Planning Physician Hires: 
A Judicious and Realistic Strategy

By Lauren Phillips

Banner Medical Group coordinates physician hiring across its 29 facilities.

By 2025, demand for physicians will exceed supply by 46,000 to 90,000 as a result of the retirement of up to a third of physicians and growth in population needs of up to 17 percent, thanks largely to aging on both sides of the equation.

“Forget looming,” says Peter Fine, president and CEO of Banner Health in Phoenix. “The shortage is already here” and making itself felt in each of the system’s 29 facilities in seven Western states, where Banner employs more than 1,700 providers. This is why Banner has put in place a strategic planning process for physician hires that ensures it brings on the right people in the right places at the right times.

We asked Michael Lewis, regional CFO, Banner Medical Group, to explain how the process works.

Does each part of the system, or each medical group, do its own planning?

Lewis: Exactly the opposite. It can’t be done individually or in a vacuum. The key is to have everyone—leadership from the ambulatory, facility, and managed care arms of the system, including the system’s strategy and planning departments—at the table. That way, everyone contributes to an understanding of our overall financial picture and we can come up with a coordinated hiring strategy that makes sense for the organization as a whole.

What is the danger in independent action?

Lewis: For one thing, you can get divided strategies that potentially compete against each other. In most healthcare organizations, there’s inherent friction between the medical group and the hospitals. The latter are typically subsidizing losses from physicians and have a large appetite for specialists and high-end proceduralists who generate a lot of downstream revenue for a facility. The medical group is more interested in growing primary care, which they see as the top of the funnel that feeds the network. What you need is a balance, which requires growing the panel sizes in your primary care network to support your specialists who support your facilities across the continuum—acute care settings, surgery centers, imaging centers, etc.—and your overall strategy.

Also, if you get physician growth out in front of what a particular facility can support, in terms of finance and capacity, you’ve got a broken strategy: You’re going to end up diverting patients to another facility, which could even be outside your network. Or, if you can’t make it work financially, you’re going to see diminishing margins.

How do you decide on your strategy?

Lewis: Banner operates in many markets with different market dynamics. So we look at the demand. Is there an area of unmet need where we can place physicians and experience very aggressive volume growth? Or is there a saturated market where we can use network strategies or offer a competitive differentiator? For example, we may be entering a new market with a large payer that we hope will let us into their narrow network. We might ask, “How many covered lives are we potentially gaining, and do we have the capacity within our primary care network to support those additional lives? What about in urology? Orthopedics? Do we have facility support for the ancillary services this population will need? Do we have the appropriate amount of leased space?”

If we want to enter a new market with a specialty, we look to see: Has the system had experience with that same specialty in a similar market that we can study? If we’re entering a new market with a new specialty, we engage our strategy and planning people in gathering as much data as we can—inpatient admissions, tumor board information, population needs, etc. If we see there’s a demand, then we look at the downstream impact on the hospitals—the imaging volumes and the physical therapy—to determine the strategic value of the service line.

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Of course, sometimes the strategic investment may be break even at best, but we’re still going to move forward because there’s a different kind of value at stake. For example, urgent care can help avoid costs in the emergency room.

How do you engage with the Banner hospitals in your region?

Lewis: In each of the different markets in my region, I and my colleagues from the
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How does all this planning dovetail with budgeting?

Lewis: Our fiscal year is the calendar year, so we start budgeting in June and July. We start the physician planning process in March. That way, we know what we need to budget for. We have shared accountability. Financial results from both the hospitals and the medical group are illustrated in a consolidated report. If a provider is budgeted but not hired, the medical group has a positive budget variance and the hospital a negative one, because it overstates expected volume; if a provider is not budgeted but hired anyway, the positions flip.

It’s also critical to look at the capital planning piece, especially when you’re launching a new service line. If you hire a gynecological oncologist but fail to realize that person is going to need a da Vinci robot surgical system that costs millions of dollars, you’ve got a problem.


difficult to the organization, what impact do your plans have on them? You don’t want them to look elsewhere, so preserving those relationships can require some carefully navigated conversations and strategic planning.

Also, are you interrupting any government relations, such as narrow network managed care arrangements with government employees? If you have a large employer in the market for which you’re the health plan of choice, are you making changes that will disrupt service to its employees—which could disrupt the relationship?

What is the biggest challenge for systems pursuing this strategy, other than getting everyone to work together?

Lewis: Patience. If you start to see growth and improvement in the performance of the organization, it doesn’t mean you should keep hiring; you have to allow the physicians you’ve already hired to adequately grow their volumes to support the system’s goals. You don’t want to have a huge influx of clinicians saturate one of your clinics and thus hurt its performance or hinder the providers’ ability to grow their practice.

Also, I can’t stress enough that if you hope to make physicians happy, leadership happy, and, most importantly, patients happy, there must be full collaboration and coordination from start to finish throughout the entire organization, with no arm acting on its own.

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Unionization Surges in Health Care

By Rich Daly

Union representation surged along with healthcare worker hiring in 2015, according to a recent Bureau of Labor Statistics (BLS) report that found the number of healthcare and social assistance union members increased by 22,000 in 2015 to reach 1,242,000.

The 2015 spike in healthcare union activity is partly due to an April 2015 decision by the National Labor Relations Board (NLRB) that changed the process for filing and processing petitions for union representation of employees. The changes essentially shortened the required time between filing a petition and holding an election.

David Rittof, president and CEO of Modern Management, an HR consulting firm, says that he has seen healthcare elections take place in as few as 17 days since the rule change.

Another change—traceable to a 2011 NLRB decision—was a surge in the number of elections involving no more than 10 workers, which increased 41 percent over the average of the previous four years.

The new labor rules have led Rittof to urge hospitals to implement labor strategies “before there is a whiff of union organizing.” That means developing engagement initiatives to address employee concerns before they look to a third party.

“If I can’t go to my boss, I know I can go to my HR department and get a fair shake,” Rittof said, describing a successful engagement initiative. “That’s an enormous campaign an organization has to launch to build the credibility of their managers and build the credibility of their HR representation, so that employees don’t feel they need to pay money out of pocket [to a union] to get a fair shake.”

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