From Fragmented Hiring to Strategic Growth

A Practical Playbook for Provider Recruitment & Alignment in Ohio Health Systems

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Strategic Market and Provider Analytics · Growth Strategy · Employed Provider Enterprise Strategy · Market Development · Service Line Strategy

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About HSG

HSG Advisors partners with healthcare organizations to transform their approach to markets, services, and providers through data-driven analytics and advisory solutions that catalyze strategic and sustainable growth.

Headquarters: Louisville, KY
Formed: 1999

Claims-Enhanced Market & Provider Intelligence

Transform **claims data into actionable market and provider intelligence,** enabling strategic decision-making through customized analytics, intuitive visualizations, and consultative guidance.

Provider Recruitment & Alignment Strategy

Strategically **evaluate and optimize provider recruitment and alignment,** ensuring the sizing and accessibility of ambulatory and hospital-based providers is aligned with market and provider strategy.

Market & Service Line Growth Strategy

Develop and execute data-driven growth strategies by assessing current performance, identifying opportunities, defining strategic pathways, and monitoring results to drive sustainable, measurable growth.

Employed Provider Enterprise

Align organizational structure and provider governance**, optimize practice access and overall operations, improve financial performance,** and drive strategic growth through data-driven insights and operational expertise.

Provider Compensation & Compliance

Design and implement provider compensation and compliance strategies with a focus on alignment to organizational goals, while supporting financial sustainability, provider satisfaction, and value-based care.

Setting the Stage

Understanding the Drivers of Strategic Provider Recruitment

The Challenge with Recruitment Planning

For some health systems, recruitment "plans" are really just a queue of requests.

Reactive Hiring

Someone retires, a department chair lobbies, a competitor poaches. Every hire is an emergency.

Political Prioritization

The loudest voice wins. Recruitment decisions driven by internal advocacy rather than data.

Misaligned Investment

Recruiting specialties that don't match market opportunity, while real gaps go unfilled.

The result: growth opportunities missed, dollars wasted, and strategic plans disconnected from provider deployment.

Recruitment Is a Growth Strategy

Recruitment doesn’t create growth in a vacuum.

Growth comes from market opportunity combined with a hospital's capacity to capture it. Recruitment is a potential execution mechanism — when it's connected to the right data and the right strategy and incrementally adds needed capacity.

Market Opportunity

Where is the unmet need?
Strategic Goals?

Capacity Strategy

Can we grow internally?
Do we need new capacity?

Recruitment Execution

Who do we recruit?
Where? In what order?

Three Lenses for Every Recruitment Decision

Strategic Priority

Does this recruitment advance a service line priority or strategic plan objective?

Community Need

Is there a real access gap? Do supply/demand data confirm unmet need in this market?

Internal Capacity

Have we maximized productivity of existing providers? Is there latent capacity to leverage first?

When all three converge, you have a high-confidence decision. When they don't, you're either chasing volume without strategy, filling a gap you can't sustain, or ignoring capacity you already have.

The Data Building Blocks

Five Analytics that Shape Recruitment Decisions

Define Your Service Area Strategically

Your market definition is the foundation. If it doesn't reflect how you actually compete and operate, every analysis built on top of it is misaligned.

Strategic Market

The broader area where you execute your strategic plan. Should be subdivided into competitive clusters around your facilities.

Submarkets

Granular definitions based on competitive activity, facility placement, and population centers. Where you actually win and lose.

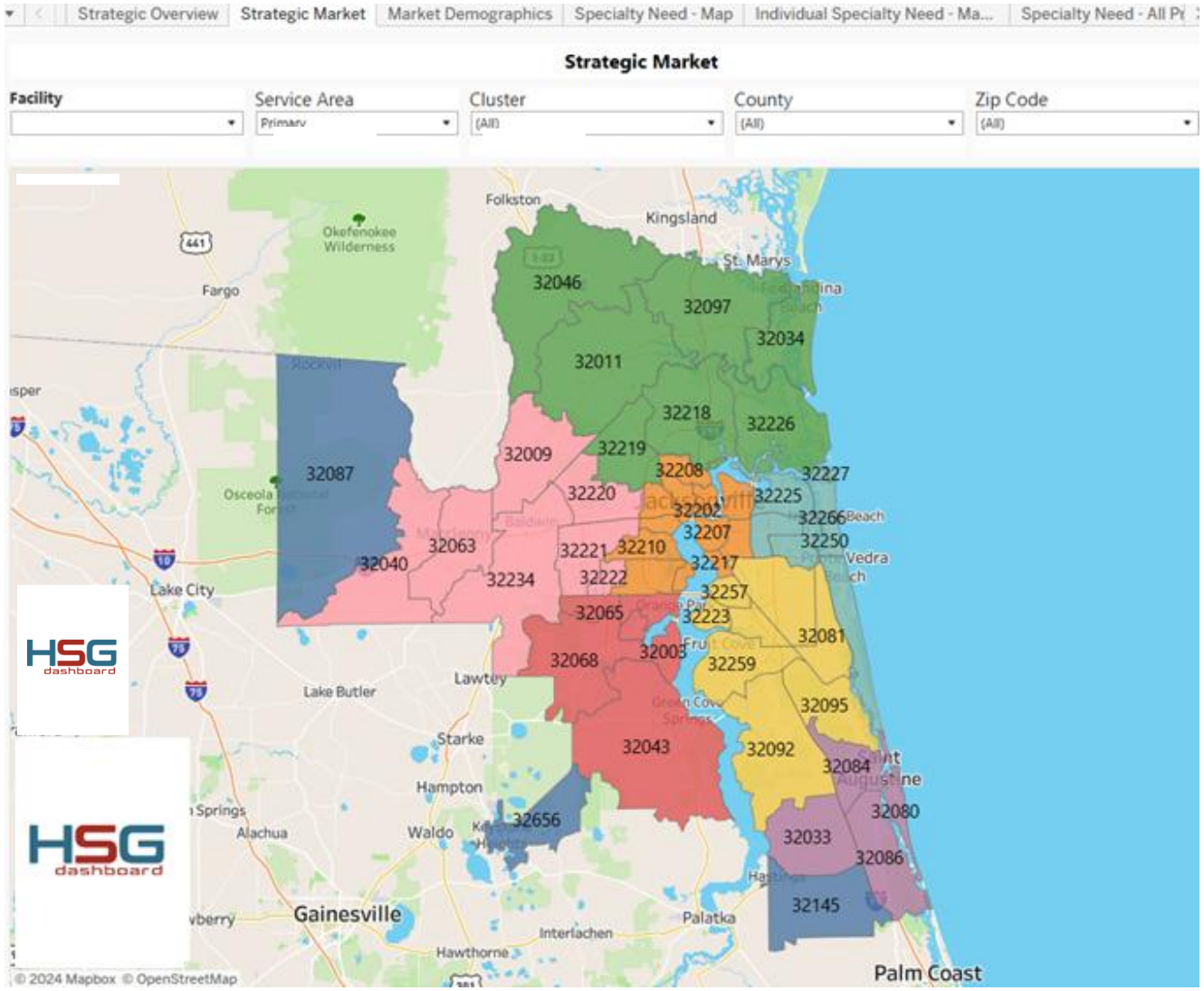
Compliance / Stark III Market

The HPSA-based market that guides recruitment support for independent practices and compliance activities.

Ohio Considerations

- Urban-rural mix requires distinct submarket strategies for metro vs. rural counties
- Cross-market competition within short distances (Columbus, Dayton, Cincinnati corridor)
- Rural counties where your system may be the only provider of key services
- Market definitions should align with how your system is already organized regionally

Strategic Market (System-Based)



Definition:

- Broader market definition focused on where health system desires to compete

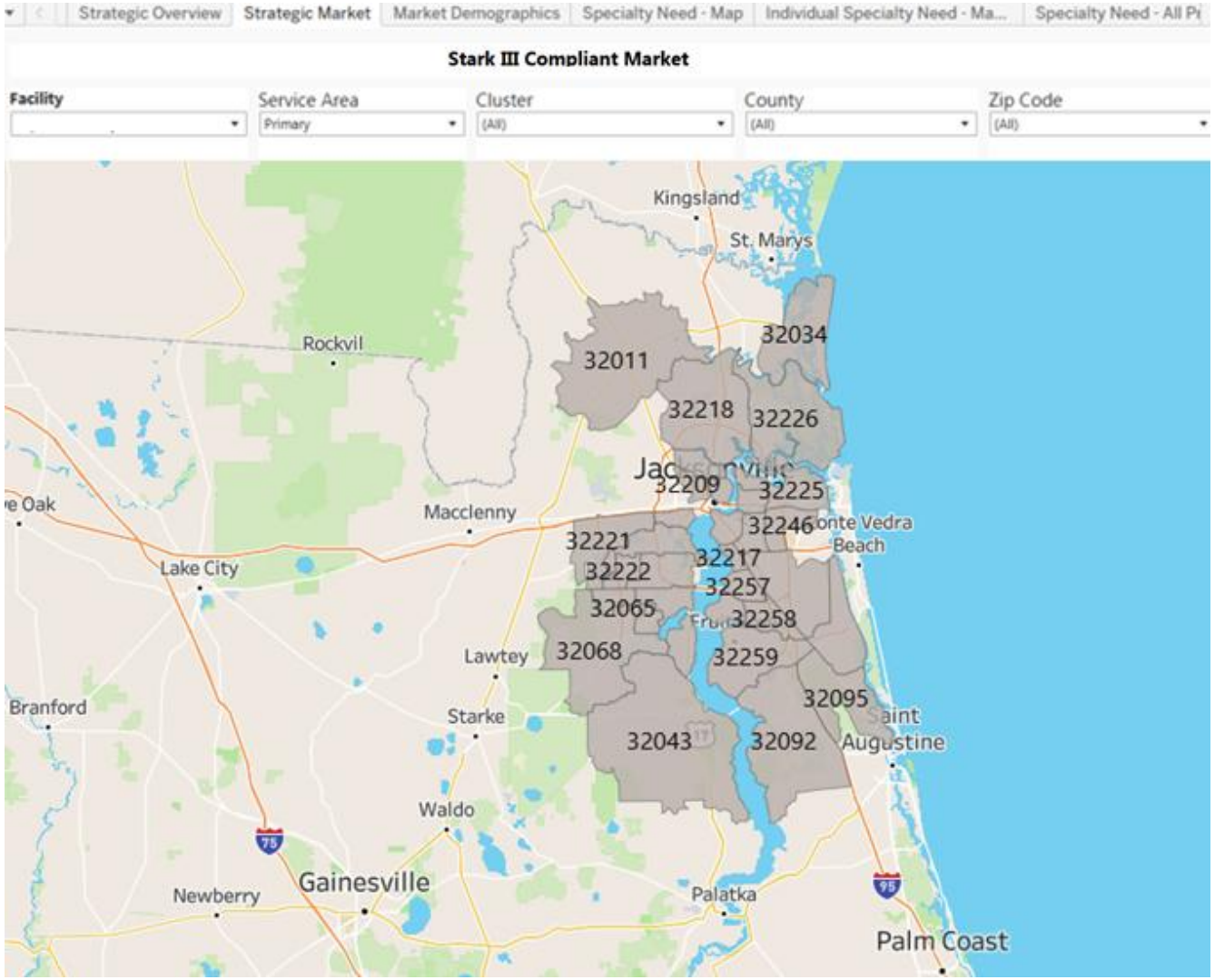
Utilized for:

- Evaluating markets at both a granular and global-level

Notes:

- Historically Primary/Secondary/Tertiary
- HSG recommends utilizing a zip-code/county based “Strategic Cluster/Submarket” definition for evaluating Strategic Markets
  - Market penetration
  - Competitive dynamics
  - Routes of travel
  - Common populations
- **Critical:** Market definitions should be non-overlapping

Stark III Market (Hospital-Based)



Definition:

- Defined by “minimum number of contiguous zip codes comprising a threshold % of IP Discharges in most recent 12-month period”
  - Urban Facilities: 75%
  - Rural Facilities: 90%

Utilized for:

- Evaluating and documenting community need for health system financial recruitment support to independent private practice

Notes:

- Stark III Markets and related community need evaluation should be comprehensively evaluated on a three-year basis
- Stark III Market community need evaluation should be performed each time a health system provides financial support to an independent private practice

Provider Inventory: Know Who's Actually There

You can't plan recruitment if you don't know who's currently practicing in your market.

By Specialty & Geography

80+ specialty categorizations, mapped to each submarket. Physicians AND APPs.

Claims-Based Accuracy

Licensure data alone is unreliable. Claims-based methodology validates who is actually practicing where.

FTE Attribution

Providers splitting time across markets shouldn't count as 1.0 in each. Accurate FTE allocation matters.

Alignment Classification

Employed, independent-aligned, independent-unaligned, competitor-employed. Know the landscape.

Foundation: Everything downstream — supply/demand, succession, capacity — depends on an accurate inventory.

Provider Supply and Demand

Provider Inventory Development

Provider Aging | Specialty Roll-Up By Geography | By Geography (1 of 2) | By Geography (2 of 2) | Market Inventory | APP FTE Ratio | Appendix

Strategic Service Area Definition (All) | **County** (All) | **Zip Code** (All) | **Specialty Roll-Up** (All)

Provider Full Name	NPI	PNA Specialty Roll-Up	PNA Specialty Name	Provider Type	Employment Status	Age Category	Practice City	Practice State	Zip Code	Provider FTE
Wei-Ning Eddie Liu	1598261620	Adult Primary Care	Internal Medicine	Physician	Employed	Age 60 or Less	Cleveland	TN	37312	1.0
Vicki Deweese	1164411559	Mental Health	Psychiatry	APP	Not Affiliated	Unknown	Dalton	GA	30720	1.0
Christopher Wheatley	1114401999	Adult Primary Care	Family Medicine	APP	Not Affiliated	Unknown	Fort Oglethor..	GA	30742	1.0
Joshua Littell	1386322147	Nephrology	Nephrology	APP	Medical Staff	Unknown	Dalton	GA	30720	1.0
John J Land	1568548220	Podiatry	Podiatry	Physician	Medical Staff	Unknown	Dalton	GA	30720	1.0
Padmavathi Geddam	1316034390	Mental Health	Psychiatry	Physician	Not Affiliated	Unknown	Dalton	GA	30720	0.2
Stephen G Rohn	1689604472	General Cardiology	Cardiovascular Dis..	Physician	Medical Staff	Age 60-64	Dalton	GA	30720	1.0
Trevor Alverson	1184179558	General Cardiology	Cardiovascular Dis..	APP	Medical Staff	Unknown	Dalton	GA	30720	1.0
Briton Jordan	1114916582	General Surgery	General Surgery	Physician	Not Affiliated	Age 60 or Less	Calhoun	GA	30701	0.2
Carl Lokko	1346506359	Gastroenterology	Gastroenterology	Physician	Not Affiliated	Age 60 or Less	Calhoun	GA	30701	0.2
Daniel Ahn	1184645558	Ophthalmology	Ophthalmology	Physician	Not Affiliated	Age 60-64	Calhoun	GA	30701	1.0
Jacob Faulkner	1780048785	Orthopedics General	Orthopedic Surgery	APP	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Jose Gomez	1447319975	Adult Primary Care	Family Medicine	Physician	Not Affiliated	Age 60 or Less	Calhoun	GA	30701	1.0
Mayur Mody	1255751277	Hematology/Oncology	Medical Oncology	Physician	Not Affiliated	Age 60 or Less	Calhoun	GA	30701	1.0
Ted Pennel	1275556078	Adult Primary Care	Internal Medicine	Physician	Not Affiliated	Age 65 or Greater	Calhoun	GA	30701	1.0
William Tong	1184971434	Radiation Oncology	Radiation Oncology	Physician	Not Affiliated	Age 60 or Less	Calhoun	GA	30701	0.2
Sheela Hanasoge	Null	Radiation Oncology	Radiation Oncology	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Stephen Golder	Null	Radiation Oncology	Radiation Oncology	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Melissa Pope	Null	General Cardiology	Cardiovascular Dis..	APP	Not Affiliated	Unknown	Rome	GA	30165	1.0
Nicole Mcdaniel	Null	General Cardiology	Cardiovascular Dis..	APP	Not Affiliated	Unknown	Rome	GA	30165	1.0
Shirley Greenway	Null	General Cardiology	Cardiovascular Dis..	APP	Not Affiliated	Unknown	Rome	GA	30165	1.0
Peyton Albertson	Null	Cardiovascular and ..	Cardiothoracic Sur..	APP	Not Affiliated	Unknown	Rome	GA	30165	1.0
Sally Smalley	Null	Otolaryngology	Otolaryngology	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Alison Petty	Null	Adult Primary Care	Family Medicine	APP	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Joni Yamamoto	Null	Adult Primary Care	Family Medicine	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Kent Van Arsdell	Null	Adult Primary Care	Internal Medicine	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Maggie Ralston	Null	Adult Primary Care	Family Medicine	APP	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Maxwell Parrott	Null	Adult Primary Care	Internal Medicine	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Susan Kim	Null	Adult Primary Care	Family Medicine	Physician	Not Affiliated	Unknown	Calhoun	GA	30701	1.0
Kimberley Weatherf..	Null	Adult Primary Care	Family Medicine	APP	Not Affiliated	Unknown	Rome	GA	30165	1.0
Cindy Jones	Null	Adult Primary Care	Family Medicine	APP	Not Affiliated	Unknown	Chatsworth	GA	30705	1.0
Cinthia Cox	1386878411	Otolaryngology	Otolaryngology	APP	Not Affiliated	Unknown	Chatsworth	GA	30705	0.2
Macie Cable	Null	Adult Primary Care	Family Medicine	APP	Not Affiliated	Unknown	Chatsworth	GA	30705	1.0

SAMPLE

- **Service Area-Wide Provider Inventory Development that includes Advanced Practice Providers with actual practicing specialty**
  - All Non-Hospital-based Providers, identified by practicing specialty
  - Physicians
  - Advanced Practice Providers
- **Critical Factors in Inventory Development**
  - Provider location(s)
  - FTE
  - Practicing Specialty – especially for APPs
  - Affiliation with Client Health System Identified
- Provider inventories need to be refreshed on at least an **annual basis**

Supply & Demand: Quantify the Real Gaps

Multiple demand models, adjusted for local factors, compared against actual supply to identify true gaps by specialty and market.

1

Population-Based Demand Models

Multiple benchmarks averaged to avoid overreliance on any single model

2

Local Adjustments

Adjusted for demographics, disease burden, mortality, and local utilization patterns

3

Supply vs. Demand

Net need by specialty, by market, for physicians and APPs separately

4

Gap Identification

Specialty-level analysis of where gaps actually exist vs. perceived gaps

Ohio Reality: Behavioral health and primary care shortages in rural counties show up clearly in this analysis — and often represent the highest-impact recruitment opportunities.

Provider Supply and Demand

Individual Specialty Need

Facility	Cluster	County	Zip Code
Jacksonville Health System	All	All	All

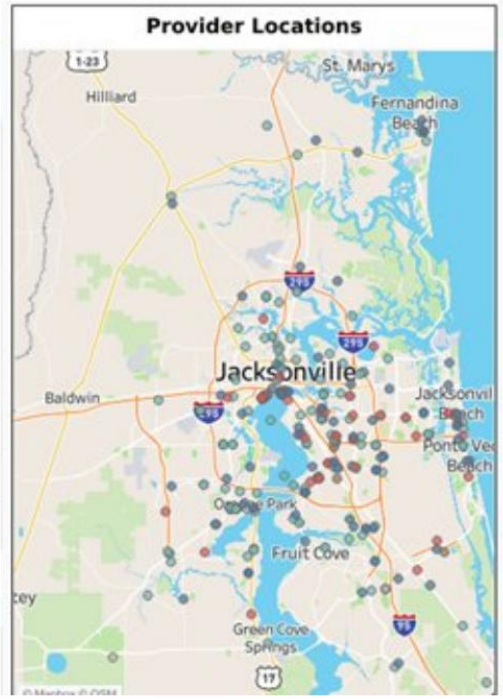
Specialty Selector
Adult Primary Care

Provider Supply and Demand Details - By Cluster

	Demand	Physician Supply	Net Need - Physician Only	APP Supply	Net Need - Including APP
Central	245.2	218.5	26.7	75.4	(48.7)
Clay County	127.3	58.2	69.1	22.7	46.4
East	138.9	135.6	3.3	25.8	(22.5)
North	124.1	41.8	82.3	19.9	62.4
South	215.3	109.2	106.1	46.5	59.6
South Expanded	52.8	37.4	15.4	4.5	10.9
West	62.1	9.3	52.8	5.8	47.0
Unassigned Zips	13.7	0.0	13.7	0.0	13.7
Grand Total	**979.4**	**610.0**	**369.4**	**200.6**	**168.8**

Provider Mix

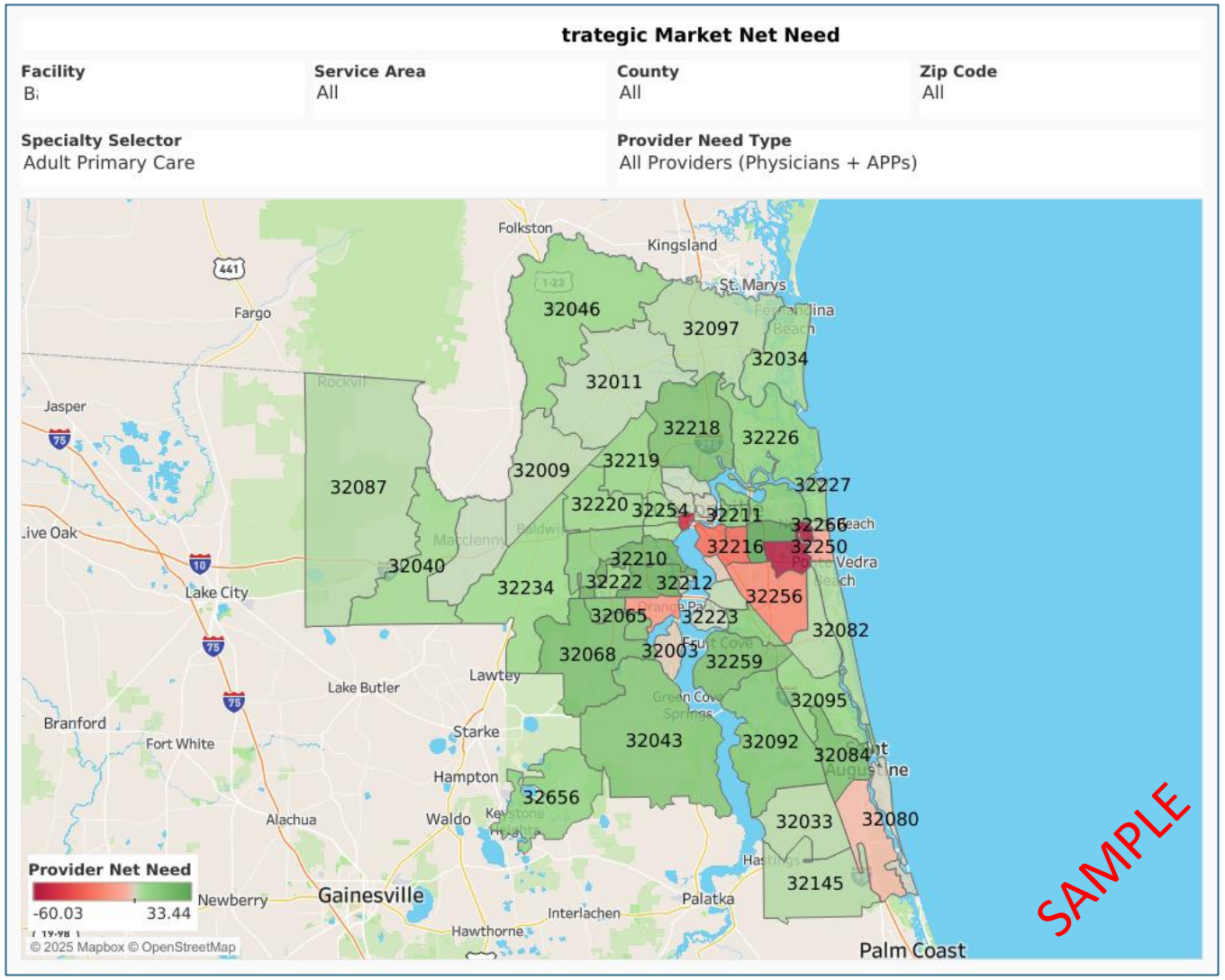
Employment Status	Physician		APP	
Employed	178.5	79%	48.5	21%
Med Staff	56.2	99%	0.8	1%
Other	374.3	74%	129.7	26%
Not Applicable	1.0	100%		
Allied Health			21.6	100%
Grand Total	**610.0**	**75%**	**200.6**	**25%**



- **Calculation of Net Need by:**
  - Service Area
  - County
  - Zip Code
- **Providers:**
  - Physicians
  - APPs
  - All Specialties
- **Key Considerations:**
  - Regionalizing provider supply and demand data is the best approach to thinking through how your provider recruitment needs may vary when focused on a specific geography or competitive dynamic.
  - Some specialties, like Adult Primary Care, are very granular. Specialties that draw from a wider service area may require aggregating data at the multi-submarket or overall market level.

Provider Supply and Demand

Regionalization of Data



- **Calculation of Net Need by:**
  - Service Area
  - County
  - Zip Code
- **Providers:**
  - Physicians
  - APPs
  - All Specialties
- **Key Considerations:**
  - Evaluating provider supply and demand data at the zip code level will produce a heat map of provider location versus population residence.
  - Specialties like Primary Care, Women's Health, and in-office procedural-based specialties typically are best leveraged "close to home."

Productivity, Access, & Capacity: Look Inside Before You Recruit

Before adding headcount, understand what you already have.

Latent Capacity

- wRVU-based productivity analysis by specialty
- Providers significantly below median = latent capacity (fractional FTEs you already employ)
- Quantify the FTE-equivalent of bringing below-median providers to median
- This capacity may offset some or all of a perceived recruitment need

Retention Risk

- Providers above 75th percentile may signal burnout risk
- High producers masking underlying access problems
- Retention risk masquerading as adequate capacity
- APPs enter proactively here — as part of the staffing model design, not a band-aid

Key question: Do I need to recruit, or do I need to optimize what I already have?

Capacity Analysis
wRVU Benchmarking by Specialty

- **Stratification of productivity by age, by specialty, by geography**
- **Measures productivity of employed providers and gives a look into capacity by specialty**
- **Comparing physician vs APP productivity can reveal operational inefficiencies in APP utilization**

SAMPLE

Facility	County	Zip Code
Jacksonville Health System	All	All

Specialty Selector
Adult Primary Care

Productivity Analysis for Employed Providers
wRVUs Compared to Benchmark Quartiles: Numbers and Percent of Providers Falling into Each Quartile

	0-25th		25th-50th		50th-75th		75th+		Grand Total	
Physician	19	10%	16	9%	26	14%	124	67%	**185**	100%
APP	11	15%	10	14%	15	21%	36	50%	**72**	100%
Grand Total	**30**	12%	**26**	10%	**41**	16%	**160**	62%	**257**	100%

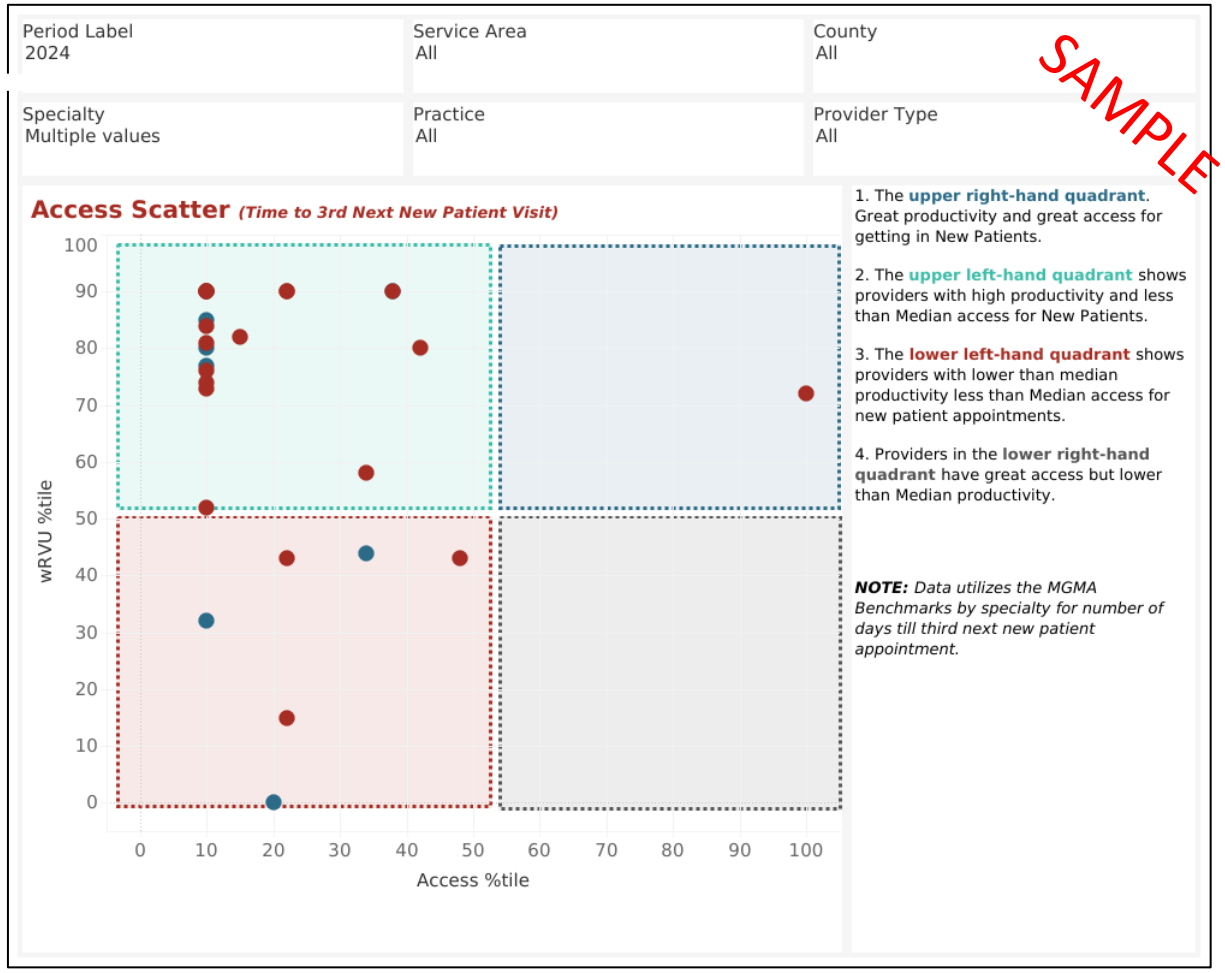
Provider Age Analysis

Provider Type	Employment Status	Unknown	Age 60 or Less	Age 60-64	Age 65 or Greater
Physician	JHS Employed		142.6	12.8	29.6
	JHS Med Staff	2.5	31.4	7.2	21.3
	Other		142.7	47.5	64.2
	Not Applicable	87.4			
APP	JHS Employed		58.7	5.6	7.7
	JHS Med Staff	1.2			
	Other	165.4			0.8
	Not Applicable				
	Allied Health	14.5	14.3	1.2	1.7

Jacksonville Health System Employed Provider Productivity by Age Cohort

	Age 60 or Less			Age 60-64			Age 65 or Greater		
	Inventory FTE	Actual wRVUs	% of Total wRVUs	Inventory FTE	Actual wRVUs	% of Total wRVUs	Inventory FTE	Actual wRVUs	% of Total wRVUs
Physician	137.4	967,562	72%	11.5	78,234	6%	36.1	287,153	22%
APP	60.8	268,427	83%	4.6	31,485	10%	6.6	22,694	7%
Grand Total	**198.2**	**1,235,989**	**74%**	**16.1**	**109,719**	**7%**	**42.7**	**309,847**	**19%**

Capacity Analysis
Access Benchmarking by Specialty



- **Time to 3rd Next New Patient Visit used as a key metric to measure patient access and supplement capacity determination**
- **Stratification of access by specialty, by practice, by geography**
- **Marrying productivity and access data tells us more than each metric independently – it helps to confirm if productive providers are actually at capacity.**
- **Operational insights can be signaled (see bottom left quadrant).**

Succession Planning: Measure Risk in Production

Age analysis alone doesn't tell you the real story.

Traditional Approach

- Count providers over age 60
- Assume 1:1 replacement
- No differentiation by production level
- Result: Imprecise, often over- or under-estimates actual need

Production-Based Approach

- Quantify wRVU production at risk by specialty
- Determine actual FTE replacement need (may be 0.6, not 1.0)
- Factor in internal capacity to absorb some production
- Result: Precise, defensible, tied to financial impact

Hospital-based specialties (anesthesia, EM, OB) in rural counties — one retirement can destabilize an entire service line.

Succession Analysis

Measure the wRVU Impact of Succession, not just Bodies or FTEs

SAMPLE

Jacksonville Health System Employed Provider Productivity by Age Cohort

	Age 60 or Less			Age 60-64			Age 65 or Greater		
	Inventory FTE	Actual wRVUs	% of Total wRVUs	Inventory FTE	Actual wRVUs	% of Total wRVUs	Inventory FTE	Actual wRVUs	% of Total wRVUs
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Grand Total	**198.2**	**1,235,989**	**74%**	**16.1**	**109,719**	**7%**	**42.7**	**309,847**	**19%**

Median FTE Replacement

Median FTE Replacement is calculated by taking the provider's actual wRVUs divided by the specialty specific Median Benchmark for wRVUs. Grouped by Age Category.

		Inventory FTE	Actual wRVUs	Median FTE Replacement
Physician	Age 60 or Less	137.4	967,562	167.3
	Age 60-64	11.5	78,234	13.5
	Age 65 or Greater	36.1	287,153	49.6
	Total	**185.0**	**1,332,949**	**230.5**

Provider Productivity Opportunity Below Median

FTE Opportunity is calculated by taking the specialty specific Median Benchmark for wRVUs and dividing by the wRVUs below the Median. This was then adjusted to the providers clinical FTE. Excludes providers with productivity > Median Benchmark and providers Age 65 or Greater.

	Clinical FTE	Total Actual wRVUs	Total Median wRVUs	wRVUs Below Median	FTE Opportunity
Physician	27.8	77,443	160,707	83,265	14.4

Succession Best Practices

- Measuring in bodies or existing FTEs may under or over-count actual needs; measure in terms of wRVUs
- Productivity at high levels cannot be assumed for new recruits – median-level is a good assumption when measuring new recruit productivity
- Measuring ramp-up of existing practices to median helps measure ability to offset recruitment needs

"We risk losing 49.6 FTEs worth of Primary Care capacity and only have 14.4 FTEs worth of incremental capacity in our existing network – meaning, if we could perfectly transition patients from retiring providers to other employed providers, **we still risk losing 28.9 FTEs worth of primary care capacity due to succession planning risk that our existing practices cannot absorb**."

Making Decisions

From Data to Prioritized Action

Provider Recruitment - What You Can Control vs. Influence

Design your strategy around the levers you actually have.

CONTROL
Employment

- Recruiting employed providers
- Retaining current team
- Optimizing productivity
- Designing MD/APP mix
- Compensation structures

INFLUENCE
Alignment

- Recruiting to aligned independent groups
- PSAs and co-management
- Building referral relationships
- Clinical integration models
- Strategic partnerships

MONITOR
Market

- Competitor activity
- National labor supply
- Residency/fellowship pipeline
- Regulatory environment
- Payer mix evolution

Prioritization: Not Every Gap Is a Recruitment Opportunity

Real-World Example (Anonymized)

A system prioritized cardiology recruitment for two years based on department chair advocacy. When supply/demand data was assembled, the market was adequately supplied in cardiology — but gastroenterology had a significant gap driving outmigration and millions in lost downstream revenue. The plan shifted. Same budget, dramatically different impact.

The Prioritization Framework

Strategic Alignment

Does this advance a service line priority?

Feasibility

Can you recruit this specialty to this location?

Financial Impact

What's the ROI and downstream revenue?

Community Access

Is there a real gap vs. a perceived gap?

Output: A ranked, defensible list — not a wish list.

Think About APPs From the Start

Build your staffing model by specialty with MD/APP mix as a design decision, not an afterthought.

APP-Led Access Extension

- Primary care and behavioral health
- Urgent care and walk-in clinics
- Chronic disease management
- Rural satellite clinic coverage

Physician-Led with APP Support

- Surgical subspecialties
- Complex medical decision-making
- Hospital-based coverage teams
- High-acuity procedural services

Ohio Context

- Tightening labor market for both physicians and APPs
- APP deployment can meaningfully address primary care access gaps in rural counties
- Behavioral health: APP-led models may be the most feasible path to expanding access
- High ED reliance in rural areas often signals primary care access issues that APPs can address

What a 3-Year Recruitment Plan Looks Like

Not a static document — a living strategic tool.

Year 1
Active Priorities

- Immediate recruitment targets
- Clear rationale tied to data
- Budget allocated
- Recruiter assignments
- Timeline to fill

Year 2
Pipeline & Emerging

- Projected succession gaps
- Growth-driven needs
- Fellowship/residency pipeline
- Alignment opportunities
- Market shifts to monitor

Year 3
Horizon Planning

- Strategic plan alignment
- Service line development
- Facility expansion needs
- Long-range succession
- Market evolution scenarios

Every line item should be traceable to at least one of the three lenses: strategic priority, community need, or internal capacity.

HSG advisors

Governance & Sustaining the Plan

The Structures that Make it Work – and Keep Working

Governance: Who Decides What Gets Recruited Where?

In multi-hospital systems, recruitment becomes political without clear governance. Hospitals compete internally, compensation varies wildly, and local advocates drive decisions without system-level context.

System-Level Prioritization

Strategic oversight committee that reviews the consolidated plan, allocates resources, resolves competing priorities across regions

Regional / Hospital Input

Local leadership provides market intelligence, clinical need assessment, and recruitment pipeline updates — feeds into system-level decisions

Single Source of Truth

One plan, updated annually with refreshed data. Everyone works from the same document. Eliminates "shadow lists" and backdoor recruiting.

Compensation Guardrails: Systemwide parameters that account for Ohio's payer environment and regional cost-of-living variation, preventing one-off deals that create downstream problems.

Alignment Models That Support the Plan

Employment isn't always the answer — and isn't always financially viable. Alignment models should be designed to support the recruitment and growth plan, not negotiated ad hoc.

High Control	**Employment** Full control. Highest cost. Best for strategic service lines and succession-critical specialties.
Moderate Control	**PSAs / Co-Mgmt** Structured alignment. Shared governance. Good for independent groups with mutual strategic interest.
Lower Control	**Clinical Integration** Network-based alignment. Quality and care coordination focus. Broader reach, lighter commitment.
Influence Only	**Referral Relationships** Relationship-based. Lowest cost but least durable. Requires ongoing cultivation.

Key: Compensation structures across all models should be consistent and defensible — guardrails that prevent one-off deals from creating system-wide problems.

The Annual Cycle: Update, Review, Reshape

A plan built on 2-to-3-year-old data is worse than no plan — it gives false confidence.

Review Progress

Update provider inventory, productivity metrics, succession planning inputs, market demographics

Refresh Data

Assess recruitment outcomes vs. plan targets. What was filled? What changed? What was deprioritized?

Reshape Priorities

Adjust the plan based on new data, completed recruitments, market shifts, and strategic plan updates

Track Pipeline

Monitor active recruitment pipeline against plan priorities. Ensure recruiter activity aligns with strategy.

The cadence matters: Annual data refresh. Quarterly plan review. Ongoing pipeline tracking. This is what separates a strategic plan from a one-time exercise.

Where to Start

1. **Define your strategic service area**
   Make sure it reflects how you actually compete — not just compliance boundaries.

2. **Audit your provider inventory**
   Compare medical staff office records against who's actually practicing. Identify gaps and ghosts.

3. **Pull your wRVU reports**
   Flag employed providers 20%+ below specialty median. That's your latent capacity.

4. **Identify your top 5 succession risks (Overall, by Service Line, by Market)**
   Rank by wRVU production volume, not just by age. Quantify what you'll need to replace.

5. **Establish a quarterly plan review**
   Get strategy, operations, and physician leadership at the same table. Create accountability.


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