Oncologist Succession Planning

Ensuring cancer program growth and future success

Succession planning has been used effectively in the corporate world for many years; however, few community cancer programs—whether freestanding or hospital-based—have thought proactively when succession planning for oncologists. Ideally, succession planning is an ongoing process that helps identify, assess, and develop physicians to ensure leadership continuity for a practice or program. Effective succession planning is reflective of and integrated with strategic objectives, which are reviewed at least annually.

As each new generation of cancer care providers brings changes to the workplace, the succession planning process itself undergoes transformation. Today's practice and hospital administrators and their providers are operating in a different recruitment environment than in previous years. For example, the new physician workforce places very different expectations and values on professional life than their predecessors, requiring that new principles of succession planning be applied (see Table 1 for more).

Here are some practical tips and strategies to help develop a succession planning program at *your* oncology practice or cancer program.

Getting Started

While the projected oncology workforce shortage, alone, is a compelling argument for proactive succession planning (see "Understand the Pipeline" on page 30), succession planning brings a host of additional potential benefits. Effective physician succession planning programs:

- Ensure continuity of practice culture and operations
- Assist with continually assessing the talent pool
- Make the practice or program more attractive to recruits
- Translate practice strategies into organizational capabilities
- Help prepare the practice or program for future environmental changes
- Help manage reimbursement environment changes, unforeseen lifestyle issues, physician supply-demand trends, and more.

In our experience, when it comes to physician recruitment efforts, one critical pitfall that repeatedly ensnares physicians, practice administrators, and hospital recruiters alike is lack of preparation. In succession planning, it is imperative that those conducting the search and recruitment process have a "tool kit" at the ready. If your oncology practice or program has not yet developed such a tool, here's how to get started.

Succession Planning Tool Kit

The first step is to develop a process for reviewing candidate CVs and selecting phone and onsite interviews. Ensure that practice physicians and/or hospital participants are "on board" with candidate profiles and selection. Simply put, ensure that selected candidates are desirable to

Table 1. Succession Planning "Then and Now"

OUT WITH THE OLD....	...In with the New
Identify candidates as critical needs arise	Develop a process for continual practice growth and development to meet expected needs
Assume physician needs will stay the same	Develop a plan that fosters growth and changes with environmental factors
Narrowly emphasize specific skills and experience	Broaden candidate pools and remain flexible to new practice cultures
Use assessments based on the judgment of individual physicians and/or practice managers	Use group feedback which is far more reliable than feedback from one or two individuals
Recruit only very high potential candidates who the physicians believe are "stars"	Focus on individuals who will add value to the overall practice versus being the "savior"
Shroud succession planning in mystery and secrecy	Keep the practice/program aware of succession plans; invite input and participation in the process
Focus only on immediate needs and ignore the "big picture" needs	Develop competencies that will help the practice/program grow in the future
Expect the recruit to integrate him or herself into the practice.	Provide a more formalized training and mentoring program consistent with practice/program culture.

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the group that is making the hiring decision. For hospital-based cancer programs advance planning is critical, especially because this process will often involve the participation of individuals with complex, demanding schedules, including medical staff, Board members, the CEO, and some community leaders. Seat your selection committee, organize your onsite interview process with key constituents, and determine participating interviewees—all well in advance.

The second step is to prepare a process for conducting phone or personal interviews and onsite visits. The "recruiter" needs to identify areas of interest for each candidate and be prepared to address these in detail, including (but not limited to):

- Anticipated patient volumes and payer mix
- A packet of information about the community and hospital(s) that includes specific oncology program information—what services are currently offered, what technologies are available, what other providers exist in the market, etc.
- Base and incentive compensation specifics
- Insurance and benefits packages
- Real estate
- Schools
- Moving and relocation
- Community
- Spouse and domestic partner interests and/or employment opportunities.

The "recruiter" should prepare a draft contract and be primed to review and present it to a candidate at the time of the onsite visit/personal interview. In terms of recruitment timing and specifics for initiating physician work efforts, the "recruiter" should be able to explain in detail:

- The process for attaining hospital privileges
- The application process for enrolling the physician in insurance plans
- Licensing time
- Anticipated start date and relocation timing
- Malpractice insurance enrollment, timing, and cost.

Be Current on Stark Guidelines

For hospital-based cancer programs, the Stark II, Phase III Centers for Medicare & Medicaid Services (CMS) guidelines include specifications about how and when a hospital must define its service area for recruitment of new physicians.[1] As a result, more intense planning for recruitment is a must for hospitals. Three core issues include: definition of the service area, recruitment timing, and community physician needs analyses.

Definition of the service area. A hospital must demonstrate community need for a specialty to provide financial recruitment assistance to a private practice physician. In Phase III of the CMS rules, there is a requirement for recruitment in a "geographic area served by the hospital (GASH)." The definition of GASH is the "area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients."[1] The CMS definition suggests that the 75 percent of inpatients can be defined as all hospital inpatients and not just those within the recruited specialty.

Recruitment timing. Unfortunately, many hospitals looking to recruit do not factor in an appropriate time frame for doing so. CMS has further delineated a timing factor for recruitment that may lead to restricting hospitals if a suitable plan is not in place before recruitment begins. CMS requires that the GASH used to determine community must be established as of the date the recruitment agreement is signed. Specifically, CMS guidelines state: "A hospital may use any configuration that satisfies the lowest number of zip codes/applicable percent of inpatients test on the date it enters into the recruitment arrangement (that is, the date on which all parties have signed the written recruitment agreement). In some cases, this may result in the use of a different geographic service area for different recruitment arrangements."[1]

In our experience, it can take months and sometimes even a year to a year-and-a-half from the start of the recruitment effort to procure an actual signed contract with a candidate. Bottom line: hospital and health system succession planning must take into account timing restrictions related to GASH.

Community physician need analyses. In our experience, most hospitals conduct physician need analyses every two years or so. With the timing implications related to recruitment and GASH, this process could easily fall behind and could definitely have a negative impact on recruitment of specialty and sub-specialty physicians in relation to the community need calculation and defined GASH for such specialties. Our recommendation is for hospitals to consider the timing of GASH studies so that these are more closely aligned to actual oncology recruitment timing, i.e., timing of actual signing date of contracts.

As always, CMS keeps hospital administrators on their toes with respect to what assistance is lent to physician recruitment, specifically in the private practice realm. As a result, it is anticipated, and the market is actually experiencing, a trending towards direct hospital employment and/or oncology co-management models as alternatives to hospital-based private practice recruitment.

Succession Planning Timeline

Here is a graduated, four-phase succession planning process to help ensure long-term success for your practice or

(continued on page 31)

Understand the Pipeline

In 2007 a study by the Association of American Medical Colleges (AAMC) Center for Workforce Studies reported an anticipated shortage of oncologists in the U.S. The study, commissioned by the American Society of Clinical Oncology (ASCO) found that "…the demand for oncology services is expected to rise 48 percent between 2005 and 2020. During the same period, the supply of oncologist services is expected to grow only by 14 percent, translating to a shortage of between 2,550 and 4,080 oncologists. That amounts to roughly one-fourth to one-third of the 2005 number."[1] During this same time frame, the population of individuals aged 65 and older will continue to dramatically increase. In fact, this population is expected to double between the years 2000 and 2030. The aging population combined with growing numbers of cancer survivors will further drive the future demand for oncology services. And all of this is occurring as many practicing oncologists are reaching retirement age. For hospital and practice administrators looking to the future of their programs, oncologist succession planning is essential to long-term stability and growth.

Solid knowledge about the supply of available candidates and the trends occurring in the oncology field are key components of succession planning. The following statistics provide a cursory perspective of industry statistics. In preparing your own succession plan, you will want to perform a more in-depth analysis to help you target the "right fit" physicians for your cancer program and community.

According to the AAMC Center for Workforce Study, a total of 10,422 medical oncologists, hematologists/oncologists, and gynecologic oncologists are in the market today, with an expected increase of only 2,125 by 2020.[2] These numbers translate to a total pool of 12,547 oncologists. (Figures 1 to 7 provide a snapshot of the most recent characteristics of the oncology physician workforce.)

Of note, declines in "feeder specialties" have been reported in recent years. According to the *Journal of the American Medical Association*, from 1996 to 2004, the U.S. experienced a decline in the number of internists from 8,288 to 8,262; and in OB/GYNs from 1,297 in 1995 to 1,215 in 2004. This decline represents a substantial challenge for feeder physicians to hematology/oncology and gynecologic oncology fellowships.[1]

Given the total number of candidates available and the projected future growth of cancer incidence, oncology practices, hospitals, and academic medical centers alike must better prepare for recruitment in order to attract desired candidates.

References

[1]Association of American Medical Colleges (AAMC) Center for Workforce Studies. *Forecasting the Supply of and Demand for Oncologists: A Report to the American Society of Clinical Oncology (ASCO) from the AAMC Center for Workforce Studies.* March 2007. Available online at: *http://www.asco.org/ASCO/Downloads/Cancer%20Research/Oncology%20Workforce%20Report%20FINAL.pdf.* Last accessed Jan. 21, 2009.

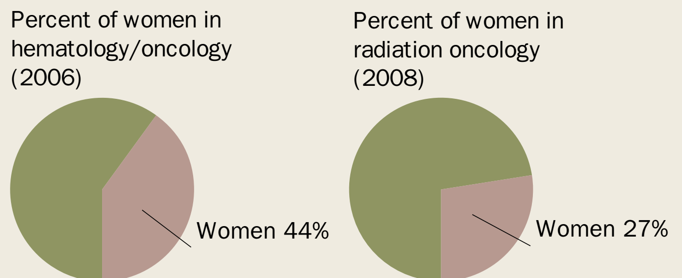
[2]Salsberg E. The future of the oncology workforce. Presentation at: Annual Meeting of the American Society of Clinical Oncology; June 2, 2007. Available online at *www.asco.org/ASCO/Practice+Resources/Workforce+Study.* Last accessed January 28, 2009.

Figure 1. Oncologists by Age

Percent of hematologists/oncologists aged 50 or older (2005)	56%
Percent of radiation oncologists aged 45 or older (2008)	60%
Percent of GYN oncologists aged 50 or older (2005)	62%

Source: AMA Physician Masterfile, January 1, 2005. American Society of Therapeutic Radiology and Oncology; *www.astro.org*

Figure 2. Oncologists by Sex



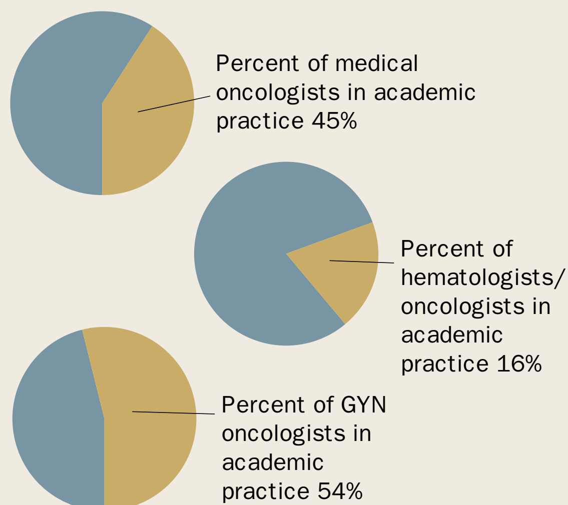
Source: American Society of Clinical Oncology Workforce Study; *www.asco.org/workforce.* American Society of Therapeutic Radiology and Oncology; *www.astro.org*

Figure 3. Oncologists by Graduate Program Type

	Foreign	U.S.
Percent of hematology/oncology, Foreign vs U.S. medical grads (2006)	42%	58%
Percent of radiation oncology, Foreign vs U.S. medical grads (2006)	4%	96%

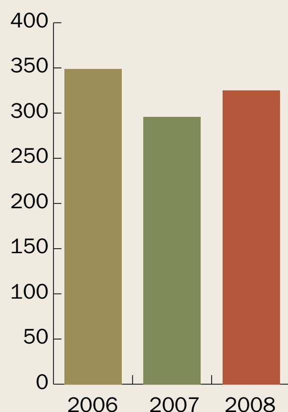
Source: American Society of Clinical Oncology Workforce Study; *www.asco.org/workforce.* American Society of Therapeutic Radiology and Oncology; *www.astro.org*

Figure 4. Oncologists by Practice Type



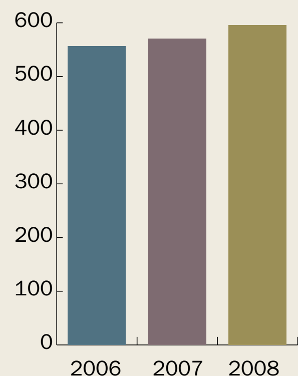
Source: American Society of Clinical Oncology Workforce Study; *www.asco.org/workforce*

Figure 5. Hematology/Oncology Fellow Trends



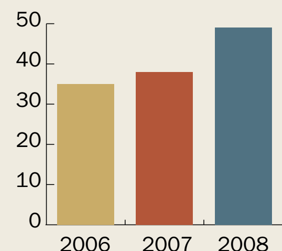
Source: American Medical Association FREIDA Specialty Training Statistics; *www.ama-assn.org/vapp/freida/spcstsc/0,1238,155,00.html*

Figure 6. Radiation Oncology Fellow Trends



Source: Association of Residents in Radiation Oncology; *www.arro.org*

Figure 7. GYN Oncology Fellow Trends



Source: American Board of Obstetrics and Gynecology: *www.abog.org*

"When the interviews are complete, develop a style profile of each candidate."

program. Figure 8 on page 32 shows a reasonable timeline for these succession planning activities.

Phase 1: Analyze the practice or cancer program environment and business. Start by analyzing existing and future projected reimbursement and costs. Next, project your market size and growth expectations. You will also want to study your current and future marketplace competition. Finally, you should analyze your hospital and referring physician relationships. Is there room to improve or strengthen your referring relationships?

Phase 2: Identify practice or cancer program goals. Start by reviewing current strategies and defining your organization's future direction. You should also assess your existing practice culture and then determine an ideal practice culture. Finally, take a look at your practice or cancer program capacity and timing related to events, such as retirement or program growth, to identify your succession needs.

Phase 3: Present and assess candidates against requirements. Identify and nominate potential candidates based on success predictors, such as historical productivity; past leadership participation; longevity of previous positions; evidence of exceptional referring physician, hospital, and community relations; and accrued honors. Lead physicians at the practice or cancer program should approve the candidates to interview. Next, define the interview pool and interview process. Finally, develop an assessment tool for rating candidates during the interview sessions. Sample factors for evaluating physician candidates include how the candidate:

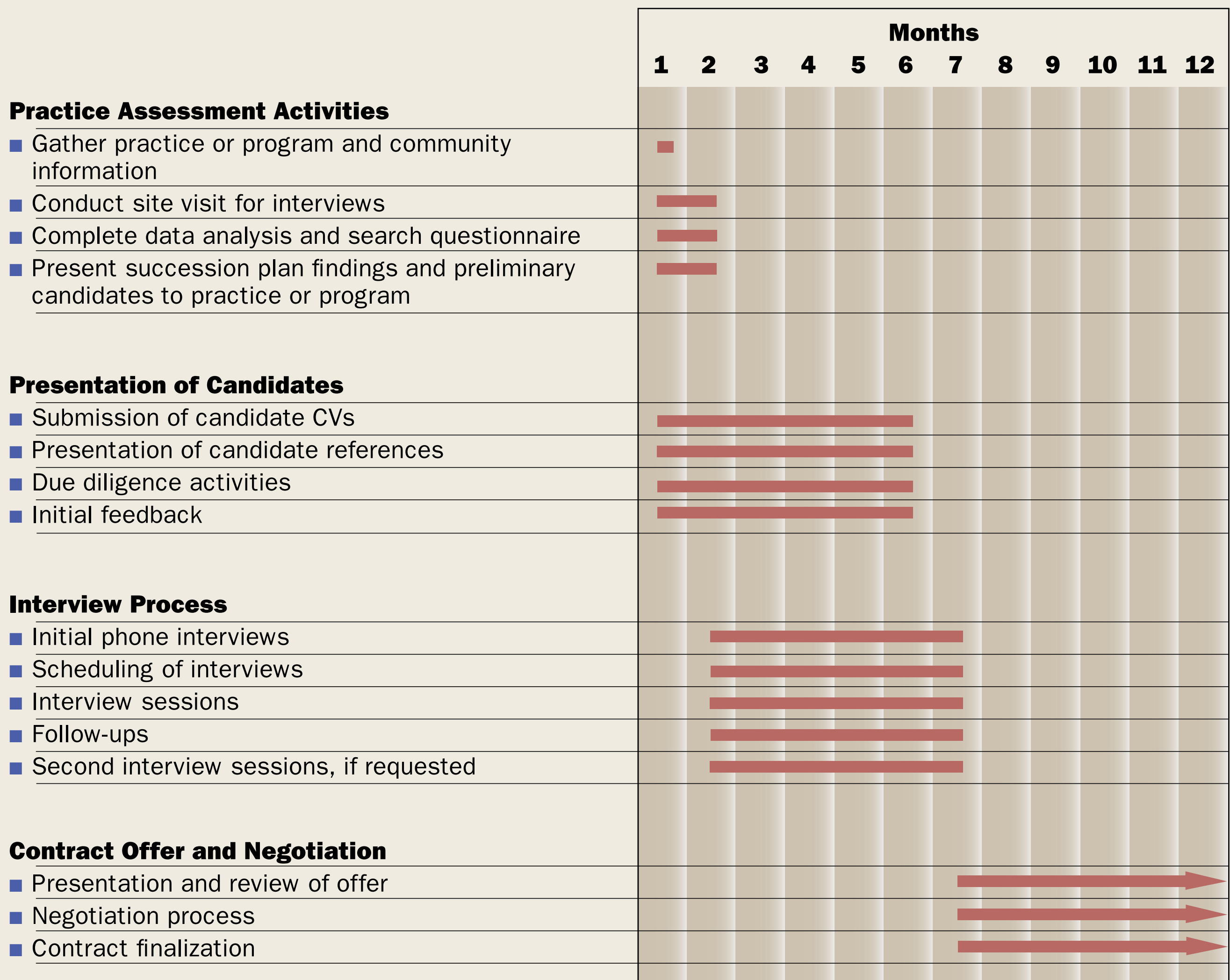
- Effectively balances quality issues with business issues when making decisions
- Ensures the confidence and respect of colleagues within his or her specialty
- Participates in clinical research activities
- Aligns his or her professional and personal values and goals to complement those of the physician members and practice culture.

Other factors to consider include:

- How the candidate's sub-specialization complements the diversification goals of the practice or program
- How the candidate's previous practice locations and situations may enhance patient load and financial growth potential.

When the interviews are complete, develop a style profile of each candidate. Then, compare candidates

Figure 8. Sample Timeline for a Succession Planning Process*



*Although a bit aggressive for today's oncology recruitment market, the timeline outlined below is achievable and can be used as a guideline during the succession planning process.

with existing and anticipated practice requirements, strategies, and goals

Phase 4: Finalize practice recruitment. From the initial interviews, select the top three candidates. Complete subsequent interview sessions with these three individuals to narrow the field to a single candidate. When you begin negotiations with the selected candidate, update second- and third-tier candidates on the process and timing of the hiring decision. Once the candidate has accepted the position, you can finalize negotiations.

Looking to the Future

Succession planning is an ongoing effort. Revisit your succession plan at least every three-to-five years and update periodically as environmental, practice culture, or other key issues arise. Successful and effective succession planning will benefit your practice and cancer program in many ways. For example, succession planning can help ensure the continuity of physician productivity, leadership, and practice or program success, as well as increase physician retention. Succession planning can engage senior physicians in a disciplined review of practice strategy and candidate talent, and guide development activities. Finally, an ongoing succession plan can help practices and cancer programs avoid transition problems and reduce "first time" recruitment mistakes.

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References

[1]Centers for Medicare & Medicaid Services (CMS). Medicare program: physicians' referrals to health care entities with which they have financial relationships (Phase III); Final Rule. *Federal Register*. 72(171):51012-51099. Sept. 5, 2007. Available online at: *http://edocket.access.gpo.gov/2007/pdf/07-4252.pdf.* Last accessed Jan. 21, 2009.