

Hospitalist Management Advisor

Finding the right ratio of physicians and patients is essential for efficiency

Determine the appropriate staffing level for your hospitalist program

As hospital reimbursement from insurance companies continues to drop and physician salaries rise, finding the right physician-to-patient balance is crucial to running a cost-effective hospitalist program.

Richard E. Rohr, MMM, MD, FACP, vice president of medical affairs at Cortland (NY) Regional Medical Center, says hospitalist programs should consider quality of care when creating this balance. "There's a delicate blend of trying to increase the number of patients your physicians can see on a daily basis with the number of patients your physicians can give safe, efficient care [to]," he says.

The false economy of hospital ratios

When a hospital increases its patient volume, it can lose productivity, lengthen patient hospital stays, decrease

patient satisfaction, and change the appropriate level of staff utilization, says Rohr.

"When trying to see more patients in a day, you wind up cutting back on time with a patient or gloss over them superficially, which causes things to get missed," he adds. "You're really creating a false economy because you're seeing more patients than you can handle."

What the hospital loses in efficiency is not made up in savings on physicians' salaries in most cases,

"Ensuring that your hospitalist service is properly staffed is a universal challenge for everyone."

—Shaun Frost, MD

Rohr says. Having fewer hospitalists, especially ones who are overworked, could decrease the quality of care and raise the chance of mistakes, he says. This can lead to increased length of stays, resulting in lower insurance reimbursement. Additionally, it is likely the hospital will incur more morbidities and mortality, causing long-term costs to skyrocket.

Reconfiguring your physician-patient ratio

There is no easy formula for how many physicians the hospital needs to appropriately staff hospitalist programs, says **Shaun Frost, MD**, regional medical director at Cogent Healthcare in St. Paul, MN.

Even if you know how many hospitalists you need in your program to achieve ideal staffing levels, there simply may not be enough hospitalists available because of the national shortage.

"Ensuring that your hospitalist service is properly staffed is a universal challenge for everyone ... in the industry," says Frost. "There's a mismatch between jobs in the country and the candidates to fill them, which makes it tough to keep the ratio correct even when you know what level you want to be at."

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HCPPro

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Despite challenges to fill hospitalist spots, it is essential to find a staffing level that does not overwork your existing physicians and allows them to pursue other professional activities. When trying to determine the right staffing ratio for your facility, Frost says to examine the following:

- Daily patient volume (i.e., how many patients are in the program)
- Daily patient encounters (i.e., how many times the physicians visit with patients each day)
- Experience level of staff physicians
- Access to nonphysician care staff such as case managers and midlevel providers

- Needs in specialty areas in your program (i.e., more ICU patients might require more physicians)
- Nonclinical expectations of the physicians (e.g., education, publishing papers, committee work)

A closer look at patient volume

Your patient volume is the most obvious indicator of what your staffing level should be. As patient volume increases, it also makes sense to increase the number of physicians. The difficulty in maintaining this ratio is that physician volume and daily patient encounters vary by program, says Frost.

The severity of patients' illnesses affects how much time the physician spends with each patient and, therefore, greatly affects the patient-physician ratio for your program, he says. The ratio depends on the number of new admissions, surgical consults, and discharges, factors which vary by time, day, or season. For example, hospitals in Florida often see a huge influx of patients, especially older patients, during the winter months as people travel from the northern states for better weather, says Frost. That increase in patient load can be tough and may require the hospitals to hire seasonal staff or locum tenens practitioners.

Because most hospitals don't enjoy the flexibility of hiring part-time or seasonal physicians, the staffing ratio should account for seasonal fluctuations. The hospitals without part-time physician options sometimes experience understaffing during the peaks or overstaffing during the lulls.

One other thing to consider with volume is strategic growth, says Rohr. If you feel the hospitalists are overworked, it might indicate that there is excess patient volume. That volume means there is the potential for more revenue, a selling point for the hospital administration. The administration is more apt to take advantage of the potential revenue if your program demonstrates its ability to get patients in quickly, treat them, and get them out without complications, says Rohr.

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Experience, support, and professional pursuits

Another consideration for targeting the appropriate staff ratio is the level of physician experience. There is often a direct correlation between experience and efficiency, Frost says. He suggests building in extra time for younger physicians to improve when determining the right staffing mixture.

“Younger physicians oftentimes are less efficient in their ability to process work flows, which is just a reflection of inexperience,” says Frost. “As hospitalists move further away from their residency, they develop an enhanced ability to multitask and, over time, they are able to see more patients a day, which can be a relevant consideration when contemplating staffing ratios.”

In addition to looking at individual experience levels, you should consider the program’s overall specialties. Determining how specialized your program is will also alter the need for physicians, says Rohr. For example, if your practice often follows up with surgical consults, you may be able to see significantly more patients than a program that deals mostly with new admissions, since the latter can take up more of a physician’s time.

Physicians’ nonclinical duties vary by seniority, type of facility, and personal desires. To keep physicians happy in their careers, you need to let them have the time to explore other professional pursuits. Giving physicians time to teach or participate in hospital committees will often benefit your program with a better overall physician attitude and retention rate, because they won’t feel the need to leave your program to pursue other ventures, says Frost.

One area that hospitals have the most control over is the amount of support staff they can allot to the hospitalist program, says Rohr. Whether it is adding case managers, midlevel providers such as nurse practitioners or physician assistants, or simply more administrative staff, anything you can do to ease physicians’ responsibilities will make them more efficient at patient care.

In addition, Rohr says he believes in providing physicians with the best technology possible. “Most hospitalists spend only about 35% of their time on the floor

speaking with and treating the patient,” Rohr says. “The rest of the time is spent looking at labs and charts, at the nurse’s station, or writing notes.”

Anything you can do to speed up those processes will allow physicians to spend more time with their current patients or see a few more patients per day, he says.

A more efficient hospital

Hospitals still haven’t figured out the best way to utilize hospitalist programs, Rohr says.

Because so many hospitalist programs are now 24/7 operations with in-house as opposed to on-call physicians, hospitals can stabilize, yet raise, the fixed costs. That overnight shift will rarely increase the hospital’s volume, but it still needs to be accounted for when determining ratios.

The ideal situation, Rohr says, is for the hospital to have several physicians work during morning hours to do rounds for labs and tests and set up for the day. Then the remaining shifts can be spread out during the day. However, unless the hospitalist group is very large, this is not often possible because many physicians do not want to work part-time or split shifts.

“Hospitals are still trying to adjust to this new world where they want to provide around-the-clock coverage, but the staffing and the dollars aren’t always there,” says Rohr. “A lot of the responsibility falls on the hospitalist program director to create schedules that work for the physicians and the patients and that work with the budget they are given.”

If the director can’t figure out how to make the schedule and budget work, that’s when programs fail, says Rohr. “I’ve never heard of a hospitalist program failing because there weren’t enough patients,” he says. “They fail because there are too many patients for them to handle, and it leads to poor, inefficient coverage.”

Hospitalist programs’ biggest value to a hospital is the ability to improve efficiency and allow physicians to see and treat patients. If your program isn’t allowing both of

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those to happen, it's time to reevaluate your staffing levels, says Rohr.

No simple answer

Despite all the options hospitals have for improving their staffing ratios, there is still no simple answer for what the appropriate level is, says Rohr.

"There are a number of formulas that people have tried to create, but none of them are really good," he explains. "It's done on the basis of what your institution can afford

and what physicians you can get. It's difficult to determine this scientifically."

There are statistics: The reported range of patient encounters per day for a hospitalist is generally 11–18, according to the Society of Hospitalist Medicine, says Frost. It's a wide range that depends on different aspects of programs.

"Every hospital needs to take all of their individual factors into account and do what's appropriate for their particular situation," says Frost. ■

Case study

Transitioning from family medicine to hospital medicine

Editor's note: This article is the second in a series that will explore the benefits of using family medicine hospitalists as a response to the current hospitalist shortage.

David Hoffmann, DO, worked for years in a community health center and family practice. He worked with a range of people and procedures, from babies to adults, from routine checkups to not-so-routine flexible sigmoidoscopies. He loved the clinical and personal aspects of the job equally. So when Chambersburg (PA) Hospital approached him in 2003 to head its new hospitalist program, promising the same professional diversity he enjoyed as a family medicine (FM) physician, he didn't hesitate. In fact, he says his FM training and experience could not have prepared him better for such a rewarding transition.

"Most of us who worked in private practice have that important experience with family, psychosocial, and life and death issues, in addition to the clinical piece," says Hoffmann. "You need all of that experience here, so I think it's a great job for [FM] physicians."

Birth of a program

Chambersburg Hospital, a 235-bed facility 90 minutes from a metropolitan area, unveiled its hospitalist program

in 2003 with four full-time physicians running a 24/7 operation. The hospital also relied on some of its pediatric physicians and several moonlighters to cover additional shifts.

Rounding out the schedule was not always easy to arrange, Hoffmann says. The pediatric physicians asked for extra pay to cover the additional shifts at night, and the hospital was initially reluctant to accommodate them.

"We had to point out how beneficial it was to everyone," says Hoffmann.

The hospital agreed to reimburse the pediatricians, who in turn provided night coverage for newborns when the internists were working.

Hoffmann's group, the Hospitalists of Franklin County, began modestly with just two family physicians and two internists.

"There was definitely some cost savings and utility in having a family doctor in the hospital," he says. For example, the convenience of having a physician on staff that could visit the OB floor and see a woman who just gave birth was invaluable to the hospital.

Within several months, the success of the program allowed the hospital to hire two more physicians. Today, the group has 10 full-time hospitalists on its staff—five

family physicians and five internists. The equal ratio wasn't just a coincidence.

"I think working together is a great learning experience for both [groups]," he says. "While [the family physicians] have more experience with the softer side of medicine, the internists have more internal medicine experience, and we can learn from each other."

The hospitalist program is ideal for FM physicians because it fosters teamwork and education. Every day, the hospitalists hold meetings at 7 a.m. and 2 p.m. to discuss specific cases. The physicians brainstorm the best approaches for patient care.

"It's the best kind of peer review; these are concurrent discussions about ongoing cases," Hoffmann says.

He adds that the peer review approach is an ideal option for someone straight out of an FM residency program who might lack inpatient medicine experience. Residency programs can vary, and students may graduate with different degrees of ability. It is important for the program director to understand that younger FM physicians may not yet have the inpatient pedigree, and they may need guidance.

In addition to providing an environment conducive to education, Hoffmann's group provides a clinical balance that ensures each physician is treated as an equal.

"In our program, we feel like there is a definite value [in this balance]," he says. "We are a tight, cohesive group."

Recruiting for FMs and internists as hospitalists

Although the program recruits heavily, Hoffmann says qualified family physicians are not as easy to find as qualified internists. The challenge is to maintain an even split of internists to family physicians as the program grows.

"We've been lucky, but I wonder if we will be able to find any FM physicians in the future, even though I believe it is a great job for them," he says.

Hoffman explains to candidates that they do not necessarily have to give up the most enjoyable portions of their job to transition to a hospitalist program, as exemplified by Hoffman's own personal experience when he integrated family medicine with hospital care. "The family

doctors we recruit don't want to give up pediatrics, but our program gives them the opportunity to [work in] pediatrics and [with] newborns," he says. "We use that as a recruitment tool."

Hoffman also notes the benefits of a hospitalist program, such as job satisfaction and appreciation from clinical peers. He adds that, especially in a midsize community hospital, hospitalists can respond to many unassigned patients, which lowers stress for other physicians.

FM training, skill sets are job qualifiers

The FM residency training covers individual patient care and the broader patient perspective, Hoffmann says. Whether that is knowing how and when to get a patient's family involved in a substance abuse case or spotting depression, FM physicians tend to get more outpatient training, which serves them well in their hospitalist role.

FM physicians also receive a broad-based education that qualifies them to respond to many situations. For example, if a female presents with abdominal pain, the FM physician has the skill set to conduct a gynecological evaluation. FM training might also give the physician a better understanding of agencies and various institutions within a community that can serve as additional resources in patient care, Hoffmann says.

Because the hospitalist group is a clinical team, team players thrive in the hospitalist role. FM physicians just out of residency are far more likely to be flexible and take on an extra admission at the end of a shift than traditional family doctors and internists. They are also far more likely to come to a consensus as a member of a team, a characteristic that program directors love, than the older physician who may be rigid about doing things his or her way, says Hoffman.

Constructive feedback from referring physicians

At Chambersburg Hospital, all of the family physicians at the hospitalist program are members of the family practice department. Each month, these physicians, whose patients the hospitalists care for, conduct peer reviews.

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Family medicine

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“If there is a problem, [the family practice physicians] just call me up instead of privately telling people we’re not doing a good job or quietly stewing,” Hoffmann says. “Whenever I get those calls, I tell them that I don’t love the fact that they are complaining, but I love the fact that they are communicating with me.”

The emphasis on communication allows the group to maintain strong relationships with referring physicians. Even though Chambersburg Hospital currently has the only hospitalist group in the area, Hoffmann feels

confident that the strong ties will keep physicians from switching allegiances if another program opens up shop.

The future for the hospitalist program

Hoffmann says he expects the program will continue to grow, and that the challenge will be to maintain a balance between internist and FM physicians. He is also exploring recruitment of private practice veterans—physicians in business for some time who struggle to stay open while managing their overhead costs. ■

Patient-physician ratio affects LOS, study says

An ideal model for patient care is one hospitalist per patient, with the physician overseeing his or her entire hospital stay. But in reality, this model isn’t so easy to achieve.

A new study, “The Impact of Fragmentation of Hospitalist Care on Length of Stay and Post-Discharge Issues,” published by IPC The Hospitalist Company, Inc., states that limiting the number of primary physicians that care for a patient during a length of stay (LOS) can have tremendous benefits.

The study, presented in April at the Society of Hospital Medicine’s annual meeting in San Diego, focused on patients with pneumonia and congestive heart failure (CHF) from December 2006–November 2007.

The results showed a correlation between the number of physician encounters and patient LOS, says **Kenneth Epstein, MD, MBA**, director of medical affairs and clinical research at Hollywood, CA–based IPC The Hospitalist Company, a faculty member at the University of Colorado School of Medicine in Denver, and the lead author on the study.

“Our results suggest that if the same hospitalist takes care of a patient for the majority of his or her stay, then the patient’s LOS is demonstrably shorter than if [his or her] care is handled by multiple hospitalists,” explains Epstein.

Study setup

The study created a formula that addressed how many hospitalists (nonspecialty physicians) a patient saw during his or her stay in the hospital. The study identified the physician who treated the patient most frequently as the primary physician. The total number of days the patient was in the hospital was subtracted by the number of days the primary physician saw the patient. That number was then divided by the LOS to come up with a fragmentation percentage.

For example, if a patient was in the hospital for five days and saw the primary hospitalist three times and other hospitalists twice, the fragmentation rate was considered to be 40%; if the patient saw just one hospitalist, the fragmentation rate was 0%.

To gather consistent results, the organizers limited the study to patients with particular illnesses, focusing on pneumonia patients with complications or comorbidities (DRG 89) and patients with CHF or shock (DRG 127). Overall, the study surveyed about 8,500 patients with CHF and 1,700 patients with pneumonia at 223 hospitals.

Study organizers primarily tracked LOS, but they also looked at three patient care qualifiers during the two days postdischarge. Specifically, they were concerned whether the patient:

- Experienced worsening of symptoms
- Had problems getting medications filled
- Had problems getting follow-up care

Study results

The study found that for every 10% increase in fragmentation, pneumonia patients stayed almost a half-day longer in the hospital, and CHF patients stayed more than one-third of a day longer. It also found that although patients' symptoms didn't get statistically worse after discharge, and patients didn't have more problems getting medications filled with increased fragmentation, there was a 25% increase in problems getting follow-up appointments, says Epstein.

Patients had a harder time getting follow-up appointments because of the lack of continuity, Epstein says. The hospitalist responsible for discharge might not know all the patient's limitations and thus won't be able to offer correct referrals or all the necessary information.

"It's clear that fragmentation results in a drop of care, and it's pretty obvious why if you think about it," says Epstein. "Any physician will tell you that they are able to do a better job if they see a patient more than once and can follow up on tests."

Fragmentation solutions

The problem with reducing fragmentation is that a physician can't work all the time to ensure he or she follows every patient from admission to discharge, Epstein says. It's really about getting to know the patients' needs, he says, and that's not always possible if a patient sees four physicians in four days.

Although the solution isn't an easy one, Epstein says there are ways hospitals can reduce fragmentation:

- **Create block schedules so physicians are in the hospital for consecutive days more often.** "There are a lot of different staffing models out there and ways to work a schedule, but we felt most of them were based on what was best for the physicians," says Epstein. However, scheduling physicians' time in the hospital is much easier in theory than in practice. Some physicians like

working a day-on, day-off schedule. Some may have other responsibilities that don't allow them to work three or four days in a row.

- **Improve the communication during physician handoffs for a complete and efficient process.** When a physician's schedule does not conveniently line up with every patient's stay, it is crucial to have effective handoffs to reduce fragmentation, Epstein says.

Handoffs can be done in many ways. IPC is trying new technology to increase in-person and phone call conversations between physicians during these transitions, says Epstein. IPC hospitalists are experimenting with e-mail and Web sites to make sure the hospitalist taking over has all the information necessary.

"There's still no substitute for face-to-face conversations about a patient [during handoffs], but access to anything the oncoming hospitalist needs can eliminate some of the fragmentation issues," says Epstein.

- **Think of the effect your scheduling has on patients.** "Hospitals are so worried about recruitment and retention that they base their schedules off making physicians happy and not what makes for the best patient care," says Epstein.

"Physicians might not be used to [the new schedules], but if you talk to just about any physician, they'll understand why it's better for the patient," says Epstein. "No physician will say they provide better care for their patient by only seeing them for one day."

Other fragmentation factors for the future

As IPC continues to analyze the study data, it is already looking ahead to how it can improve its hospitalist programs. With so many hospitalist groups across the country, IPC continues to try different staffing models and getting physicians to adjust to nontraditional schedules.

IPC is also looking at how fragmentation affects patients differently during the weekend, at night, and during the week, says Epstein. Some of the fragmentation results may be due to other parts of the hospital, such as getting labs or scans performed, he adds.

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LOS < continued from p. 7

But IPC continues to focus on what is best for the patient. Epstein says this study is the start of collecting empirical evidence that shows staff schedules can really affect patient outcomes. He hopes that as IPC gathers more data, steps can be taken to help create a hospital environment that will lead to better physician access for patients. Epstein says this study is just the tip of the iceberg regarding the types of data that can be discovered by looking at how different hospitalist models affect specific aspects of patient care. ■

Editor's note: IPC The Hospitalist Company, Inc., is a leading physician group practice company focused on the delivery of hospitalist medicine services. IPC's physicians and affiliated providers manage the care of hospitalized patients in coordination with primary care physicians and specialists. IPC has approximately 700 physicians in 200 practices across 16 states. This particular study was coauthored by Esther Juarez, Kathy Loya, and Adam Singer, MD, of IPC and Anne Epstein, PhD, assistant professor at the Division of Healthcare Policy and Research at the University of Colorado School of Medicine in Denver.

Real estate slump can affect hospitalist shortage

You've heard it before. The real estate market is in the midst of a colossal nosedive. The values of homes are plummeting. If you're a hospitalist program director, though, the bad news doesn't end there.

Research from Delta Physician Placement, a national healthcare staffing agency in Dallas, suggests the current decline in the real estate market might be affecting hospitalist programs, namely efforts to recruit and hire physicians from out of town.

Scott Hurst, the director of consulting at Delta, says he first heard about the possible connection between the real estate market and recruitment struggles when casually speaking with a hospitalist colleague in 2007. After surveying many of Delta's 25 physician recruiters, Hurst found that every one of the surveyed recruiters cited the real estate market as a determining factor for physicians when deciding upon a position out of state.

"I learned that it was clearly an issue with physicians looking to relocate," Hurst says. "This was especially true where the market is more heavily affected in places like Phoenix and California."

Aaron Gottesman, MD, FACP, CHCQM, the director of hospitalist services at Staten Island (NY) University Hospital, says he hasn't heard recruits mention this concern yet, but says it may affect their decisions.

"There is probably extreme geographic divergence," he says about different recruiting rates around the country. "[The real estate market] may also impact academic centers and teaching hospitals less so, as these programs more easily recruit from within their own residency program."

Even so, hospitals should be aware of how the market is faring in the areas they recruit and be prepared to address their candidates' real estate concerns at all times.

The house-hospitalist correlation

The real estate slump is a recruitment and financial challenge for some hospitalist programs. If a sizable percentage of candidates decline a hospitalist position strictly because they cannot sell their homes to relocate, the small pool of hospitalist candidates becomes that much smaller.

Many programs are already struggling to recruit, hire, and retain physicians from their respective communities, and the struggle of the real estate market only serves as another speed bump to the growth of the program.

This challenge can also be a financial drain on the overall hospitalist program. After weathering the expenses associated with the interview process, candidates may decline a job offer in the final hour of negotiations. Then the hiring process must start from scratch, and the program takes a financial hit.

Sometimes a candidate does accept an offer but ultimately cannot take the position because of an unsellable home. The candidate may even fail to show up on his or her start date for the same reason.

"In addition to the extreme candidate shortages and intense competition that are common in most specialties, clinics and hospitals now have to worry about whether physicians they sign to employment contracts will ultimately arrive," Hurst says.

Nix the bonus and pay for the mortgage

Hurst described a recent situation in which Delta placed an Oregon physician in a program in Appleton, WI. The physician wanted the job and accepted the offer, but then backed out.

"She was deathly afraid of not being able to sell her house," he says. "There were 12 houses on her street, and six had been for sale."

The hospital decided not to give up so easily. In lieu of a signing bonus, the hospital offered to pay the physician's mortgage on her house for nine months, with the intent that the physician could sell the house during that window of time.

The candidate ultimately accepted the position.

But it wasn't the easiest move to pull off. Hospitals routinely give physicians large signing bonuses with the intent that the physicians will stay on for long-term positions. Rewriting recruitment policies with consideration to the real estate market might take some creativity to navigate around red tape, but it's a change that could help your organization survive the hospitalist shortage.

"The client understood what it took to be successful," Hurst says. "You have to be flexible and understand the challenges facing your physicians. For big earners in expensive homes, the ability to sell a house is certainly one of them."

Hospitals should make the extra effort

For hospitals, the most challenging aspect of negotiating is that it requires them to become more creative with

their offers, rather than falling back on traditional signing bonuses on a sliding scale.

"If you are already planning on paying a \$40,000 signing bonus, what is the difference between that and agreeing to pay that physician \$4,000 a month for 10 months? It's the same general principle as paying a stipend to someone in the last year of [his or her] training," Hurst explains.

Hospitals should go the extra mile, but Hurst says they are reluctant to engage in any significant recruitment effort.

"They're not excited about spending \$50,000 on a signing bonus, but the market dictates that," he says. "They must move quickly and do what's necessary to be successful, because if they don't, someone else will."

Hurst says hospitals should change the way they negotiate to leave wiggle room for extenuating circumstances, such as the struggling real estate market, and then create a policy that reflects that strategy.

"The signing bonus continues to be a popular way to close the deal, and this is just an application to how you structure the signing bonus better," says Hurst.

The finances favor creativity, and paying a candidate's mortgage is one creative strategy that can result in more hired hospitalists.

Gottesman says, "I suspect that creative solutions are imperative, but a signing bonus alone would either have to offset the potential mortgage payments for an agreed-upon period, as well as take into account the potential for further home value deflation and prolonged distant-homeowners' anxiety."

Gottesman adds that the bulked-up signing bonus and the mortgage considerations could be just the start of these new solutions. ■

Questions? Comments? Ideas?

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Sample professional reference verification form

This form supplements the June **HMA** article "Define your needs, prepare a process, and sell your hospitalist program's strengths."

Reference on: _____ **Given by:** _____ **Title:** _____ **Phone:** _____

Background

1. How long have you known this physician? _____
2. What was your relationship? _____
3. Have you directly observed this physician? _____
4. Why do you think he or she is considering changing practices? _____

Evaluate

Please rate this physician in the following areas using Excellent (E), Good (G), Fair (F), or Poor (P).

	Circle one	Additional comments
Medical competencies		
Diagnostic skills	E G F P	_____
Clinical skills	E G F P	_____
Medical knowledge	E G F P	_____
Decision-making	E G F P	_____
Inpatient management skills	E G F P	_____
ICU management skills	E G F P	_____
Interpersonal skills with:		
Other physicians	E G F P	_____
Nursing staff	E G F P	_____
Administrative	E G F P	_____
Patients	E G F P	_____
Families	E G F P	_____
Communication skills		
Verbal skills	E G F P	_____
Handwriting	E G F P	_____
Documentation	E G F P	_____

Personal characteristics

1. How would you describe his or her work ethic? _____
2. How would you describe his or her personality? _____
3. How well does he or she handle stressful situations and resolve conflict? _____
4. How would you describe his or her interaction with patients? _____

Credentialing

1. Describe your level of confidence in this physician. _____
2. Does he or she use consults appropriately? _____
3. Is he or she current with specialty knowledge, continuing medication education, and reading? _____
4. To your knowledge:
 - Has he or she ever been named in a malpractice suit? _____
 - Has he or she ever abused drugs or alcohol that would affect his/her practice of medicine? _____
 - Has he or she ever had hospital privileges suspended, restricted, or revoked, either voluntarily or involuntarily? _____
 - Has he or she ever had his or her licensure suspended, restricted, or revoked? _____
 - Has he or she had any delays in passing academic tests, including the USMLE or board exams? _____
 - Is there anything not discussed that may be of concern to a potential employer? _____

If you answered yes to any of the above questions, please explain in "Please list any other comments" below.

Professional characteristics

1. Describe any subspecialty or clinical areas of interest to this physician. _____
2. How would you describe his or her practice philosophy? _____
3. List three of his or her strengths (medical or nonmedical):
 - a. _____
 - b. _____
 - c. _____
4. List three areas this physician could improve upon (medical or nonmedical):
 - a. _____
 - b. _____
 - c. _____
5. Would you allow this physician to treat someone in your family? _____
6. How does this physician rank in comparison to others with whom you have worked/trained? _____

Summary

1. If you were looking for an associate, would you hire this physician? _____
2. In conclusion, would you:
 - Recommend highly and without hesitation: _____
 - Recommend without hesitation: _____
 - Recommend with hesitation: _____ (Please explain in "Please list any other comments" below)
 - Not recommend: _____ (Please explain in "Please list any other comments" below)
3. Please list any other comments: _____

Taken by (reference person): _____ **Date:** _____

Source: Inpatient Management, Inc., St. Louis, MO. Reprinted with permission.

Recruiting tip of the month

Restructuring to improve hospitalist recruitment

Before searching for hospitalists outside your hospital, consider that the best approach may come from within through restructuring.

Consider the example of a hospital in a small Midwestern community that employed one staff hospitalist and contracted with a hospitalist group when the hospitalist was off duty. However, the staff hospitalist had a patient load higher than one person could handle. The hospital recognized the need to recruit two additional full-time hospitalists to meet continuity of care needs.

Cejka Search in St. Louis, MO, foresaw a significant power balance issue that might turn qualified candidates away: The current hospitalist was not interested in bringing partners to the organization, and the new physician would likely face difficulty finding new patients and receiving referrals from doctors with whom the original solo practitioner already had relationships. The job description and setting were not viable unless the hospital was willing to restructure the organization.

Strategy

Cejka Search recommended that the hospital create a new coordinator position to serve in external and internal roles. Externally, the coordinator would be a positive face for the community to interact with. Internally,


he or she would schedule and organize among the soon-to-be three full-time hospitalists. The coordinator would ensure balance in the scheduling and assignment of patients and manage the use of the contracted hospitalists as needed.

Results

The hospital established a proven and equitable method for distributing patients among the hospitalists, and as a result brought in a number of qualified candidates to be interviewed. After learning about the system's positive structure, many candidates left their interviews interested in the position, and the hospital was able to hire its two top candidates. The organization now has a hospitalist system that serves the best interest of all parties—the hospital, the physicians, and, most importantly, the patients.

If an organization is planning to grow, it is important to bring new physicians into fair work environments, which positively affects physicians' tenures. ■

Editor's note: This month's recruitment strategy was submitted by Diane Safner, senior search consultant at Cejka Search. For more information about recruiting and retaining hospitalists, visit www.cejkasearch.com or call 800/678-7858.

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An HCPPro, Inc., seminar

Developing and Maximizing Your Hospitalist Program

A symposium by Hospitalist Management Advisor

Dear Readers,

If you haven't already made plans to join us in Chicago for HCPPro's "Developing and Maximizing Your Hospitalist Program" symposium, then gather your colleagues and mark your calendars.

This unique and interactive networking event will take place September 25–26 at the Hyatt Regency in Chicago. Led by national experts, the symposium will offer the most recent tips and tools for managing a top hospitalist program.

Join speakers **Martin B. Buser, MPH, FACHE; Ron Greeno, MD, FCCP; Beth Hawley, MBA, FACHE; Roger A. Heroux, MHA, PhD, CHE;** and **Kirk Mathews**, as they present a dynamic program to help you navigate through common program management challenges.

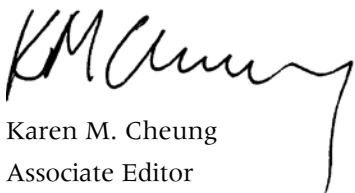
Agenda items this year include:

- ▶ Key components to building a fourth-generation hospitalist program
- ▶ Strategies to recruit quality hospitalists through communication and contracts
- ▶ Strategies to retain hospitalists with compensation and collaboration
- ▶ Common pitfalls and why hospitalist programs fail
- ▶ The rise of the -ist movement in surgical specialty hospitalist programs

The first day of the symposium will provide participants with the skills and knowledge necessary for tackling top hospitalist program management challenges. With guidance from two preeminent hospitalist experts, attendees will build on these skills during an interactive workshop on day two of the program.

To register or for more details, visit www.hcmarketplace.com/seminars or call 800/650-6787. **Register before July 24 and save \$100.** Mention the early bird special (source code MT65915A) to get your discount. We look forward to seeing you in Chicago!

Sincerely,



Karen M. Cheung
Associate Editor

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