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Health Strategies & Solutions, Inc., is a national health care management consulting firm that provides state-of-the-art strategic and business planning services for health care organizations and their in-house and external legal counsel.

## Top 9 Medical Staff Development Planning Mistakes

Industry forecasters have moved beyond speculation about whether a physician shortage will occur and are now reflecting on when it will happen and how pervasive it will be. A medical staff development plan can help mitigate some of the effects of the physician shortage by focusing and prioritizing recruitment efforts in an increasingly competitive environment.



If completed correctly, communities, hospitals, and physicians will realize substantial benefits from medical staff development planning, such as ready access to providers, premier market positioning, and thriving practices. When medical staff development planning is handled without the appropriate level of expertise and thoughtfulness, community resources can be wasted on misguided hospital recruitment and retention initiatives and physicians can be alienated from the hospital.

Some common and potentially damaging mistakes made during medical staff development planning are presented below.

- 1. Not accounting for changing patterns of care.** Surging demand for screening colonoscopies to detect colon cancer has significantly increased the need for gastroenterologists; growth in interventional cardiology procedures has decreased the need for cardiac surgery. Failing to thoroughly analyze changing patterns of care can result in skewed physician need calculations.
- 2. Assuming that one set of physician-to-population ratios**

**applies to all markets** . Differences in physician supply can reflect true variations in population-based need—typically resulting from underlying differences in the health status or the age mix of the resident population. But the concentration of medical and surgical specialists in urban areas is largely attributable to other factors such as having a sufficient population base to support highly specialized disciplines, having access to cutting-edge technology and highly trained staff, and being able to practice with renowned faculty and leading specialists.

**3. Failing to account for regionally specific practice patterns.**

The distribution of a physician's time can vary significantly depending on prevailing practice patterns and expectations in a given geographic region. For example, in some markets, family practitioners may devote a substantial portion of their practice to obstetrics, while in other markets, they provide no obstetrical care at all.

**4. Failing to account for time physicians spend in other-than-patient care activities.** Physician need and supply should be determined by focusing on the time physicians spend on indirect and direct patient care activities. Time spent on teaching, research, and administrative activities should not be factored in.

**5. Ignoring the effect of nonphysician clinicians.** The availability of nonphysician clinicians, such as certified nurse practitioners or nurse midwives, varies throughout the United States. Physician-to-population ratios should be adjusted downward in markets where the prevalence of nonphysician clinicians is well above the national norms.

**6. Ignoring the fact that many medical subspecialists devote a portion of their practice to primary care.** Some medical specialists spend 20 percent or more of their time providing primary care services to patients under their care. These physicians should be considered as general internists (typically .2 FTE) and medical specialists (typically .8 FTE).

**7. Not accounting for the role hospitalists play.** Hospitalists are a rapidly growing specialty, typically functioning as internists, but in some cases working as subspecialists, especially in pulmonary medicine. Their contribution toward meeting community need should not be overlooked.

**8. Inappropriately using the medical staff development plan.** Linking investment in physician recruitment to additional referrals from physicians or looking at a hospital's strategic or economic requirements rather than community needs during the medical staff development planning process can lead to risky regulatory exposure and inappropriately biased numbers in medical staff development plans.

**9. Failing to understand the importance of the process.**

Physicians must be actively involved and engaged in the medical

staff development planning process so they understand and feel ownership of the outcomes. If plans are developed exclusively by senior executives and the board, physicians will feel that the plan is being imposed on them and they may be less committed to assisting with successful roll-out of the plan.

### **What Should a Medical Staff Development Plan Do?**

- Define the size and composition of the medical staff organization
- Identify geographic-specific and subspecialty-specific physician needs
- Prioritize physician recruitment efforts
- Identify specialties where competition for patients is likely to intensify because of projected physician surpluses
- Provide information to support physician growth plans

Medical staff development plans, when done well, address physician need at multiple levels to the benefit of the community at large, the hospital or health system medical staff, and individual physician practices. But hospitals and systems must proceed with diligence to avoid pitfalls that can derail accuracy and successful outcomes.

For more information on medical staff development planning, contact [Craig Holm](#) or [Robert Hill](#) or call (215) 636-3500. You can also visit our website at [www.hss-inc.com](http://www.hss-inc.com)



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