

Hospitalist Management Advisor

Making your choice: On-call overnight physicians versus 24/7 staffing

When it comes to overnight shifts, the decision to either staff your hospitalist program with around-the-clock physicians or on-call physicians can greatly affect your program's budget, staffing, and effectiveness.

Although programs are increasingly choosing the 24/7 staffing route, the decision still comes down to what is best for your program, as industry experts continue to debate whether having attending physicians on the floor is always necessary.

On-call versus 24/7 staffing

In an ongoing retrospective analysis, **Kenneth Epstein, MD, MBA**, director of medical affairs and clinical research at IPC The Hospitalist Company, Inc., a leading physician practice group, and a faculty member at the University of Colorado School of Medicine, both in Denver, says he finds scant evidence of a difference between quality indicators

of patient care in departments that use on-call physicians and those that use attending physicians at night (nocturnists). Epstein says there seems to be little difference between the programs in terms of length of stay (LOS), readmission rates, and patient satisfaction.

However, **David J. Shulkin, MD**, president and CEO of Beth Israel Medical Center and professor of medicine at Albert Einstein College of Medicine, both in New York City, says that based on his experience in rounding overnight at his hospital, he finds a clear difference in

"Since the most critical time for many patients is during those first few hours of admission, this need can be impacted by who and what services are available."

—David J. Shulkin, MD

the quality of overnight care provided in hospitals without nocturnists compared to those with them.

The case for on-call coverage

Although no one would ever say it's a bad thing to have a hospitalist physician on the floor at all times and ready to attend to patients, Epstein questions whether 24/7 coverage is necessary and financially feasible for all facilities.

Epstein originally reported his findings in a 2007 abstract at the Society of Hospital Medicine's annual conference. He is currently concluding his research in a retrospective analysis article to be published in 2009.

Epstein studied 85 IPC hospitalist programs; some are 24/7 programs, and some use a traditional on-call system. He found no measurable advantage to 24/7 programs.

"Hospitals are paying a lot for 24/7 coverage, and there is no data in the literature that it improves quality, reduces mortality, or shortens LOS," he says.

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Making your choice

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One reason for this lack of difference in the data is admission times, Epstein says. At most hospitals, the majority of admissions come in during the day shift or the evening portion of the night shift. Most of the night shift is simply about being in-house and available for emergencies, he says, although, at some of the busier programs, the night shift doctors are occupied all night with admissions. Similarly, like admissions, most patient encounters occur during the day.

Because quality measures don't drastically change in 24/7 programs, says Epstein, the night shift is a cost that does not pay for itself since it creates more admissions

and billable services and, therefore, requires hospital subsidy.

Epstein notes that there are hospitals where nocturnists can be quite beneficial, mostly the larger facilities that have a lot of overnight admissions. In these facilities, nocturnists are more likely to cover their salaries by seeing more patients and performing more services, while helping to "significantly reduce the daytime workload of the other doctors," he says.

Although hospitals that need nocturnists for night admissions and busier workloads can more easily justify the costs of having around-the-clock coverage, hospitals without that need may be spending too much money for quality improvement that isn't necessarily taking place, Epstein says.

One reason this improvement might not be occurring is a general lack of extra resources and less staffing during the night and weekend shifts, Epstein says.

"Most programs usually only have one doctor on at night," says Epstein. "Also, [hospitals] can use nurse practitioners [NP] and physician's assistants [PA] during the daytime easier because more physicians are available for backup."

On the other hand, there are benefits to an on-call program as opposed to a 24/7 program, Epstein says, including:

- Lower costs
- The ability for physicians to go home if it is quiet and then come back to the hospital if needed
- The difficulty of finding physicians who are willing to work overnight frequently

The case for nocturnists

Shulkin positions himself on the other side of the overnight hospitalist argument. Although the numbers may not show it, Shulkin says, there is a clear difference in the quality of care during the overnight shifts at most hospitals, especially those without an attending physician on hand all night. Patients do not get the same attention

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at night if they are relying on a nurse, PA, or NP to call a physician at home with changes in status, he says.

Even though many hospitalist services, such as teaching hospitals, only have in-hospital staffing during 12-hour daytime shifts, overnight patient care tends to decline in those cases, Shulkin says.

“Fewer people can mean that there are weaker responses during emergencies and crisis,” he says. “[It] can also mean that staff can be stretched thin, especially during times of volume surge.”

Shulkin adds that even in 24-hour models, many of the physicians staffing the night shift aren’t as experienced as their counterparts from the day shift. “Finding qualified hospitalists to work nights and weekends is a challenging task in a competitive market,” he says. The more experience most physicians gain, the more they want to work predictable, 9 a.m.–5 p.m. hours, he adds.

Effective nighttime coverage depends on a strong system in all areas of the hospital. Having attending physicians at night is a good start, but then you need to work on systems and communication channels, says Shulkin. Simply adding nocturnists doesn’t improve quality of care if you aren’t integrating them correctly and using the same hiring standards to staff all shifts, he says.

Admissions occur at all hours in a hospital, and “since the most critical time for many patients is during those first few hours of admission, this need can be impacted by who and what services are available,” says Shulkin.

For example, when you admit a patient, you need the diagnosis to be correct, the management plan to be established, and the treatments started right away. You are diminishing the quality of care if there are limitations in any of the resources needed to accomplish these tasks.

Not having specialists available or not being able to run a test that is needed to assist in diagnosis or a treatment will reduce the effectiveness of patient care, says Shulkin. When starting an around-the-clock program, these are issues you must consider to ensure that having the nocturnists is worthwhile.

Your staffing levels don’t necessarily have to be the same at night as during the day to successfully run a

around-the-clock program, Shulkin says. “Staffing patterns should correspond to the workload. If a hospital had more admissions at night, then, yes, it should be staffed that way. The key is that the staffing must align with patient needs,” he says. “The nocturnist must have good handoffs and access to information. They must have support from specialists and intensivists if needed, including radiologists and others.”

To improve your care during overnight hours, you should also look for weaknesses in the system, especially in medication practices and other ancillary support services.

Shulkin says there are data that show that large teaching hospitals perform better on many key quality measures. He notes that adding attending physicians at night will only improve those statistics.

“The key is that in hospitals, the more people around, the more redundant systems, the better the chance to avoid complications and error and improve outcomes,” he says. “Junior residents, senior residents, chiefs, fellows, attendings, and specialists all feed off each other and provide this level of redundancy and safety.”

Shulkin says financial constraints often make it difficult to ideally staff the hospital at night, and on-call physicians can be extremely responsive. “However, if the system is designed so that the attending physicians do not ever come in and the staff is left to fend for themselves, then the system can be flawed,” he says.

Mixed findings

Shulkin and Epstein say there is no system that works for all hospitals.

Although some facilities clearly need overnight staff members to handle the patient volume, others would be wasting valuable resources by having a physician constantly present during the night for minimal amounts of patient care.

The field is always changing; the important thing for hospitals to do is to analyze their own situation and make the decision that is best for their patients, Epstein and Shulkin say. ■

Case study

New York hospital launches 24/7 hospitalist program with successful recruiting methods

To keep up with growth, some hospitals are expanding their hospitalist program into around-the-clock services for overnight inpatient care. It is a change that requires the support of the staff and the administration. Transitioning into a 24/7 hospitalist program can be rewarding and successful, says **Dahlia Rizk, DO**, one of the founders of the hospitalist program at Beth Israel Medical Center in New York City.

In 1999, the program's goal was to treat inpatients and support teaching practices. But the program quickly grew as private physicians began to see the benefits of hospitalist care. Community centers and nursing homes began using the program instead of going to private physicians.

Once the emergency room started admitting qualified unassigned patients to the program and other hospital specialists began using hospitalists to manage their patients, things really took off, Rizk says.

Beth Israel's program continues to grow and will discharge roughly 9,000 patients this year, says Rizk, the hospitalist program director. But even in the face of such growth, Rizk says the program must continue to evolve to sustain its success.

The most important change was the move this year to a 24/7 operation in which the hospitalists took admissions, performed rounds, ordered tests, and kept up with patient flow.

"It was something we had always wanted to accomplish, but now it was starting to become a burden on our regular physicians because they'd be called at all hours and wind up here extremely late in the day," she says.

Building from the ground up

When Rizk resolved to make the project a 24/7 operation in late 2007, she knew there was one thing she needed more than anything else—support from the hospital

administration. Because of the demand for new staff members, the hospital administration needed to support the financial costs to launch a full-time operation.

When expanding into an around-the-clock program, consider the following tips:

- Find additional staff members to cover the overnight shifts
- Get the administration's support to budget for more staff members
- Focus on recruitment efforts
- Be flexible with physician schedules

"It'd be easy to look at our staff and say you have enough bodies to cover an overnight shift and weekends," says Rizk. "But then who would cover all the day shifts?"

Rizk cautions against requiring your daytime staff members to suddenly start working nights. "Once you have an established practice, if you try to suddenly change it, you'll end up with a lot of unhappy doctors and a lot of turnover," she says.

Rizk says she received the support and budget from the administration to recruit and hire night shift physicians by stressing quality of patient care and convincing the administration that it was best for the patients and for the current staff. The program hired two new physicians who specifically sought out night shifts, she says.

Recruiting the night owl

Rizk placed ads in major medical journals and *The New York Times*. The ads specified that the jobs were overnight and weekend positions.

"I've found that there are a specific group of physicians who really like the night shifts," says Rizk. This group includes working parents and teaching hospitalists. It is also an attractive option for some physicians because nights tend to have a different culture, she says. "The [nights]

can still be hectic, but a lot of the things that take up so much time during the day, like meetings and paperwork, don't take place at night. Some doctors just prefer that quieter atmosphere where you can just be a doctor," she says.

To make the program more appealing to potential applicants, the hospital was flexible, allowing the physicians to determine their own schedules as long as the shifts were covered.

As Rizk looks for more attending physicians, she also looks for physicians' assistants who are willing to work the overnight shifts. "To make this work the way we want to, you really need that support staff so that doctors can spend time making management decisions and be more effective with patient care and communication," she says.

The learning curve

Once the decision was made to convert to a 24/7 hospitalist program, it all came together pretty quickly. But that quick turnaround required Rizk and her staff of 12 full-time attendings and two part-time attendings to constantly adapt to the new situation.

Rizk says she has already seen improvement in the quality of care. "It's a big help to have admissions, evaluations, and studies done by our attendings throughout the course of the day. It's helping with our continuity, and our house staff [residents, interns, etc.] gets the benefit of having attendings there to help them," she says.

Even with evaluations, some questions about how to run the 24/7 process still remain, including nighttime lab tests. The hospitalist program is still deciding whether to run more tests at night or to wait until the morning, when more lab technicians are available.

There's also the adjustment of running a staff that normally has up to eight physicians during the day but is reduced to one or two attending physicians during the night.

But as the program progresses, Rizk says she hopes the physicians whose beepers are still on won't be paged as often, which should lead to more productive day shifts and, ultimately, more physician satisfaction.

Budgetary concerns

Beth Israel is a busy hospital and admits a lot of overnight and weekend patients, says Rizk. She's skeptical that the 24/7 program will be a big moneymaker for the hospital, because most of that admitting and billing can still take place without attending physicians on hand.

Hospitals may find it difficult to come up with money to add more full-time physicians and the necessary support staff, but it can't always be about the money, Rizk says.

"You should be putting this system in place to improve the quality of care being delivered and to increase patient satisfaction," she says. "If you only look at this as something that may lose you money, I think you're being shortsighted about the role of a hospitalist program."

Rizk says she believes Beth Israel will start to see reduced lengths of stay and fewer hospital-acquired infections because the hospital will have experienced physicians who order and check tests at more appropriate times and gain patient trust.

"There's no question that whenever you're asking administration for more staff, it's a challenge to prove it's needed, but you can show that additional staff will help stave off burnout and that it takes a special physician to be able to work overnights long term," Rizk says. "You can't make your program a one-size-fits-all schedule, because not everyone will want to work the same shifts. Accommodating physicians' interests will ultimately lead to long-term retention and career satisfaction."

The case for 24/7: Peace of mind

Rizk says the biggest benefit so far is that she can tell patients there is a board-certified physician on the unit at all times, she says.

Although it's too early for data to show whether the program is working, Rizk says she has found that patients feel more comfortable knowing someone is there to check on them if their status changes.

"A program like this can really benefit staff and patients if done correctly," says Rizk. "What you're trying to do is build up patient-physician relationships that lead to better care with more continuity." ■

Improve patient discharge with low-cost strategies for hospitalist-PCP communication

Even a clear and concise discharge plan can have holes when it comes to patient care.

As the medical director at Somerville (MA) Primary Care and a hospitalist at Cambridge (MA) Hospital, **Richard Balaban, MD**, understands both sides of hospitalist-primary care physician (PCP) miscommunications that can arise during patient discharges.

Far too often, patients leave the hospital confused about their diagnosis, medication, or the next step in their care, according to a recent study, *Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study*, coauthored by Balaban. In another study on discharged patients, Balaban found that half of discharged patients didn't know their diagnosis, and the other half didn't fill their prescription for new medications during the two weeks after discharge.

Balaban's study showed that a concentrated team effort among medical staff members can enhance patient follow-up in relatively low-cost ways. The study calls for the:

- Hospitalist to electronically notify the PCP office about the discharge plan with an effective discharge form
- Nurse in the PCP office to then follow up with the patient by phone

This effectively minimizes the likelihood of a poor outcome. "There's certainly some coordination that needs to occur," Balaban says. "But acting proactively and not reactively is best."

The root of the problem

Problems with discharge planning have as much to do with systemic problems as the condition of the patients. There are challenges to each side of the equation, says Balaban.

"It's a very vulnerable time for patients, and on the hospital side, there's a tremendous rush to get people

out," he says. "The process is sometimes rushed or incomplete. You're trying to transfer information in one fell swoop, but it's hard for a patient to absorb it all."

From the standpoint of a PCP, the emergence of the hospitalist movement may have created an information gap between the two groups of healthcare professionals. Balaban says PCPs complain that hospitalists don't give enough information (e.g., recommendations for future tests and medication changes) in a timely manner.

Because the PCP decides on the course of action in care of his or her patients, the study evaluated methods of how to incorporate the PCP into the discharge process at the exact time of discharge.

Step 1: Redesigning the discharge form

Discharge instructions are often too clinical for patients to fully understand. Further, if patients require instructions in another language, translations are frequently unavailable.

Step one in Balaban's study was to develop a user-friendly format for the discharge form, translated into several languages.

A discharge planning nurse prepared the form with help from a discharging physician. The redesign of the form aimed to address patients' inability to state their diagnosis or recall changes to their medication list. It also addressed PCPs' failure to act on abnormal test results or to complete recommended outpatient workups.

The redesigned discharge form included the following information:

- Patient demographics
- Discharge diagnosis
- Names of hospital physicians who attended to the patient (including residents, hospitalists, and specialists)
- Vaccinations given
- New allergies
- Dietary and activity instructions

- Home services ordered
- Scheduled upcoming appointments with a PCP, with a specialist, or for diagnostic studies
- Pending medical test results
- Recommended outpatient workups
- Discharge medications, list of continued drugs with dose changes highlighted, new medications, and discontinued medications
- Nursing comments (optional)
- Reminder to patients to bring the form to their next PCP appointment

“We tried to use as little text as possible,” Balaban says. “It also encouraged us not to send too much information; a lot of times, less is more.”

The floor nurse reviewed the information with the patient, aided by an interpreter when necessary. And the nurse reminded the patient, in writing, to bring the discharge form with him or her to follow-up appointments.

Step 2: Sending the discharge form to the PCP office

During the study, the nurse electronically sent the discharge form (via e-mail or fax) to the RNs at the PCP site on the same day the patient left the hospital. That form then became part of the patient’s permanent medical record.

“In our initial model, there had to be some sort of electronic communication, so this works best in an integrated system where they share an electronic record,” says Balaban.

But an integrated system isn’t essential for this exchange to work. “There really just has to be a commitment from both sides,” he says.

Step 3: Reaching out from hospital to home

When the PCP office received the discharge form, it signaled the nurse to call the patient on the next business day.

“One of the ideas is getting the nurses to make this initial outreach,” says Balaban. “The PCPs are too busy.”

During this outpatient follow-up call, the nurse used a telephone script to ask questions about the patient’s medical status, review the discharge form with the patient, explore any patient questions or concerns, and confirm any scheduled follow-up appointments.

“A lot of times, discharged patients are in limbo and they don’t know who to call if they have a problem or a question,” Balaban says.

This conversation makes it clear to patients that they can contact the RN at the PCP’s office.

In the study, the nurse then forwarded the call notes electronically to the PCP, who either signed off on the hospitalist’s recommendations or modified them if needed.

This outreach process not only satisfied the PCP and the patient, but the nurses felt fulfilled too, Balaban says.

The inpatient nurses also felt the redesigned process provided an avenue of communication with PCPs and an avenue to explain what they’d learned about the patients.

“A lot of times, [nurses] have concerns but no one to share [them] with,” Balaban says.

For example, a nurse may worry about the possible onset of early dementia and wonder how a patient could manage at home. “This way, they could send their concern in the electronic transmission,” says Balaban.

Assessing the study results

The study measured four undesirable outcomes following hospital discharge to see how the new process affected patient care. The studied outcomes are:

- No outpatient follow-up within 21 days
- Readmission within 31 days
- Emergency department visit within 31 days
- Failure by the PCP to complete an outpatient workup recommended by the hospitalist

Only a quarter of the intervention patients had one or more undesirable outcomes, compared to more than half of the concurrent cases not included in the study and 55% of historical controls. The study indicated that the redesigned discharge plan reduced negative outcomes.

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Patient discharge

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Only 15% of the intervention patients failed to follow up within 21 days, compared to 40.8% of the concurrent and 35% of the historical controls. Only 11.5% of recommended outpatient workups in the intervention group were incomplete, as compared with 31.3% in the concurrent and 31% in the historical controls.

Balaban says patients in the study were more likely to follow up with the PCP within a few weeks of discharge, and the PCP was more likely to initiate and complete the hospitalist's recommendations.

This indicates that the PCP took the recommendation into account and decided whether to follow it, says Balaban.

"We counted the PCP not following the recommendation as completing the recommendation," he adds. "Presumably, he had a reason. He responded and there was ongoing care." The PCP reviewed the discharge form on the day of or the day following discharge—an improvement in patient care, Balaban says.

The study also found that during one-quarter of outreach calls, the nurses made some form of assistance intervention. In some calls, the patient didn't have his or her medication, and the nurse assisted by reminding the

patient what medication he or she needed and called the pharmacy for fulfillment. In other calls, the patient didn't realize he or she had scheduled an appointment with the PCP.

Inexpensive tactics

Balaban is often asked why a physician would discharge a patient out of the hospital without following up with the PCP right away. In response, he quotes a colleague who asserts that discharging patients should be done with the same intensity as admitting them.

"People are so focused on working in their site that their purview doesn't extend beyond that," Balaban says.

"Part of this is built on redundancy; you're often just reviewing the material that was given the day before," he says. "But we have to acknowledge that no matter how good a job we do, there will always be holes, and the patient is going to walk away with certain misunderstandings. That's why it's important."

It's important—and inexpensive. The low-tech fix doesn't require any additional personnel; it only requires using existing nurses to make the outreach calls and the will to make a change. ■

Streamline the welcome orientation process

Within the competitive college ranks, National Collegiate Athletic Association coaches, regarded as cutthroat recruiters, pursue candidates. Recruits will ultimately decide on one destination, and the smallest detail can influence their decision.

Similarly, in hospitalist recruitment, what seem like small factors can weigh heavily. The state of your program depends on your ability to recruit top talent and then keep them satisfied and productive.

Since you're probably focused on long-term physician satisfaction and program stability, it's easy to forget that first impressions are critically important. What happens

during the initial stages of recruitment, hiring, and orientation can have lasting effects. "First impressions can directly impact your program's retention rate," says **Jon Hersen**, administrative director at Legacy Inpatient Medicine Service (LIMS), part of the Portland, OR-based Legacy Health System. "The way in which your program handles the physician orientation process is a critical factor toward achieving long-term employee satisfaction."

Streamlining how your process works

Since Hersen joined LIMS three years ago, he says he has watched the hospitalist service balloon from a group

of approximately 30 physicians at four sites to 70 physicians at five sites. Most impressively, this significant growth occurred at a time when programs nationwide are struggling to find and retain qualified physicians.

Programs can be successful when they favor gradual employee adjustment rather than immediate production, says Hersen, and LIMS' growth spurt is no fluke. LIMS has learned that a solid infrastructure, with staff members specializing in different roles such as recruiting and credentialing and matched with a strong orientation program, makes the program an attractive option for the best candidates.

Hersen says he attributes the success of the program to its orientation philosophy. "We take a broad-based multidisciplinary approach to physician orientations, starting with the first time a potential candidate contacts our program about potential employment. Our orientation process continues all the way through a physician's first several months of employment," he says.

Building the infrastructure was the first step for LIMS and Hersen three years ago. At the time, the multiple internal groups—recruitment, medical staff credentialing, and orientation—didn't work independently from each other, but they didn't work together either, which proved problematic. There were often information gaps that led to delays in hiring. For example, LIMS once hired a recruit but did not pass that information along to the credentialing contact. Completing the hiring process set back LIMS for weeks, Hersen says.

Now, LIMS has initiated weekly meetings with leaders in each department (recruitment, credentialing, and orientation, including the medical director), to thoroughly communicate about the status of new hires.

The agenda for these weekly meetings generally addresses the following topics:

- Who are the active recruits?
- What steps do LIMS and the new hire need to take to obtain the right credentials in time for the new hire's start date?
- Are easily overlooked details in place (lab coats, pagers, etc.)?

"Now we have much better information flow," says Hersen. "Even if it's six months down the road, our team knows about everything in the pipeline. There are very few last-minute surprises," he says.

During the weekly team meetings, the recruiter spends 15–20 minutes discussing each candidate's qualifications with other team members.

The recruiter then responds to the candidate via e-mail or telephone, usually within 48 hours of the candidate expressing interest in the program. That contact usually comes from Hersen, as the administrative director, or from an assigned physician recruiter in charge of tracking all of the candidates who have expressed interest in applying for a position.

Decide and respond quickly

After the initial contact, the recruiter either crosses the candidate off the list or asks him or her to come in for an interview. Several people usually interview the candidate to assess his or her qualifications.

Following these interviews, LIMS makes it a point to contact the candidate within two to five days with either an offer or a rejection. The weekly meetings are used to facilitate these decisions.

"We can turn around a decision really quickly. These days, we have to," says Hersen. "For every one hospitalist, there are eight to 10 jobs. You have to act quickly and make decisions. When a hospitalist candidate doesn't hear something back from a potential employer right away, they go off and make other decisions."

Early credentialing gets the ball moving

The moment a candidate signs a contract offer, he or she moves into the next stage: credentialing. The credentialing representative updates the weekly group regarding each candidate and tracks when each candidate is likely to get his or her medical staff credentials.

"We've had people delayed a month or longer because of delays in credentialing," Hersen says. "Our current process allows them to know when they are targeted to start

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Streamline

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and where they are in the process. We now have a much better track record of hitting targeted start dates.”

The biggest obstacle in hiring is late applications from physicians. It’s less of a concern with experienced physicians, but younger ones can underestimate how long it takes to complete the process, Hersen says.

“That’s another benefit to our process—we can usually catch [delayed applications] before it is too late,” he says.

Orientation process provides smooth transition

After the offer acceptance and credentialing stages, administrative staff members at LIMS use an orientation checklist (see p. 11) to ensure that training processes, along with office supplies and setups, are in place before a physician’s first day. That list might include business cards, computer training, billing training, office space, and a phone number.

LIMS is also currently assembling a binder with orientation documents for its new physicians.

“In the past, most of our on-site orientation occurred verbally, but we have found that it is difficult for a newly employed physician to retain all of this information without printed materials that they can reference later,” Hersen says.

Kenneth G. Simone, DO, founder and president of Hospitalist and Practice Solutions in Brewer, ME, suggests including paperwork, tours, and follow-ups.

Consider the following tips for use in your orientation program:

➤ **Review documents and procedures.** The new provider should sign off and date materials, indicating that he or she has reviewed the following orientation documents and procedures:

- Policy and procedure manual
- Job description
- Program mission, vision, and objectives
- Clinical protocols (e.g., admission, communication, sign out and handoffs, off-service, comanagement, consultative, and discharge)

- Documentation and coding
- Medical records policies and procedures

Reviewing the program’s mission statement and hospitalist job duties serves to align the new hospitalist’s vision and objectives with the program’s vision.

“This process should reinforce the recruitment process, which should have included review of the program mission, vision, objectives, and values,” Simone says.

➤ **Serve as a tour guide.** The recruitment team should show the new hire the building and office layout. Remember to review service hours and coding and billing forms and introduce the new hire to staff members.

➤ **Meet and greet.** The recruitment team should introduce the new hospitalist to members of the program by doing the following:

- Assign a mentor for the first six to 12 months
- Set up a weekly meeting with a mentor to obtain feedback from the new hospitalist
- Introduce the new hospitalist at a medical staff meeting
- Introduce the new hospitalist with a brief bio note in your facility’s newsletter

Assigning a mentor provides an open line of communication between the new hospitalist and a seasoned employee.

Simone says the mentor should serve as a resource regarding clinical questions, operational questions, and integration of the new employee and his or her family into the community.

➤ **Follow up.** Consider these ideas for follow-up with your new hospitalists:

- Set up one-, three-, and 12-month reviews, shifting to annual reviews thereafter
- Design strategies to help integrate domestic partners or family members into the community
- Survey the hospitalist’s satisfaction

Get feedback from your new hires whenever you can, Simone says. The surveys show that people who

Physician orientation checklist

Item	Completed
Hospital privileges and general program orientation	
Contacted medical staff office to make sure privileges were granted to hospitalist day of start or before	<input type="checkbox"/>
Spoke to hospitalist (date/time: _____)	<input type="checkbox"/>
Contact number for new hospitalist	<input type="checkbox"/>
Billing training	<input type="checkbox"/>
Echart/Cerner training	<input type="checkbox"/>
Health plan applications	<input type="checkbox"/>
New physician orientation (new employee orientation)	<input type="checkbox"/>
Assigned mentor	<input type="checkbox"/>
Payroll overview	<input type="checkbox"/>
Scheduling/vacation overview	<input type="checkbox"/>
Incentive plan overview	<input type="checkbox"/>
Information resources	
Echart/Cerner sign-on	<input type="checkbox"/>
Novell sign-on	<input type="checkbox"/>
Internet sign-on	<input type="checkbox"/>
Outlook e-mail	<input type="checkbox"/>
PACS sign-on	<input type="checkbox"/>
Muse sign-on	<input type="checkbox"/>
Personal pager	<input type="checkbox"/>
LIMS pager	<input type="checkbox"/>
Voicemail number	<input type="checkbox"/>
Code It Fast	<input type="checkbox"/>
Palm Pilot software installation (optional)	<input type="checkbox"/>
Other desktop-related items	
Epocrates	<input type="checkbox"/>
Web portal access	<input type="checkbox"/>
Supplies	
Business cards	<input type="checkbox"/>
Fee tickets	<input type="checkbox"/>
Lab coats	<input type="checkbox"/>
Palm Pilot	<input type="checkbox"/>

Source: Legacy Inpatient Medicine Service, Portland, OR. Reprinted with permission.

leave do so within six months of hire, particularly because of dissatisfaction from family or their significant other.

Make sure you are doing everything you can to integrate the family into the community and enhance the experience for everyone, says Simone. “This initiative helps prevent employee isolation and diminish the likelihood that he or she will become discouraged and dissatisfied with the job. It also sends employees a message that the program has an interest in their perspective and values their opinions,” he says.

The first week on the job

Most candidates, in Hersen’s experience, have overwhelmingly expressed a desire to ease into the new job. That’s why LIMS moved from one day of orientation to a slightly longer shadowing period. Now, a new hire receives at least several days, if not a week or more, of shadowing with another physician. The plan is for the new physician to start seeing patients at the end of the first week, with full adjustment after two weeks.

Simone recommends a three- to seven-day orientation period with two to five days of shadowing. Anything less than that can be a major point of dissatisfaction, says Hersen. “Every case is different, and some will take longer to adjust than others, but being thrown into rounding too quickly can directly lead to turnover,” he says.

Job satisfaction and retention

LIMS’ success is its understanding of what physicians want: sticking to a patient-encounter-per-shift rule and accommodating vacation schedules. In general, taking a slower orientation approach can result in happier physicians, says Simone.

The program should succeed in providing support and resources—professionally, emotionally, operationally, and educationally. The program should also provide concurrent review and feedback for the physicians. All of this, says Simone, “will contribute in a positive manner to job performance, job satisfaction, and long-term physician retention, which are the primary goals of any orientation program.” ■



Recruiting tip of the month

Training your interviewers

When recruiting for available hospitalist positions, busy physicians at one southern New Hampshire hospital interviewed candidates for about 15 minutes, evaluating them based on their instinctive feelings rather than quantified data.

After struggling to find qualified candidates because of a disorganized interview process, the physicians enlisted Cejka Search experts to help create a successful interview process for the hospital, physicians, and candidates.

Strategy: Behavioral interviewing

Most physicians' busy schedules leave little time to concentrate on interviewing a candidate effectively.

Nonetheless, Cejka Search concluded that the physicians had to make their interview process a higher priority.

Cejka Search suggested the following action steps:

- Introduce the candidate to the entire interviewing team
- Assign each interviewer to evaluate specific competencies and qualities of the candidate
- Allow enough time for answers from the candidate
- Apply behavioral interviewing, a technique that highlights a candidate's experiences (e.g., how he or she reacted to a past situation)
- Evaluate a candidate within 24 hours

The recruitment training includes role-playing with mock interviews. Afterward, the physicians in the group then became comfortable asking interview questions.

Results

As a result of the physicians' use of behavioral interviewing, the team found that each qualified candidate proved that he or she identified with the core values of the hospital and would make a good long-term fit for the organization.

The improved process helped the hospital hire several candidates quickly and efficiently. ■

Editor's note: This month's recruitment strategy was submitted by Michael Tucker, senior search consultant in the physician search division of Cejka Search. For more information, visit www.cejkasearch.com or call 800/678-7858.

Questions? Comments? Ideas?

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