

Six Things Every Rural Hospital CEO Must Do: Part Two

Rural hospitals are closing at a record pace, and many of the reasons why could have been avoided.

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Last week, I introduced the topic of “Six Things Every Rural Hospital CEO Must Do,” starting with “Fair Market Value Exercises for Physician Compensation.” This week, we will focus on Topic #2, Physician Demand Analysis.

Part Two: Physician Demand Analysis

Many leaders in rural communities do not bother conducting a physician demand analysis since the populations are so small and the supply of physicians so lean, that they feel they already know the needs. While they may need “all specialties,” they may only need a piece of each and could never really justify a full-time presence of a particular specialty in their communities. That being said, it is best to be proactive in knowing the needs of your community so you have some direction. Also, as I referenced in my previous post on [physician compensation](#), knowing how much of a physician’s time you may need can influence the compensation you plan to pay. You should have a range in mind that falls within Fair Market Value *before* you enter into discussions. You are doing this for your protection as well as the physician’s.

So, where do you start? Whether it is part of your strategic planning process, Community Health Needs Assessment or just in response to some of your PCPs telling you about the number of patients they are referring to specialists in other communities, you need data. And, the more accurate the data, the better your response to needs. Some leaders use rough ratios to gain an idea of need; however, these ratios are often outdated and loosely applied without regard to market variables. A more accurate means of assessing needs should take a number of variables into consideration, including market demographics and population trends, current and anticipated medical staff succession, patient access issues, open versus closed practices, wait times for an appointment, referral and outmigration patterns, and other factors. Such an analysis should be conducted at least every three years, with annual adjustments, so that a three-year forecast and medical staff

development plan, prioritized by specialty demand, may be created and followed. This plan may also be used to create a compelling argument to convince specialists to work with your community; and, it can be used, along with your anticipated Fair Market Value compensation ranges, to create a realistic budget for compensation of a “fractional-presence” of specialists in your community. Such plans are also considered a best practice for demonstrating responsiveness to community needs. And, in the event you are asked to assist an independent provider in the recruitment of an associate, such a plan is the most compliant means to show you exercised proper due diligence in meeting OIG and IRS requirements for community need.

Sound daunting? It isn't, especially when you consider the alternative of “flying blind.” Reach out to me at rthorn@askphc.com, and I would be glad to help.

In next week's edition of this six-part series, we will explore topic #3 of the “Six Things Every Rural Hospital CEO Must Do.” I hope you will join me. Should you have any questions in the meantime, please feel free to contact me at rthorn@askphc.org or (720) 598-1443.