Hospitalist recruitment

Facing a shortage, your program must be creative and selective

In 1996, when hospital medicine was in its infancy, there were approximately 1,000 hospitalists in the United States. Today, according to estimates from the Society of Hospital Medicine (SHM), there are more than 20,000.

SHM estimates that the need for hospitalists will continue to grow and could exceed 40,000 during the next five years. “No other specialty in the history of American medicine has grown at this rate,” says Eric Siegal, MD, regional medical director at Cogent Healthcare in Brentwood, TN.

But growth isn’t always a good thing. Qualified hospitalists aren’t easy to find in today’s employee market. Providers have been forced to hire reactively instead of proactively, and desperation hires have taken their toll on hospitalist programs that see significant turnover.

At Staten Island (NY) University Hospital, Susan Wisniewski, MD, associate director of the hospitalist group, says her goal is to explore a physician’s nonclinical areas of interest when considering a candidate, which helps to establish a well-balanced, diverse team.

“But I don’t really see this is as a feasible goal at this moment in time,” she says. “Despite the fact that the field of hospital medicine is ever-growing, the truth is that there is definitely a shortage of appropriate candidates in the workforce.”

Siegal says it’s time for hospitalist programs to rethink how and where their organizations find candidates, pursue new employee avenues, and, in some cases, reconsider growth altogether.

Pinpointing the shortage

The reason for the current hospitalist shortage is two-fold, says Siegal. First, 85% of hospitalists are general internists, and that talent pool is shrinking.

“The best and brightest medical residents are overwhelmingly likely to subspecialize. The primary care physicians who were sufficiently disgruntled to jump ship to hospital medicine have already done so,” he says. “The low-hanging fruit is gone.”

Second, the Association of American Medical Colleges reports that 49% of medical school graduates in 2007 were women, and Siegal says a significant percentage of them work less than full time to juggle family and work.

The shift from yesterday’s physician to today’s physician is evident in other ways too. For example, many
facilities often realize that it takes more than one full-time-equivalent employee to replace the work output of an older physician when he or she retires, says Siegal. “This is even true in a field as young as hospital medicine, and work expectations have dropped precipitously over the past decade,” he adds. “When I started in 1997, we worked way harder than my docs work now, but we also burned out at a phenomenal rate.”

**Turn attention to family practitioners**

In order to stave off the negative effect of such a shortage, hospitalist programs should begin identifying alternative talent pools from which to recruit. For example, an increasing number of family practitioners (FP) are expressing interest in hospitalist careers. The Phoenix Group, a think tank for hospital medicine, recently published a white paper, *Confronting the Hospitalist Workforce Shortage*, and identified the more than 100,000 FPs and doctors of osteopathy (DO) as prime targets for hospitalist recruitment.

“This will require a campaign to change the mind-sets of referral partners, hospital administrators, and other stakeholders to embrace osteopathic and non-internal medicine physicians as hospitalists, which in turn will require training programs geared toward these specialties to develop them into seasoned hospitalists,” the paper states.

But FPs have highly variable inpatient clinical skills, ranging from very good to wholly inadequate, Siegal adds. That means hospitalist programs looking to recruit these practitioners will need to have a strategy. “We are trying to find the FPs who have the skills and find ways to mentor and develop those who have interest but need additional training,” he says.

Specifically, Siegal looks for experienced FPs who have maintained their inpatient skills during the course of their careers and are now considering a jump to hospital medicine.

But he’s cautious of the fact that practices may vary significantly; some mostly do pediatrics and obstetrics, others are virtually indistinguishable from internal medicine. “We look for the latter,” Siegel says.

In most FP residencies, there are a few residents who are expressing interest in hospital medicine. The Phoenix Group, a think tank for hospital medicine, recently published a white paper, *Confronting the Hospitalist Workforce Shortage*, and identified the more than 100,000 FPs and doctors of osteopathy (DO) as prime targets for hospitalist recruitment.

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In most FP residencies, there are a few residents who gravitate toward inpatient medicine. Although such residents probably should have opted for an internal medicine residency, they can skew elective rotations to emphasize inpatient medicine if they identify this preference early enough in their training, he says.

“I have met and hired several of these folks, and their skills are commensurate with their internal medicine-trained counterparts,” he adds.
Some of Cogent’s hospitals have partnered with local FP training programs to help mentor and train interested candidates. Such a partnership requires a sympathetic FP training program director, which is increasingly common, and a willingness to share in teaching opportunities, curriculum development, and other considerations, Siegal notes.

“Some hospitalist programs have gone so far as to pay stipends to FP residents while in training, in return for a work commitment when they graduate,” he says.

Internal medicine residents are a group that receives a lot of inpatient training during residency, Siegal says. “They are presumed to be competent to do this right out of the box, which is usually true,” he adds.

But not everyone has had the same luck.

“Most of the potential candidates we interview are recent residency graduates, with, unfortunately, little experience,” Wisniewski says.

Look to NPs, PAs

Another avenue hospitalist programs can explore is using nurse practitioners (NP) and physician assistants (PA), who are increasingly coming out of training with the intent of being hospitalists, Siegal says. 

“They are presumed to be competent to do this right out of the box, which is usually true,” he adds.

But not everyone has had the same luck.

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Think critically about growth

Another suggestion from Siegal, although far more complicated, is to stop growing altogether.

For the past few years, Siegal has advocated that hospitalist groups think critically about how and where they grow. He says providers generally act quickly to add new services without asking whether those decisions add value to patient care. “For a while, I was a voice in the wilderness, but recent studies have bolstered my argument, and others are now starting to echo the same sentiment,” he says. “Even those who think that this growth curve is desirable have begun to concede that the manpower shortage may force our hands.”

The pressure to fill open slots often leads hospitalist programs to make poor staffing choices that have lasting consequences.

“We thought that it might cause a credibility gap. Why would a primary care physician surrender his inpatients to the care of a nurse? But I don’t hear that as an issue anymore, and we can expect to see far greater integration of nonphysician providers into hospitalist teams,” Siegal says.

Regardless of where you find your talent, Wisniewski says you cannot give in to lesser candidates. The hospitalist’s role is too important to the team, the organization, and your patients.

“I think a more realistic goal at this time would be to recruit strong candidates who possess excellent clinical and interpersonal skills and attempt to foster their development within the group ... so that, over time, they will become a valuable asset and an employee with longevity in both the group and the institution,” she says.

Editor’s note: The Phoenix Group’s white paper is available at www.phoenixgroupwhitepaper.com.
Strategic planning is essential to keep your hospitalist program on the cutting edge

When hospitalist programs started popping up around the country back in the mid-1990s, the thought was that they would make hospitals more efficient by always having on-site physicians who could attend to patients and intimately understand the hospital’s processes.

But as hospitalist programs mature, they need to be more than a service that fills in for private practice physicians, says Sylvia Cheney McKean, MD, FACP, medical director of Brigham and Women’s Faulkner Hospitalist Service in Boston.

“It’s still about efficiency, but hospitalist programs have to keep evolving,” says McKean. “Always be thinking about what value you can bring to the hospital, how you can improve patient safety, quality of care, and disparities in care in addition to saving costs through enhanced efficiency and reducing the overuse of limited resources for the hospital.”

Because service obligations come first and it seems everyone wants to use hospitalists to provide care, and because there are limited funding sources for protected time for innovation, many hospitalist programs struggle to assume leadership roles in systems improvement while also providing inpatient care, McKean says. Although patient care must always come first, it’s important to look beyond that responsibility and determine your patient census and new ways to make your program more effective and desirable.

Leadership opportunities for hospitalists also might not be on the radar screen of senior hospital leaders, who might be more likely to identify colleagues in their divisions for leadership positions.

But by making strategic planning part of the hospitalist program’s mission statement, hospitalists and hospital leaders can always plan for improvement, McKean says, adding that she and her staff regularly review and revise the program’s mission statement to ensure that it’s accurate and true to where the program is headed. Currently, that mission statement is:

➤ To promote high-quality, efficient, comprehensive, compassionate inpatient care, especially for those who are disenfranchised
➤ To excel as educators in conveying the principles of evidence-based inpatient medicine to students, residents, fellows, colleagues, and patients
➤ To be national leaders in hospital medicine and agents of change in quality improvement initiatives, patient safety, and clinical research

Using the mission statement to strategically plan for the service, McKean says she and her hospitalists can prioritize how the service expands in keeping with core values.

Thorough growth

As hospitalist programs evolve, they will have to find ways to grow in terms of the services they provide, says Alpesh N. Amin, MD, MBA, FACP, executive director of the hospitalist program and vice chair for clinical affairs and quality in the department of medicine at the University of California Medical Center in Irvine.

Clinical growth is one way of doing this, Amin says. You can have hospitalists create new programs such as an anticoagulation clinic, or hospitalists could comanage a psychiatric unit, he says.
But growth comes in many forms, Amin says. Consider the following strategies:

- **Develop a multidisciplinary hospitalist program.** Amin’s facility has nine specialties in one program, including internal medicine, pediatrics, neurology, critical care, infectious disease, geriatrics, and palliative care. It has physicians to focus on inpatient issues dedicated to that specialty, but the teams also frequently work together because so many patients have comorbidities. By putting all these specialties in the same overlaying hospitalist program, it makes interaction much easier, helps with retention, and brings value to the institution, Amin says.

- **Become true systems and quality-improvement leaders.** Hospitalists are in a great position to help the hospital achieve Joint Commission (formerly JCAHO) goals, decrease medical errors, and improve medicine reconciliation, Amin says.

- **Educate others.** This is especially true in teaching hospitals, but hospitalists can educate all staff members in a hospital. Maybe it’s educating nurses or physician assistants and developing a curriculum to drive a particular care process that gives your facility trouble.

- **Set up a system to avoid constant turnover.** Education is part of this, as is setting up senior faculty to mentor junior faculty. Keeping a good hospitalist group together allows you to find optimal ways to run the program. Turnover costs a lot of money and time that could be best invested in your staff, says Amin. By fostering physicians’ interests, you will develop them into leaders and strengthen your program’s investment in the innovation you need to thrive going forward, he says.

**Failure is okay**

Besides the relatively young age of so many hospitalists in a field that is still less than 15 years old itself, another barrier to innovation is the fear of failure, says McKean. You can’t be afraid to run a pilot test because it might not work, she says, but you also should be able to end or change a program if it’s not working.

For example, you may try to create a comanagement plan with the hospital’s orthopedic surgeons. Maybe you’ve noticed inefficiencies or quality issues with how you interact with orthopedic surgeons, but there isn’t an obvious inroad to creating a comanagement service.

McKean says you should find a way to develop such a service. You might find it saves everyone a lot of time and resources, or you might find the two programs’ styles are too incompatible; either way, you tried and learned from the experience.

This process may lead to the development of other comanagement models (e.g., with neurosurgery or psychiatry) even if it does not work for orthopedics.

“You don’t have to be successful to do something innovative,” McKean adds. “The key is to measure the service you provide and respond to your findings.”

**Planning to plan**

A big part of strategic planning is setting aside time to plan. It might seem like there’s never enough time to sit down and come up with short- and long-term goals for your program, but you have to make time. Maybe that means hiring an extra full-time employee to allow physicians to use a percentage of their hours each week to work on projects, says McKean.

To spark ideas, McKean and her staff have a retreat once per year to discuss ways to improve the program. The retreat may only be for a few hours in the evening, but getting the entire staff in one room and away from the hospital has a way of creating conversation and energy, she says.

Ideas from the retreat are followed by hospitalist committees and task forces that meet regularly to continue momentum.

McKean says a strategic plan should have the following four basic parts:

1. An understanding of the hospital’s expectations (e.g., 24-hour patient care, performance measures)
2. Solutions for creating a stable working environment (e.g., job satisfaction)

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3. Expectations of external sources (e.g., The Joint Commission, the Centers for Medicare & Medicaid Services)

4. Ways to evaluate and measure successes and failures (e.g., patient and primary care physician satisfaction surveys)

Although your focus should be on the future, it’s also important to look at what you’ve done in the past and what hospitals around you are doing, McKean adds. For example, if you find there are inefficiencies because your hospitalists are spread out so much through the hospital that they are always working with different nurses who aren’t familiar with your system, find a way to ensure geographic localization as much as possible, she says.

Documenting your success

The main goal of your improvement plans should be to create a more efficient environment that is better for your staff, your patients, and the hospital. But it’s also important to make people aware of your successes, says McKean.

One way to do this is through quarterly reports that are given to the hospital’s administration. The report should succinctly describe your mission statement, your goals, opportunities for improvement, and, most importantly, highlights of innovative projects you’ve done and achievements you’ve made, McKean says.

Another way of documenting this success is to publish in medical journals information about pilot studies you’ve performed.

Document what you’ve done, why you did it, and what happened, McKean says. Not only will this get you noticed by readers of the journal, but it will put your hospital in a good light.

“Hospitalists have a chance to change the hospital setting,” says McKean. “They see so many patients that they can be the leaders in defining metrics and figuring out the physics of what works in a hospital.”

Are you prepared for value-based purchasing?
Show your program’s worth with Medicare’s pay-for-performance system

In a move that the healthcare world has been anticipating for quite some time, the Centers for Medicare & Medicaid Services (CMS) released its plans for value-based purchasing (VBP) in late 2007, and hospitalist programs must be prepared to demonstrate their value in this evolving pay-for-performance environment.

Although CMS has yet to finalize some of the details of VBP—particularly regarding payment—it’s clear that CMS is expecting hospitals to meet standards that go beyond proper documentation alone.

Specifically, the new plan means that hospitals will be held accountable for how they compare to other hospitals around the country, which will give hospitalists the chance to shine and prove their worth, says Richard E. Rohr, MMM, MD, FACP, vice president of medical affairs at Cortland (NY) Regional Medical Center.

“However, it’s also going to put the onus on everyone in the hospital to deliver value,” he says. “Hospitals spend a lot of money on hospitalist programs, but they’ll stop spending that money if it turns out it’s not helping hospital finances.”

VBP details

Rohr says CMS developed the VBP system because the agency has cut costs as much as it could and will now try to create a budget by rewarding high-performing facilities and penalizing the lowest-rated facilities. The
The premise of the VBP program is laid out in the Deficit Reduction Act of 2005, which authorizes the secretary of the U.S. Department of Health and Human Services to alter Medicare’s payment program. Payment changes will begin in fiscal year 2009.

CMS says the plan must include consideration of at least the following four design issues:

1. The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings
2. The reporting, collection, and validation of quality data
3. The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for the value-based payments
4. The disclosure of information about hospital performance

CMS is proposing to transform Medicare from a passive payer of claims to an active purchaser of care. The VBP program would make a portion of a hospital’s payment contingent on actual performance on specified measures, rather than simply on the hospital’s reporting data for those measures.

Under the VBP plan, payments to high-performing hospitals would be larger than those to low-performing hospitals. And for the first time, the inpatient prospective payment system will provide financial incentives to drive improvements in clinical quality, patient-centered care, and efficiency, CMS says.

Public reporting of hospitals’ performance on Medicare’s Hospital Compare Web site will be an essential component of VBP.

CMS says the VBP plan may include the following basic components and enhancements of current data submission and public reporting:

- A Performance Assessment Model that is used to score a hospital’s performance on a specified set of measures, generating a total performance score for each hospital
- Translation of the VBP total performance score into an incentive payment
- A measure development process, including selection criteria for choosing performance measures for the VBP financial incentive and candidate measures to support ongoing expansion
- Redesigned data submission and validation infrastructure to support the VBP program requirements
- Enhancements to the Hospital Compare Web site to support expanded public reporting of performance results
- An approach to monitoring VBP effects, including potential effects on health disparities

The Performance Assessment Model

The Performance Assessment Model is the methodology that CMS is considering to score hospital performance and compute each hospital’s VBP total performance score. That score would then be translated into a specific level of incentive payment, CMS says.

CMS would assess each hospital’s performance annually using the methodology. This proposed model combines scores on individual measures across different performance domains (e.g., clinical process of care, patient perspectives of care, and 30-day mortality outcomes at the start of the VBP program) to compute a hospital’s VBP total performance score, which CMS would then use to determine the percentage of the VBP incentive payment earned by the hospital.

To comply with the Performance Assessment Model, hospitals must submit data for all VBP measures that apply to their patient population and service mix. CMS could use the measures for incentive payments, public reporting, or measure development.

Dealing with change

As the VBP system gets under way, hospitals shouldn’t see any major changes in their day-to-day operations,

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Value-based purchasing

says Kevin Nash, MD, medical director of the Alliance Hospitalist Group, Inc., at Alliance (OH) Community Hospital.

“Developing local care protocols that exhibit ease of use and high levels of utility and efficacy is where most of the extra work lies,” says Nash.

Most hospitals have been reporting on these measures for quite some time, and the system is going to start out accounting for only a limited number of quality measures, says Rohr.

“It’s a program that will evolve, so some of the most important work hospitals will have to do is staying updated with the changes and understanding how you’re being measured,” he adds.

The current proposed measures include many of the quality measures hospitals have already been reporting, including:

➤ Aspirin prescribed at discharge
➤ ACE inhibitor or angiotensin receptor blocker for left ventricular systolic dysfunction
➤ Adult smoking cessation advice/counseling
➤ Beta-blocker prescribed at discharge
➤ Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival
➤ Primary percutaneous coronary intervention received within 120 minutes of hospital arrival
➤ Discharge instructions given
➤ Pneumococcal vaccination status
➤ Blood culture performed before first antibiotic received in hospital
➤ Appropriate antibiotic selection
➤ Influenza vaccination status
➤ Prophylactic antibiotic received within one hour prior to surgical incision
➤ Prophylactic antibiotics discontinued within 24 hours after surgery

Although most hospitals are already familiar with how they fare on Web sites such as Hospital Compare, this system will make it crucial to ensure that you are at least average in everything, says Rohr.

“You certainly don’t want to be in the bottom 25%,” he adds. “Being in the top 10%, where it’s likely you’ll be rewarded, is ideal, but only so many hospitals can achieve that. It’s avoiding the financial penalties that will be important for most programs.”

A hospitalist’s role

Although the current VBP system will be grading hospitals as a whole, hospitalist programs at many facilities will bear much of the burden for living up to the standards, says Rohr.

“VBP will give a committed hospitalist program the opportunity to shine in a leadership role in its institution,” says Nash. “Institutions that forge strong linkages with hospitalists will be able to more readily implement quality initiatives, demonstrate compliance with quality indicators, etc.”

This could lead to expanded roles for hospitalist programs, but also a keener eye from management on performance, Rohr says.

Hospitalist programs may either grow or be replaced by a new hospitalist team that can move the hospital up the rankings, he adds.

“It’s hard to expect private practice physicians to always live up to the standards and also comply with reporting guidelines when they have a business that is only periphery to hospital,” he adds. “They might not spend the time to make sure all the paperwork for the hospital is done and that all patients get the proper vaccine.”

But that’s a burden hospitalists should welcome, says Nash.

“Measuring what we do and endeavoring to improve upon what we measure is what is currently fueling this evolution. Hospitalists need to challenge themselves and their institutions to take these initiatives to the next level,” he adds.
Hospitalist programs at rural hospitals face uphill climb

It’s no secret—rural hospitals have always struggled to compete with larger metropolitan hospitals for patients and clinical staff members.

Hospitalist programs in these settings are the most recent to suffer.

Hospital medicine has become so important to quality patient care that rural hospitals should fight to keep these programs afloat, says Kenneth G. Simone, DO, founder and president of Hospitalist and Practice Solutions in Brewer, ME.

He says open-mindedness, creativity, and honesty are a few ways to help you sell your rural organization as an optimal destination for patients and physicians.

Identify your specific obstacles

Every organization is different from the next. So it’s important first to decide internally which specific obstacles your hospital faces before you brainstorm ways to tackle them. If you’re uncertain why your program isn’t surviving or is unable to retain physicians, do some research.

Simone says the following are some obstacles that plague most rural programs:

➤ Recruiting and retaining providers willing to practice in a rural setting. Physicians may be turned off by isolation, Simone says.

“[The challenge is] both geographical and professional,” he says. “Rural areas tend to have fewer providers on staff, therefore there is less camaraderie and less clinical support from specialists.”

➤ Offering competitive recruitment packages. Many rural hospitals have tight budgets because of their small bed capacity and limited patient base, says Simone. As a result, it may be a challenge to offer hospitalists a competitive salary and compensation package when compared to the national marketplace.

➤ Unappealing schedule and call responsibilities. Because smaller hospitals are financially limited, the call and work burden is usually greater.

“This phenomenon self-perpetuates the difficulties in recruitment and retention,” says Simone.

Your staff size and capacity may be limited by the average daily census of your organization—which may relate directly to community size.

If the census is low, the staff size will typically be smaller, increasing the workload and call burden for each provider, Simone says.

“That’s possibly making the opportunity less attractive to potential recruits,” he says.

➤ Obtaining medical staff buy-in. The average physician who chooses a rural area over a metropolitan one does so because rural hospitals afford him or her the chance to provide a wide variety of services because there are fewer physicians and a greater opportunity to dabble in different areas of care.

For example, a general internist in a rural community may provide cardiac and respiratory services, including performing treadmill stress tests, running the ICU, and managing ventilators.

But if the local provider creates a hospitalist program in the community, the general internist’s or family practitioner’s practice scope may decline, affecting job satisfaction and his or her bottom line, Simone says.

“Therefore, some may be resistant to and unsupportive of a hospitalist program,” he says.

➤ Gaining patient buy-in. In a rural community, unlike in a larger area, patients likely have unlimited access to their primary care physician (PCP) in the community and hospital settings. It’s a convenience all patients can appreciate.

“A hospitalist program would change that relationship,” says Simone.

➤ Retaining foreign medical graduates. Many rural areas are designated as underserved and attract foreign medical graduates.

Initially, this is great for the community and the hospitalist program.

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However, it can create instability within the medical community and result in further turnover if these physicians serve their time and move away.

Sell the pros to PCPs and patients

On the surface, your hospitalist program may not look attractive to local PCPs. That doesn’t mean there aren’t plenty of reasons why the PCPs should support the program; you may just need to convince them.

Simone says explaining the pros of the hospitalist program may help convince physicians that the program is a benefit for them and their patients by:

➤ Increasing practice efficiency
➤ Increasing outpatient access
➤ Improving quality of care
➤ Allowing PCPs to devote more time to sicker outpatients
➤ Enabling PCPs to focus on preventive medicine
➤ Providing the potential to decrease outpatient costs by increasing efficiencies
➤ Offering the PCP an opportunity to expand office hours
➤ Increasing opportunity for revenue
➤ Supporting recruitment and retention of practice associates
➤ Improving patient satisfaction

Perhaps a hospitalist program’s most significant benefit to a PCP is the possibility of fewer work hours and an improved quality of life.

“Because the call burden is greater in rural areas, some physicians may welcome a hospitalist program with open arms,” Simone says, “as it may decrease the call burden and improve their quality of life.”

Convincing patients is a little different, Simone says, but he suggests using the following selling points:

➤ Greater access to physicians (inpatient and outpatient)
➤ Shorter length of inpatient stay
➤ The potential for decreased costs to the patient
➤ The potential to increase the quality of care and patient safety

Strategies for recruitment and retention

Obtaining physician and patient buy-in is one step in the process of developing a healthy program. But it means very little if you cannot recruit and retain hospitalists. Simone compiled a list of recruitment and retention strategies that should work in a rural setting:

➤ Be aware of the current job market and practice opportunities on a local, regional, and national level.
➤ Be aware of the generational expectations of the candidates and understand that candidates from Generation X and the Millennial Generation have different work expectations and values than the baby boomer and mature generations. “Gen-X and the Millennials tend to gravitate to programs offering scheduling flexibility and/or job sharing. They place a high value on personal time,” Simone says.
➤ Know the selling points of your community and within your hospital and practice and showcase these strengths.
➤ Be honest about the possible drawbacks of the practice opportunity. “Be forthcoming, but also share your thoughts regarding solutions and approaches to the problems,” says Simone. “It’s best not to hire anyone at all than to hire a physician who will be unhappy in time.”
➤ Gain a sense of the candidate’s values, vision, and objectives, and make sure they align with the values, vision, and objectives of your program, Simone says.
➤ Involve the spouse, significant other, and/or family in the recruitment process. “They may be key in the
candidate’s acceptance of a position, or, conversely, they may be the reason why a physician leaves the community,” Simone says.

➢ Create a recruitment, retention, and orientation plan and implement it.
➢ Be creative with scheduling to allow for job sharing and flexibility.
➢ Offer a fair-market (or above) salary with a meaningful incentive program.

Simone also added the following list of strategies to sell and grow your hospitalist program:

➢ Distribute patient education brochures regarding the hospitalist program in the PCP/referring provider’s offices, emergency department, and hospital wards.
➢ Meet with the referring providers as an educational and goodwill visit.
➢ Undertake a market assessment and develop a marketing plan.
➢ Update the medical staff about the state of the hospitalist program at least annually (perhaps at quarterly medical staff meetings).
➢ Increase the visibility of the hospitalist providers within the community.
➢ Communicate well and provide compassionate and quality medical care. “If the hospitalist physicians practice quality medicine and communicate well with patients, their families, and the referring physicians, they will garner support for the program and win over the critics in time,” says Simone.

Hospitalist programs in rural settings: One organization’s struggles

In 2002, the family practice physicians at Cheboygan (MI) Memorial Hospital (CMH) wanted out.

It was a familiar scene played out all over the country—physicians unhappy about too many hospital calls, too many hours spent working outside their offices, too much hassle. So the family physicians in rural Cheboygan asked CMH to move in the same direction as other organizations with the creation of a hospitalist program to remove some of the physicians’ clinical burden.

In July 2002, CMH unveiled its program with two full-time hospitalists on board.

The initial phase was smooth, as the patients trusted the hospitalists because they were well-known in the community and provided high-quality care.

But recruitment and retention since the program’s implementation has been a nightmare for the small community hospital with 60 beds and about 60%–70% occupancy.

“We have not been able to retain anyone for longer than two years due to family, financial, and fellowship constraints,” says Don Watson, DO, an internal medicine physician who started at CMH in December 2002.

Now, CMH is down to three part-time hospitalists and has decided to contract with a hospitalist company to provide coverage for the hospital.

Staffing, recruiting challenges abound

The biggest challenge CMH faces, as most rural organizations do, is keeping appropriate staffing and finding quality hospitalists.

“It is extremely hard to compete financially with the bigger facilities to compensate hospitalists,” Watson says.

But money isn’t the only drawback, he adds. As a rural hospital, CMH has no subspecialties. The hospitalist must be the expert in all fields of internal medicine. Although that could be an attractive aspect of the job for some, it isn’t for everyone. The turnover has made it not only difficult to maintain consistency in care, but it has kept CMH from building structure for the program, such as written policies and procedures, schedules, and pathways.

“This makes recruiting a hospitalist difficult when there is no predetermined schedule and structure to define the program,” Watson says.

So CMH, for the time being, has given up on recruiting hospitalists by itself or through locum tenens companies. The hospital is currently signing a contract with a company that promises to fully staff the program and define the structure with policies, procedures, and pathways for patient care, Watson says. “Right now, we are putting our hopes in the contracting company to recruit for us globally,” he adds.
Setting clear expectations for compensation is one of the most important strategies identified by respondents of the American Medical Group Association (AMGA) and Cejka Search 2007 Physician Retention Survey.

One recruitment challenge that exemplifies this principle involves a nonprofit regional health center that enlisted Cejka Search’s expertise. It is a 392-bed acute care facility with a Level II Trauma Center and an accredited Chest Pain Center located in an East Texas city with a population of approximately 200,000.

The health center was recruiting two pediatricians for two positions when Cejka Search was retained. The first was a position in its Family Care Center for uninsured and underinsured women and children. The health center paid these physicians a straight salary. The health center was also searching for a pediatric physician who would treat insured patients in a traditional-style practice. The components of this financial package did not limit income, providing both a base salary and productivity bonus option in addition to a signing bonus. This was a challenging search because the requirements for both positions were very similar, although the salary and benefits varied. The health center needed to fill the positions immediately, but did not want all of the candidates to apply only for the more traditional practice setting.

Cejka Search used industry supply-and-demand trends from the retention survey to support its recommendations for the client, such as the 39% of respondents who cited increasing signing bonuses, loan repayments, or other incentives, as a strategy for attracting and retaining primary care physicians. Thus, Cejka Search’s recommendations began with marketing the clinic position by highlighting the signing bonus.

To make the position more competitive, it was also recommended that bonuses based on productivity would attract more highly qualified candidates.

Results

Once Cejka Search publicized the signing bonus and told the potential candidates of an anticipated change in the compensation plan, the position attracted several qualified applicants. Cejka Search has already helped the health center fill both positions. The health center implemented Cejka Search’s same recommendations in another specialty in December 2007, interviewing and hiring a highly qualified candidate within 60 days.

Editor’s note: This month’s recruitment strategy was submitted by Cheryl DeVita, senior search consultant at Cejka Search.