validation service where physicians are called to verify their location and days of operation and so on, and so we're able to track and calculate these error rates.

Physician supply can certainly be very difficult to wrap your arms around, especially for those of you in large markets with lots of physicians. But the quality of this information on the list will obviously impact the quality of the report. Nevertheless, some hospitals still take the quality of that list for granted and just sort of view it as



another box to check off on the data request and don't really give it a whole lot of thought, when it's really so key to the outcome and the quality of the work.

**Ralph:**

Excellent. Thank you, Ashleigh. Listeners, these very important points that Ashleigh just discussed with us are at the bottom of page eight on the handout.

Marc, here is another very thoughtful question that I would like to direct to you:

**“What is the best way for us to determine the mix and number of specialty physicians we need to support the patient populations we have or will capture in our affiliated primary care practices?”**

**Marc:**

Well, we can all look, of course (and we often do), at the community need estimates to justify our efforts to recruit specific specialties as Ashleigh mentioned earlier.

Competitive strategies will most certainly affect our thinking as well as those community need numbers, but we have found that the most important indicator of medical staff strategy is primary care patient referrals.

Understanding primary care referrals is critical to the development of sound specialty mix strategy. What specialties do the PCPs require to meet the clinical needs of their patients? That's a very critical question, so we always engage primary care physicians and other providers in planning for the specialties that we might recruit.

Sometimes the resulting answer identifies a need for a missing specialty or a missing service line. Other times that



specialty is present, but not accessible because there is more demand for the service than supply. Sometimes the specialist is not what we call “the specialist of choice” due to service quality issues, or on occasion, the specialist may have clinical quality issues.

Market managers (which is our code word for effective hospital CEOs), should monitor the referral experience of their employed and independent primary care physicians on an ongoing basis. Now, that sentence is so important I’m going to repeat it. Market managers, again, our code word for hospital CEOs that are thinking as they should be, those market managers should monitor the referral experience of their employed and independent primary care physicians on an ongoing basis.

This, of course, is more difficult now that primary care physicians have been replaced, as it were, by hospitalists in the acute care setting; they may never darken the hospital door. So today, CEO market managers have to reach out to these primary care physicians in ambulatory settings to visit with them as critical holders of the market share for the hospital and the specialists.

**Ralph:** Thank you, Marc, for that very valuable information.

On page nine of the handout, listeners, the answer for the box at the top of the page is “primary care referrals.” “Understanding primary care referrals is critical to the development of sound specialty mix strategy.”

Also on page nine are issues we should discuss with primary care physicians during the strategic medical staff development process.



Ashleigh, this next question is one that you will be particularly adept at answering. The listener asks:

**“When you are doing medical staff development plans, which demographic indicators do you pay the most attention to? Which do you think are most important?”**

**Ashleigh:**

Well, as you might guess, we’re very focused on growth rates in various parts of the market, and then where appropriate, establishing a presence where the health system can benefit from that anticipated growth.

We also take a look at key population segments; for example, the pediatric population (those under 18); the 55-plus population, because of their higher utilization of key medical services; and women of child-bearing age, who are defined as women between the ages of 15 and 44.

Then we’ll also look at indicators like education levels, because - and perhaps this isn’t surprising - but lower education levels are positively correlated with higher hospital readmission rates.

Identifying those population segments provides a lot of insight into what the specific market’s needs are.

**Ralph:**

Great information for our listeners, Ashleigh. Thank you. Listeners, you will see that those key population segments are listed for you on the upper half of page ten.



Marc, listen to this very perceptive question:

**“What indicators should we be most sensitive to in determining when we need big boxes to provide expanded imaging, laboratory, surgery, and other specialty services in certain geographies?”**

**Marc:**

That’s a great question, and we run into the big box question, “Where does it fit in strategy?” in many markets.

The big box strategy really is a good one when it supports several neighborhood primary care practices. Ideally, the big box includes more advanced ancillary services closer to the neighborhoods, more accessible specialty physician services, again, closer to the neighborhoods, perhaps some additional and expanded procedures, and often an urgent care setting to support the existing primary care practices after hours.

Ideally, a big box and a big box strategy should reflect, again, the needs of local primary care physicians and their patients.

**Ralph:**

Very helpful information, Marc. Thank you.

Listeners, the box at the bottom of page ten should read: “A big box should reflect the needs of local primary care physicians and their patients.”



Ashleigh, here is a very interesting question from one of our listeners:

**“What are some of the current challenges that you believe our health systems should be especially sensitive to during the physician recruitment process?”**

**Ashleigh:**

One that comes to mind, a recent example, and I think I may have mentioned earlier, are income guarantees. With a lot of hospitals, that’s their method of choice for bringing new physicians to the market, instead of employment, obviously the other option. We’re finding that income guarantees are becoming less and less effective.

The physicians coming out now want to be employed; they don’t just want to be guaranteed income for two years and then feel like they’re on their own. They’re not interested in what is traditionally considered running a business. So those types of offers, the income guarantee offers, are not as competitive as they once were, and hospitals that are relying solely on such guarantees as a reliable recruitment strategy are going to have a lot of trouble competing against the other health systems.

**Ralph:**

Ashleigh, is that because the market just seems to be changing so much? What’s causing that difference?

**Ashleigh:**

Yes, in our estimation it’s really driven by the preference of those physicians coming out. They like the security of employment. To them, that’s a way that they don’t have



to worry about the business. They can still make a good paycheck; they can have more work-life balance, which we hear a lot about these days. It's kind of a win-win.

Now, having said that let me back up. Really, probably one of the main drivers behind where physicians are going to choose to practice has to do with where they can have the lifestyle they want. Areas that are in or around metropolitan areas, or in and around mountains, or the beach, or somewhere where people want to live are certainly going to have more recruitment options available to them. Income guarantees could very well work there because physicians will make certain compromises to get that lifestyle that they want.

On the other hand, an income guarantee that is associated with a location that has less lifestyle appeal may not work, just because if the physician is going to up and move somewhere that is by most standards less desirable, they're going to want something a little bit more stable, if that makes sense.

**Ralph:**

Yes, that makes perfect sense.

Listeners, we're now on page 11 of the handout, and Ashleigh has given us the answer for the box at the top: "A recent challenge involves income guarantees, which are not as competitive as they once were."

Marc, here is a very difficult, multi-faceted question:

**"What are the factors we should be considering as we make decisions regarding the priorities for our capital and for our management team? What are the most important questions we should be asking ourselves to determine whether to buy specialty practices and employ the specialists or whether to give primary care physician investment the priority?"**



**Marc:**

Well, Ralph, this again is a fine question. As a general rule, the priority we recommend to our clients is to focus first on capturing market share, and then on attracting that market share to our affiliated specialty physicians and to our hospital ancillary outpatient and inpatient services.

The former days of “if we build it, they will come” are long gone, and everybody knows that, in most markets. The effective market manager CEO tends to eat, drink, and sleep market share. He or she is contemplating questions like “How do we capture that market share and in which neighborhoods? How do we then attract referrals from primary care physicians to what we call ‘specialist of choice’ and to the ‘hospital of choice’? How do we provide our high quality care and caring both efficiently and effectively?”

CEOs must ensure that the relationships all along that demand chain that Ashleigh has referred to a couple of times, from the primary care physician through the specialist to the hospital to the hospital-based specialties and all the services that support that demand chain, that those relationships between both employed and independent primary care physicians and their affiliated specialists remain absolutely strong and sound. Hospital service lines and hospital-based physicians must be the services of choice.

**Ralph:**

Thank you, Marc. Wonderfully helpful information.

Listeners, on page 12 of the handout, you will see a very important summation of Marc’s answer to the previous two-pronged question.



Ashleigh, I think we have time for one or two more questions from our listeners in order to stay within the 60 minutes we promised. The first question I want to present to you is this one:

**“I would like to present my medical staff development plan to my board in a format that is easy to understand. With the volume of statistics involved and projections for anticipated community need, physician shortage, I’m struggling to find a format that would be meaningful. I have ten minutes allocated on the agenda.”**

**Ashleigh:**

Ten minutes, that’s tough. But what a great, practical question, and certainly a situation to which I can relate! There are definitely a wide variety of audience types out there, some who want every speck of detail that went into the MSDP, and others who are just looking for the bottom line, and it sounds like your audience is definitely the latter.

When we have audiences like that, here has been my approach. Prior to the presentation, we’ve gone through several processes and analyses and put together these one-page dashboards for each specialty, and these dashboards are organized very efficiently and contain sections with quantitative figures, the demand and the supply. It also includes a list of physicians who are counted in that specialty supply count; there’s also a section with the feedback from the medical staff survey, and then finally, a section with the life stage piece, or the ages of the physician in that specialty. So basically this page has included all the information we’re looking at when we make the recommendations.

But getting to your question, in preparing the slides for the presentation, I would put together maybe four slides: methodology/approach, key findings, recommendations, and tactics, and keep them all very high level.



Invariably, at least in my experience, someone in the room will fixate on one or two of the recommendations and want a bit more detail. The trouble, of course, is that going into the meeting, you may not know which specialty recommendations that the group is going to focus in on and question, so we have the dashboards available in the background, PowerPoint slides up front, and then when these questions come up (and they always do), we can switch gears, pull up the dashboards, and provide the detail or the answers that the audience is looking for.

So basically to answer your question, I plan for half of the presentation and then allow the audience's questions to guide the other half of the presentation, and that's really what has worked best for us.

**Ralph:**

That's a great response, and I'm sure will be very helpful to our listener.

The next question is:

**“What is the most effective way to plan for the retirement of senior physicians in small independent practices when younger physicians want to join larger entities?”**

**Ashleigh:**

We know that the physicians coming out of med school now want very different things than those who joined the work force 30 years ago. We touched on that earlier with the work-life balance discussion.

Many older, independent docs are looking to stay independent, but they're certainly starting to think about what they'll do with their practices when they retire.



Some have even approached the hospitals; they ponder succession planning, and so we encourage our clients to identify and engage all of the physicians in this life stage.

There's an opportunity to match a younger, newly recruited physician to these practices and preferably before the older physician has started winding down or shrinking his or her patient base. The hospital can hire the new physician, and consequently provide that larger entity support that the physician is looking for, and place the physician in a side-by-side arrangement with the older physician until the point at which the physician is ready to sell the practice.

A side-by-side, for anyone who is not familiar with the term, is basically an arrangement where the physicians in the practice have different employment statuses, but share overhead with staff and all of that.

Alternatively, we do see cases where the retiring physician is willing to sell his or her practice prior to retiring and then just spend the last year or so of his or her career in an employment situation with the hospital.

**Ralph:**

Very good. Excellent suggestions. Thank you, Ashleigh.

Well, Marc and Ashleigh, this has been a most informative and valuable hour. Thank you both for teaching us the crucial differences between strategic medical staff development planning and traditional medical staff development planning, and the critical questions that every medical staff development plan should answer, as well as the basic tenets of effective medical staff development planning.



Listeners, please note that if you would like to purchase a copy of Marc's most recent book, *Owning Medical Practices: Best Practices for Sustainable Results*, you can click on the multi-colored *Owning Medical Practices* link at the bottom of your screen.

Marc, what is the best way for our listeners to contact the Halley Consulting Group to arrange for an organizationally specific analysis of their health system, hospital, or group practice?

**Marc:** Ralph, there are two ways. First of all, we have a website that explains a lot about our company, our approach, our services, and our team: [www.halleyconsulting.com](http://www.halleyconsulting.com), and then we also have a toll free number, which is 1-866-706-5373.

**Ralph:** Thank you again, Marc and Ashleigh, for joining us today and providing the really tremendous insights which I know will be so valuable to our listening healthcare professionals.

What parting thoughts would you both like to convey prior to the conclusion of this event? Ashleigh, why don't we start with you?

**Ashleigh:** Sure. What I'd like to emphasize is that while consultants can obviously play an important role in developing medical staff plans, hospital and practice administrators like yourselves need to play a critical role in the plan's development. You live, work, and breathe in your markets



and will always understand your local market dynamics better than any consulting firm, any expert you bring in, and so your involvement plays heavily in both the quality and usability of the final report.

**Ralph:** Very excellent. Marc, what thoughts do you have as we conclude?

**Marc:** I'd like to just focus on the fact that success in markets today and the success of a medical staff development plan really revolves around our understanding and our focus on capturing market share and attracting that market share. It needs to be strategy-based as opposed to just a reliance on supply and demand statistics.

Most organizations at some point have limited resources, limited capital, limited human time and energy and so on. So it is only in understanding our strategies and then developing a thoughtful response to those strategies (certainly supported by sound business analytics as Ashleigh has discussed today), a very thoughtful response that forces us to prioritize our top market capture and market attraction tactics that will yield truly what becomes a strategic medical staff development plan as opposed to a recruitment list.

Again, the essence of that successful strategic medical staff development plan is a CEO who understands the importance of his or her involvement from the hospital and market perspective in capturing market share in primary care practices, in attracting that market share to the specialists of choice and to the hospital of choice by being the hospital of choice.



I think those would be my concluding thoughts and comments, Ralph.

**Ralph:**

Thank you so much, Marc. Very excellent conclusion. Special thanks to all of you listeners who have invested your time today to join this seminar.

For your convenience and the convenience of your colleagues who may not have been able to attend, a recording of this seminar will be available on the Halley Consulting Group website, along with a written transcript for your use.

We will give you notice within the next few days so you can visit the Halley site at [www.halleyconsulting.com](http://www.halleyconsulting.com) and access this very valuable information. Until then, our most kind regards and appreciation for the opportunity to be with you today.