WISCONSIN HOSPITAL ASSOCIATION · AUGUST 4, 2026

SEEING THE REAL MARKET

Using Claims-Enhanced Intelligence to Make Better Strategy, Access, and Growth Decisions

Internal reports tell you what happened inside your walls. This hour is about the market outside them — and how claims-enhanced market and provider intelligence turns that view into strategy, access, and growth decisions.

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THE ONE IDEA FOR THE HOUR

Internal reports tell you what happened inside your walls. They can't tell you what the market did around you.

That gap — between what your data shows and what the market is actually doing — is where strategy, access, and growth decisions go wrong. Claims-enhanced market and provider intelligence closes it: a high-fidelity picture of patient behavior, provider activity, and geographic opportunity outside your walls.

THE MARKET CONTEXT

Wisconsin at a glance

The workforce and access math facing Wisconsin hospitals is sharper than the national picture.

~2,000

Physician shortfall projected statewide by 2030 — about 942 in primary care alone

44 / 72

Wisconsin counties designated as primary care Health Professional Shortage Areas

31%

Wisconsin physicians already within retirement range

7% vs 13%

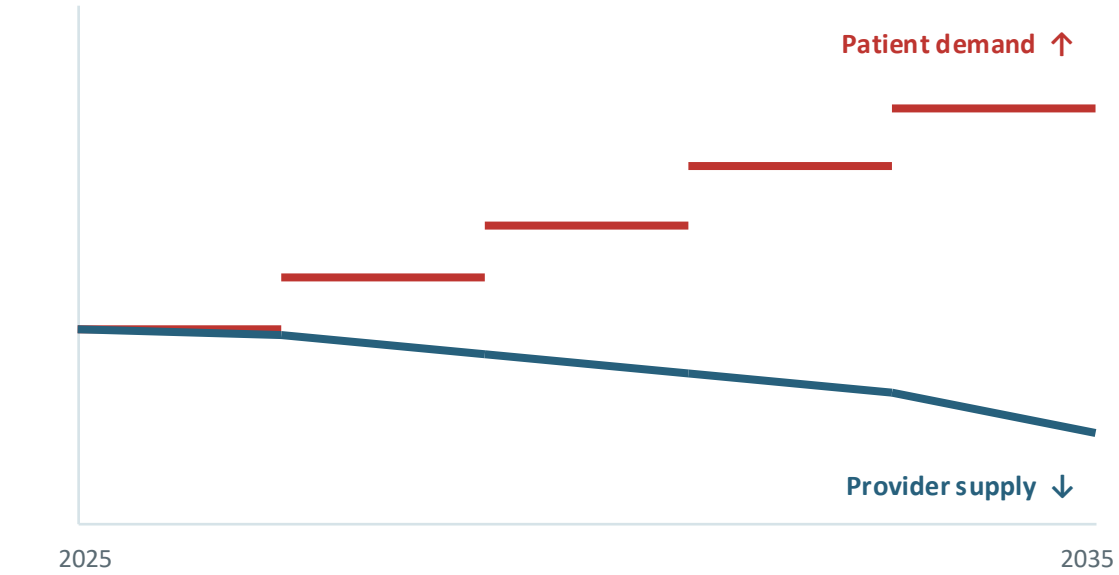
Primary care grew just 7% in a decade while total physicians grew 13%

THE HSG POINT OF VIEW *Wisconsin's rural geography, aging workforce, and county-level shortage areas compound national trends — so statewide averages hide the real opportunity. Seeing the market at the submarket level is the baseline, not a nice-to-have.*

Sources: Wisconsin Council on Medical Education & Workforce; HRSA; Cicero Institute; AHW. Figures are directional context.

THE DUAL PRESSURE

Demand is climbing while supply is falling



Aging population

By 2050 nearly 1-in-4 Americans will be 65+. Patients 75+ use physicians ~50% more than those 65–74.

Provider supply

A projected U.S. shortfall of up to 86,000–124,000 physicians by the mid-2030s; burnout and early retirement steepen the slope.

Changing expectations

Patients now expect self-scheduling, virtual options, and same/next-day access — raising the access bar.

GEOGRAPHIC MALDISTRIBUTION

The rural challenge is the multiplier

61%

of counties are primary care shortage areas

45%

of PC residents trained in WI practice out of state

278

primary care residency slots statewide per year

~100/yr

new physicians WI must add to avoid the 2030 gap

WHAT THIS MEANS FOR WISCONSIN HOSPITALS

Succession risk is front-loaded.

Rural physicians skew older; losing one high-producer can erase a community's access overnight.

APPs are necessary — but insufficient.

Advanced Practice Providers help, but the mix must be planned, not incidental.

Submarket strategy beats broad averages.

Statewide or primary/secondary lenses mask local dynamics; ZIP- and submarket-level planning reveals the real opportunity.

Retention matters as much as recruitment.

In rural Wisconsin, losing a provider often means losing a service line.

Three moves that build on one another

We focus on practical application, not analytics theory. Each move connects data to a real decision — with a short discussion prompt to apply it to your own organization.

1

See the real market

Define the market the way patients actually use it — and measure the outpatient and ambulatory activity your internal data can't see.

2

Find leakage & opportunity

Use patient flow, productivity, access, and market share to locate hidden leakage, growth zones, and the provider gaps behind them.

3

Turn insight into decisions

Connect the data to service line strategy, access, and investment choices — on a cadence, with a partner, not a one-time report.

Better data in. Aimed at the real market. Turned into decisions that hold.

01

MOVE 1

Seeing the real market

Before you can measure opportunity, you have to define the market the way patients actually use it — and see the activity that never touches your inpatient data.

Most of the market happens outside your walls

INSIDE THE WALLS

- Inpatient discharges & HOPD volume
- Your EHR and internal reporting
- Service line P&L and productivity
- What your own patients did with you

Shows what happened inside — roughly half the picture.

50–80%

of most systems' revenue lives outside the hospital — where internal data can't see it.

OUTSIDE THE WALLS

- Outpatient & ambulatory market share
- Where competitors capture volume
- How patients move across the market
- Provider supply, demand & migration

The all-payer, market-wide view internal systems can't produce.

Claims-enhanced analytics supply the outside view — where patients go, what competitors capture, where the market moves.

STRATEGIC SUBMARKETS

Define the market the way patients use it

The legacy trap

Primary / secondary / tertiary definitions built on inpatient discharges hide outpatient opportunity, blur competitive dynamics, and treat geographically diverse areas as one.

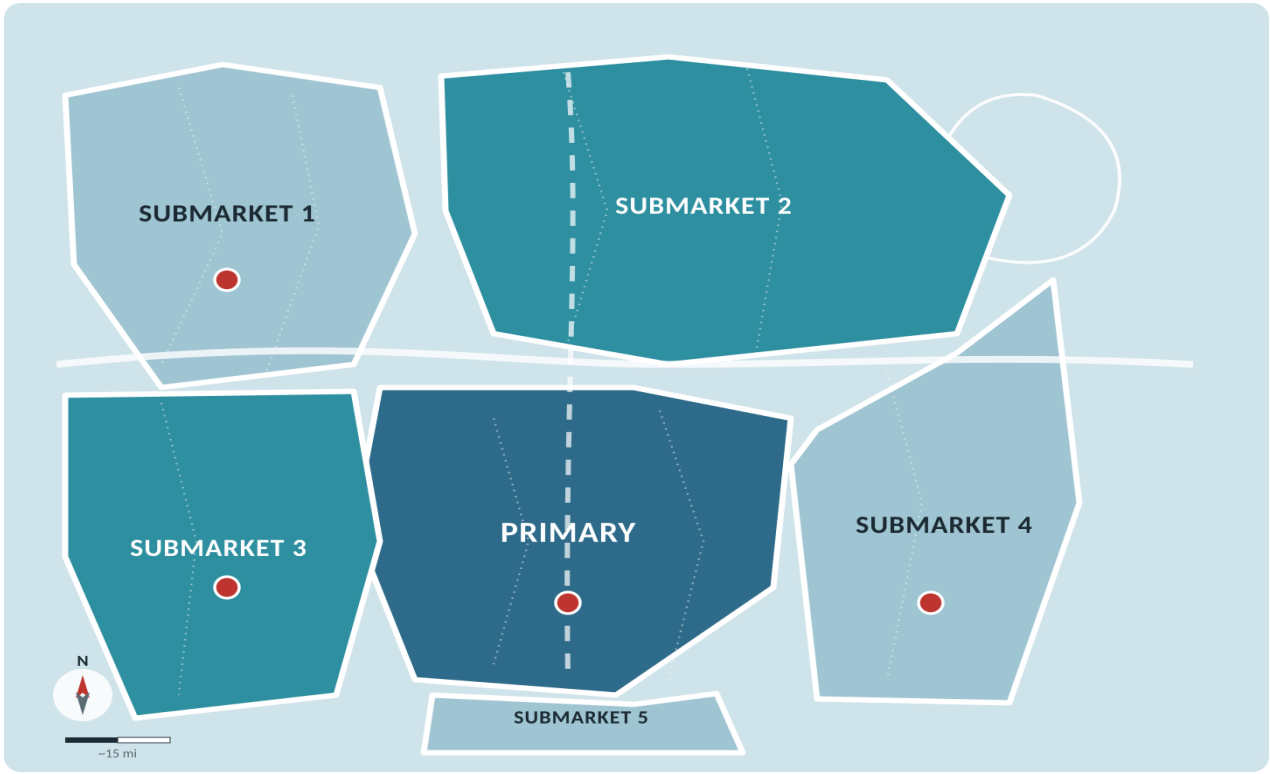
The HSG approach

Non-overlapping strategic submarkets, drawn from how patients actually behave — so each area gets the strategy it needs.

SUBMARKETS ARE BUILT FROM

- Common routes of travel
- Historic penetration
- Demographically similar populations
- Common competitive threats
- Strategic priority

ILLUSTRATIVE SUBMARKET MAP



Each submarket gets its own read — and its own play. ● *= our access points*

ONE MARKET, MANY LENSES

The data sets that make the market visible

IP / HOPD Market Share

Complete inpatient & hospital-outpatient share from state hospital association data.

Outpatient & Ambulatory Share

All-payer, CPT-level share across ASC, practice, and retail sites — the growth battleground.

Patient Flow & Retention

How patients move provider-to-provider — where the network holds and where it leaks.

Provider Productivity

wRVU production benchmarked to MGMA — who is above and below median, and by how much.

Patient Access

New-patient access measured as days to 3rd-next-available — the real front door to the market.

Provider Need & Age / Capacity

Supply-vs-demand, provider age and succession risk, and the FTEs behind each retiring producer.

Provider Specialty Share

Specialty-level presence across the market; who is ramping up or down, and where.

Market Demographics

Population, age, growth, income, and insurance mix at ZIP and county level.

All-payer claims turn these lenses into one measurable, comparable market picture — inpatient through ambulatory.

DISCUSSION 1

Take it back to your own organization.

DISCUSS / POLL AT YOUR ORGANIZATION

When you define your market today, is it built on inpatient discharges — or on how patients actually seek care across every setting?

What would change if you could see the ambulatory half?

Sets up Move 1 — seeing the real market.

02

MOVE 2

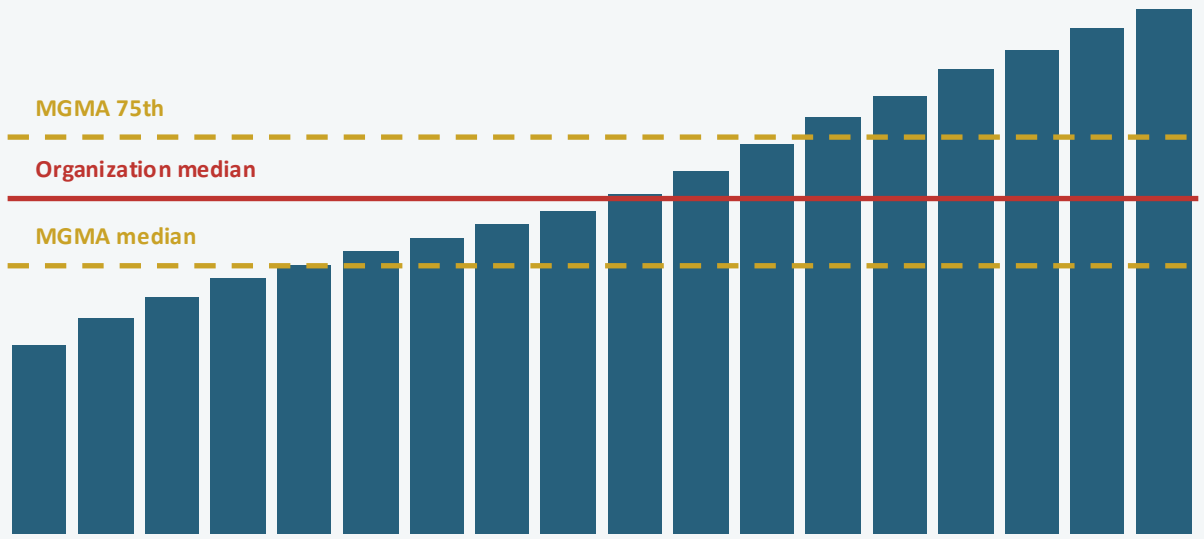
Finding leakage and opportunity

Productivity, access, market share, and patient flow together pinpoint where you're losing patients, where the high-value growth sits, and which provider gaps are driving both.

STEP 1 — WHAT THE FIRST CUT SHOWS

Case study: the productivity story

EMPLOYED PRIMARY CARE wRVUs — SORTED LOW TO HIGH



WHAT THE DATA SAYS

Fantastic productivity.

Median wRVU production sits above the MGMA benchmark, with several providers well past the 75th percentile.

THE ASSUMPTION

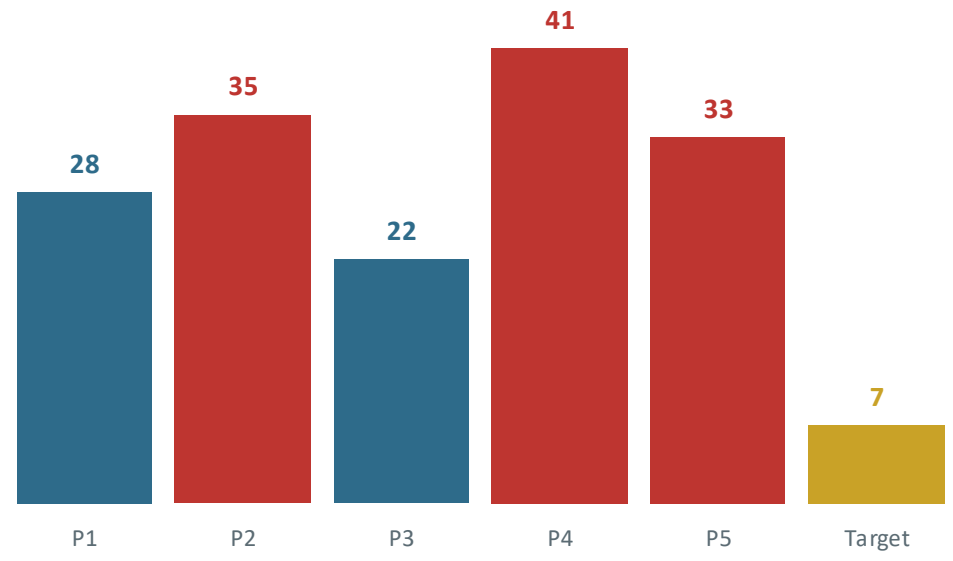
"We should be crushing primary care in our market."

Hold that assumption — two more data cuts will test it.

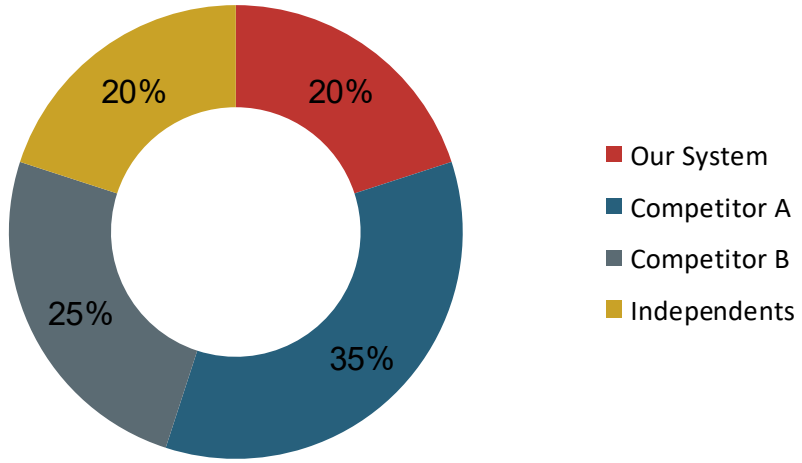
STEP 2 — OVERLAY ACCESS & MARKET SHARE

The story shifts with access and share

NEW-PATIENT ACCESS — DAYS TO 3RD NEXT AVAILABLE



PRIMARY CARE MARKET SHARE — TOTAL MARKET



The picture just shifted: access is poor (28–41 days vs. a 7-day target) and you hold only 20% of your own market. High productivity is masking a capacity ceiling.

STEP 3 — CAPACITY & REPLACEMENT

Succession risk adds fuel to the fire

34%

of primary care capacity is over age 60

25%

at risk of exiting in the next 2–3 years

1.5–2.0

median FTEs needed to replace one retiring high-producer

OPPORTUNITIES

- Improve access for providers not yet at 75th+ productivity
- Recruit strategically to backfill succession exposure
- Expand primary care footprint into adjacent geographies
- Rebalance APP mix — intentional, not incidental

THREATS

- Market share loss portends rising outmigration
- Succession will compound near-term access issues
- Low barriers to entry for larger systems & retail
- Existing staff can't absorb retirement loss — all already producing high

MARKET EVALUATION FRAMEWORK

From market signals to a prioritized play

The same market read applies at two levels — the strategy for each submarket, and the play for each provider or practice within it.

SUBMARKET STRATEGY

Reinforce & Defend

Strong share, low incremental need — protect access, plan succession.

Grow

Unmet need near your resources — expand primary care and ambulatory.

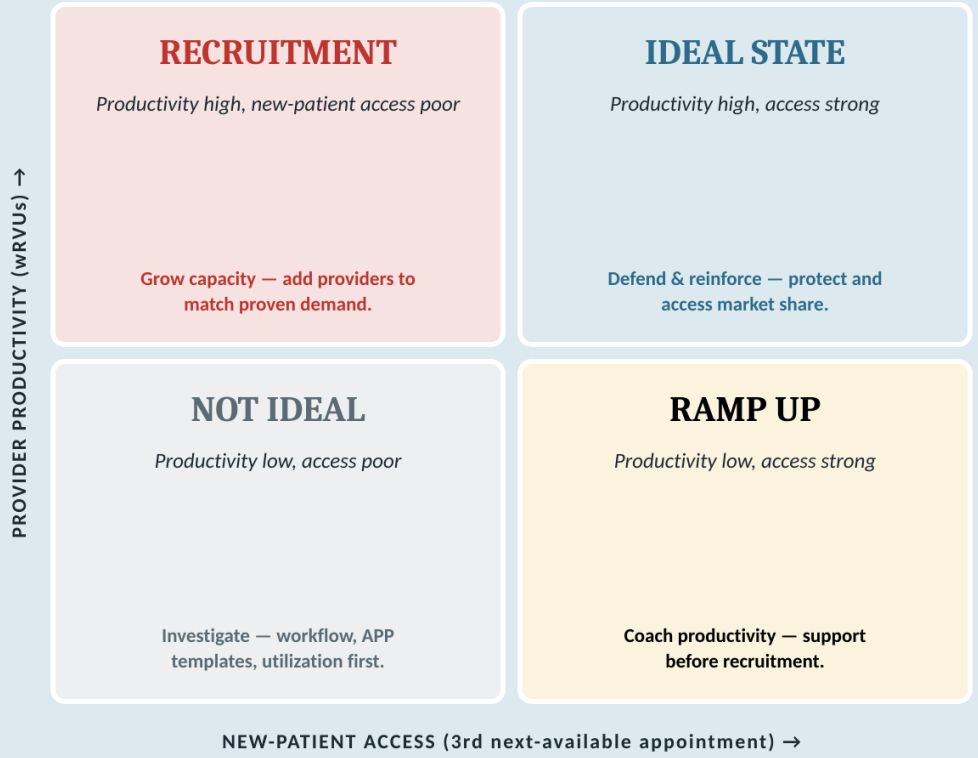
Penetrate

High demand but entrenched — enter only with investment to disrupt.

Deprioritize

Low demand, encroaching competition — reallocate with intent.

PROVIDER & PRACTICE STRATEGY · ACCESS × PRODUCTIVITY

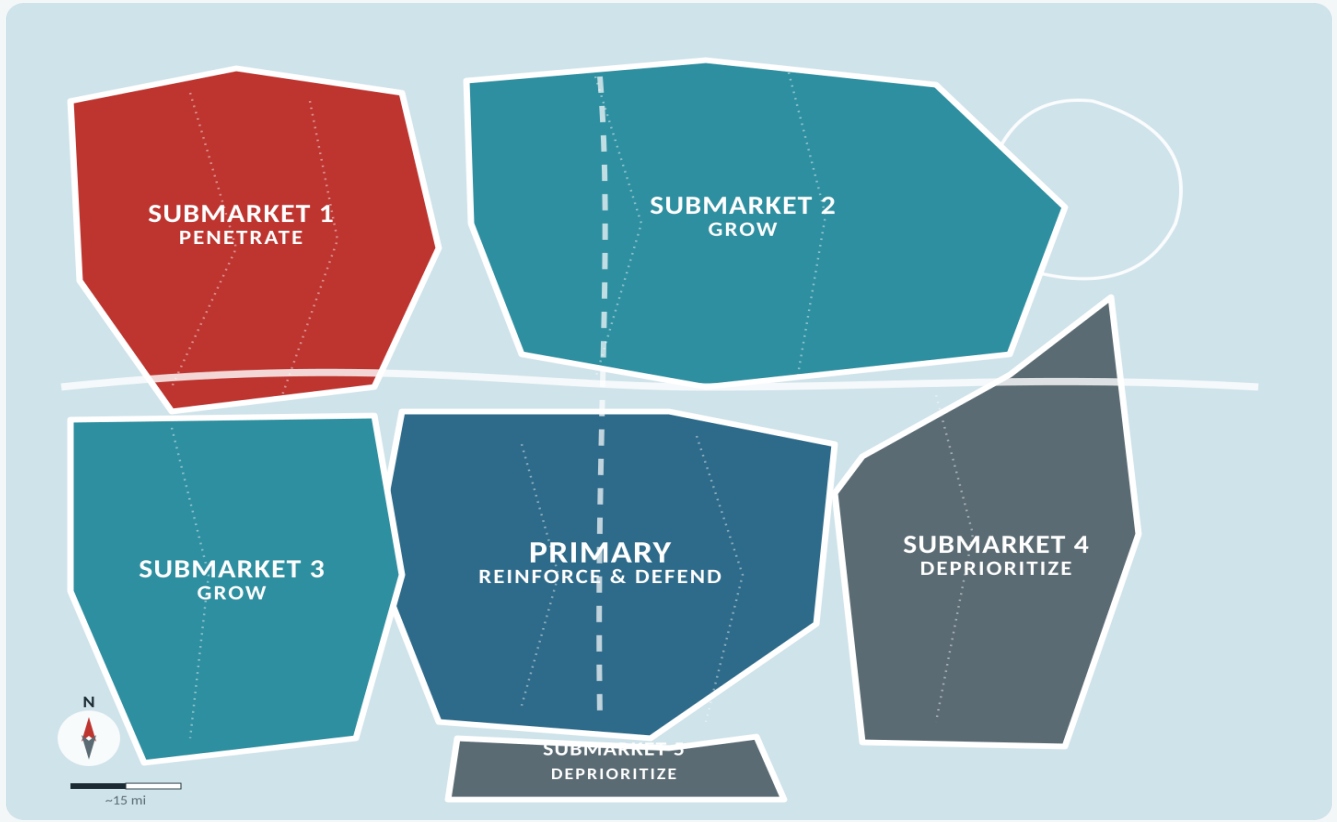


Same market signals — a defensible play for every submarket, and every provider within it.

FRAMEWORK IN ACTION

Applying the signals: every submarket gets a play

ILLUSTRATIVE — SUBMARKETS SCORED & ASSIGNED



Reinforce & Defend PRIMARY

Strong share, low unmet need — protect access and plan succession.

Grow SUBMARKETS 2 & 3

Unmet need near your resources — expand primary care and ambulatory.

Penetrate SUBMARKET 1

High demand but entrenched — enter only with investment to disrupt.

Deprioritize SUBMARKETS 4 & 5

Low demand, encroaching competition — reallocate with intent.

The same market signals, applied — turning one map into four distinct, defensible strategies.

DISCUSSION 2

Take it back to your own organization.

DISCUSS / POLL AT YOUR ORGANIZATION

Name one growth or recruitment decision you made in the last year. What did you assume about productivity, access, or leakage — and how would you have tested it with market data?

Builds on Move 2 — leakage and opportunity.

03

MOVE 3

Turning insight into decisions

Data only matters when it reaches the decision. That takes a repeatable framework, the right view for each leader, and a partner who stays between the big decisions.

One source of intelligence, a view for each leader

ONE SHARED MARKET PICTURE

Strategy & Growth

Where to grow, where to defend, which service lines and geographies to fund — with the market math behind it.

Physician Network

Where the network leaks, where alignment sits, and which specialties and locations need providers.

Finance & Board

The investment case and the cost of getting it wrong — one number and the 'so what' for the board.

Same numbers, no competing spreadsheets — each function sees what it needs to act.

WHAT THIS LOOKS LIKE IN PRACTICE

An illustrative decision, changed by the outside view

The setup: A regional system planned to add two cardiologists at its main campus, based on inpatient volume and internal wait times.

1

The outside view

Claims showed outpatient cardiology migrating to a neighboring county, employed-PCP referrals leaking to a competitor, and unmet demand two submarkets over.

2

The decision changed

Place one cardiologist plus an APP-supported clinic in the growth county, and fix the referral leak — instead of concentrating both at the hub.

3

The result

Recruitment dollars followed real demand, retained referrals recaptured downstream volume, and Strategy, Network, and Finance worked from one picture.

Same providers, same budget — a better decision, because the market picture was complete and shared.
Illustrative scenario for discussion; not a specific client engagement.

Keeping the picture complete — on a cadence

Market intelligence goes stale. It stays useful only when it's refreshed on a predictable cadence — so results are tracked against the plan, not rediscovered each year.

CONTINUOUS

Data governance

Market share, patient flow, and provider data kept current — one clean, consistent source for every function.

QUARTERLY

Decision sessions

Refreshed views feed a real working strategy conversation — a decision session, not a slide dump.

ANNUALLY

Strategic reset

Step back, measure results against the plan, and recalibrate where to defend, grow, penetrate, or reallocate.

The difference between a report and a partnership: the intelligence stays complete, current, and shared.

DISCUSSION 3

Take it back to your own organization.

DISCUSS / POLL AT YOUR ORGANIZATION

Where does market insight get stuck in your organization — which team has data another team needs but never sees?

What is one decision you'd revisit if you had the outside-the-walls view?

Turns Move 3 into one concrete next step.

THE THREE MOVES, BROUGHT HOME

Seeing the real market — start to decision

1

See the real market

Define the market by patient behavior, and measure the ambulatory half your internal data can't see.

2

Find leakage & opportunity

Read productivity, access, share, and flow together to locate leakage, growth zones, and provider gaps.

3

Turn insight into decisions

One shared picture, a view per leader, refreshed on a cadence — connected to real choices.

Complete data in. Aimed at the real market. Turned into decisions that hold.

Thank you.

Let's keep the conversation going. HSG is built to be a growth intelligence partner between the big decisions, not just for them.

HSG is a growth intelligence partner.

Claims-enhanced analytics surface what's changing in the market. An HSG partnership team translates it into strategy and execution. AI-augmented delivery accelerates the work.

For hospitals, health systems, physician groups, FQHCs, and hospital associations.

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