Is a family medicine practitioner the right fit for your hospitalist program?

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

At first glance, the numbers jump off the page. In hospitals, the reality is even more staggering. The Society of Hospital Medicine (SHM) estimates that there are about 20,000 hospitalists in the United States today. It also projects the need to exceed 40,000 during the next five years.

The demand for qualified hospitalists has far outgrown the supply, and hospitals are scrambling to staff their hospitalist programs with qualified physicians.

Unfortunately, it’s just not that easy.

“This issue has arisen out of a significant shortage of physicians when compared to current and projected need,” says Robert Harrington, Jr., MD, the vice president of medical affairs at IN Compass Health, Inc., in Alpharetta, GA. And although the cause of the issue might be black and white, the solution is all shades of gray.

In November 2007, Harrington was invited to participate on a task force to brainstorm a strategy “that might allow us to better serve the needs of the rapidly expanding patient population in the fastest-growing specialty in medicine,” he says.

The task force identified a handful of undertapped pools of potential hospitalists that included foreign medical graduates, mid-level providers (nurse practitioners and physician assistants), medical students, and family medicine physicians.

Although many hospitalist programs have already begun to look toward family physicians to meet staffing needs, it’s important to know exactly how well this group of physicians matches up with your program.

Harrington says that even though these practitioners might be excellent candidates, the marriage between physician and program should ultimately come down to individual traits, abilities, skills, and experiences rather than mere titles.

“The heavy outpatient component of family medicine residency training has proven to be an asset with the family physicians in our hospitalist program, and likely in others.”

—Shannon Jenkins, MD

Training program in the works

Hospital medicine appeared after the development of traditional residency curriculums for internal medicine (IM) and family medicine (FM). At that time, hospitals staffed their programs with internists because the IM
training program provides applicable inpatient experiences and exposure to medical subspecialties, including critical care. “However, even most IM programs lack the education in physician documentation, metrics, resource utilization, etc. ... necessary to be an ‘ideal hospitalist,’” Harrington says.

This idea of training the ideal hospitalist has been addressed by SHM’s recent creation of a fellowship in hospital medicine. Harrington adds. SHM designed it to meet needs that traditional training programs do not address.

“I feel strongly that we want to avoid drawing a line in the sand between the traditional IM and FM residency training,” says Harrington. “I believe the characteristics that make someone an ideal hospitalist are more a series of individual traits and skill sets that can be adequately obtained through either an IM or FM residency training program, and individual physicians should be evaluated on a case-by-case basis.”

**Unique training and perspectives**

Still, the FM residency training program does tend to give physicians the background that can lead to a successful career as a hospitalist.

Shannon Jenkins, MD, associate chief of hospital medicine at the University of Massachusetts Medical School in Worcester, says her hospitalist service boasts a one-day-shorter length of stay and decreased cost of hospitalization than its IM counterparts.

That’s “because there is an understanding of what is possible, and sometimes easier, with an outpatient work-up,” Jenkins says. “The heavy outpatient component of FM residency training has proven to be an asset with the family physicians in our hospitalist program, and likely in others.”

The FM physicians in Jenkins’ program also understand the key components that they must communicate with the patient and the primary care physician for a successful handoff from the inpatient to the outpatient setting.

Financially, it makes sense as well. “Family medicine physicians are trained in adult, pediatric, and obstetrical medicine, so they are ideal for smaller hospitals that could not sustain the cost of three separate hospitalist services,” Jenkins says.

Harrington adds that the following FM residency training aspects could prove useful for FM physicians transitioning into hospital medicine:

- The training received by FM physicians in the psychosocial aspects of medical care brings a unique understanding of serious illness and end-of-life discussions to the bedside.
Exposure to palliative care programs and treatment models, an emerging need in hospital medicine, are part of the curriculum.

There is a focus on the system in which FM physicians practice and deliver care. This instills an awareness of available community resources and allows for improved coordination of care and effective discharge planning.

Because of their pediatric training in residency, FM-trained hospitalists may be a good fit for smaller, community-based hospitals that have a need for adult internal medicine and pediatric coverage.

There is a patient-centered approach to care, which plays into improving patient satisfaction and the ability to ensure that the patient and/or family is at the center of the medical decision-making process.

FM physicians have an awareness of family dynamics and their role in treating acute and chronic illness.

FM physicians also tend to have certain skill sets that can make them strong hospitalist candidates. For example, the extensive procedural training of FM physicians helps a great deal. “No consult is needed for arthrocentesis, lumbar puncture, central lines, paracentesis, thoracentesis, or PICC lines,” Jenkins says.

This has a dual benefit of providing the following:

- Comfort for the patient, because, in most cases, they can have a procedure done in their room rather than within another hospital department
- Increased revenue for hospitalists

**Transition of care expertise**

FM physicians also have extensive experience in the outpatient setting during the residency program.

“The detail in transition of care is what sets FM hospitalists apart,” Jenkins says. “We know what information is crucial to communicate with the referring physicians to ensure good care at follow-up. We understand the continuity of care that the referring physicians desire and communicate any change in status to them.”

For example, the patient’s family often will call the primary physician for guidance on how to proceed when a family member is in the ICU.

“It is important for them to know those details,” says Jenkins.

**Broad experience can trump training**

As a physician in a multipractice hospitalist group who has exposure to many physicians of various training backgrounds, Harrington says physicians with a broad base of experience make ideal hospitalists.

“Those who have had previous private practice experience, emergency department [ED] experience, and especially those who have had medical staff leadership experiences usually rise to the top,” he says. “I think this relates to their ability to understand the interface between hospitalist and another physician—whether it be an ED physician, a primary care provider, or a specialist—from both sides.”

They understand what it is like to reevaluate a patient after they’ve been hospitalized, and they understand what information is important to have at that follow-up visit.

“They also understand the difficulty an ED physician might have in getting a patient admitted that might not meet strict admission criteria, but certainly is not medically safe to send home,” Harrington adds. “They tend, in these instances, to do what is right for the patient and find a way to make the system work so that the needs of all parties are addressed. Family medicine training programs provide this broad base of exposure.”

**Challenges recruiting FM physicians**

The biggest draw for a FM physician interested in a hospitalist program is the opportunity for growth and change within a system, Jenkins says.

“I think most family physicians that enter into hospital medicine see it as a long-term commitment,” she says. “They are less likely to take a position as a

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workhorse for 23 shifts a month or just to fill time prior to a fellowship.”

However, the biggest problem is communicating these opportunities and advertising hospital medicine as a viable and sustainable career for FM-trained physicians, says Harrington.

“Because of the lack of widespread acceptance, it has not traditionally been a door that has been open to most graduates of FM programs,” Harrington says. “However, I do think, because of focused efforts on the part of organizations like the SHM, that the word is getting out, and, consequently, there will be more interest among family physicians in the future.”

SHM has been proactive on this subject and has begun discussions with the American Board of Family Practice and the American Academy of Family Physicians to design a recertification process for physicians who choose a career in the hospital.

Feedback from SHM Workforce Summit participants was overwhelmingly positive in terms of their acceptance of the concept, Harrington adds.

For many FM-trained physicians, hospital medicine is an optimal career. Initial interest came from a “small group of family physicians who enjoy acute care and were reluctant to give up that portion of their practice despite enormous pressure from hospitals, managed care [organizations], and the economic forces driving the surge in hospitalist programs,” says Harrington.

Keep the big picture in mind

Although hospital medicine is certainly entrenched in a staffing crisis, it’s important to remember that primary care is suffering as well, Harrington says.

“Increasing the number of physicians in hospital medicine must not be done in a bubble and must be sensitive to the possibility of stealing from the other primary care specialties, which are also in desperate need,” he says. “There is no benefit to us, as hospitalists, to have an adequate work force when we don’t have enough primary care physicians to meet the needs of the population.” In such a scenario, hospitalists would ultimately feel the burden stemming from a lack of access to preventive care.

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Recruitment and retention strategies

Define your needs, prepare a process, and sell your hospitalist program’s strengths

As the leader of your hospitalist program, you’re probably familiar with the hiring process. If turnover and growth haven’t affected your team, the odds suggest your luck will soon change.

The need for hospitalists grows each day, and hospital administrators look to program leaders to keep their departments fully staffed, happy, and productive. It’s a tall task, and one that can lead to bad hiring practices and, worse, bad hiring decisions.

Kirk Mathews, CEO of Inpatient Management, Inc., in St. Louis, says you can make your life easier if you follow a few simple steps.

Mathews says you should first develop a game plan. He suggests the following:

➤ Clearly identify the qualities you are looking for in a candidate and prioritize these qualities in the likely event that Mr. or Mrs. Perfect doesn’t walk through your door
➤ Prepare for the interview process by knowing what questions you want to ask and what reactions or responses to watch for
➤ Understand how important it is to be honest and sell your program and organization for what it is

Develop a recruitment game plan

It’s probably a familiar feeling. You have an opening or multiple openings, and you’re smothered by the pressure to fill those openings to respond to a growing patient population.

But before you look into the market for help, conduct an inventory of your program and the jobs your current hospitalists are doing.

“Think through the issues that will affect recruiting, such as uncertainty with scheduling, your staffing model, and call schedule. All those things will kill recruiting,” Mathews says. “You need a game plan that is defined.

That’s a mistake many hospitals make.” And it’s a mistake you can’t afford, he adds, because the market is incredibly competitive. “We’re going to need to double the work force over the next five to 10 years,” he says.

Scheduling is a critical consideration. If you’re in an existing program, most of the operational elements of the practice are likely in place. “But with growth, those dynamics become moving targets,” Mathews says.

Do you have mechanisms in place that will adjust the schedule to accommodate more hospitalists? If not, the discussion should include the practice leader and someone from the hospital management team, because, ultimately, the program should serve the organization’s goals first.

If you’re a start-up program, then you must establish those initial operational elements, such as scope of practice, schedule, etc. That discussion should include a representative from the senior management team. You should also include medical staff leadership in these decisions.

Mathews says it’s a mistake to say to your medical staff, “We are going to start a hospitalist program. How do you think it should be structured? Will you participate and refer patients to it?” This approach invites too many cooks to the kitchen.

“The problem is people will fill in the blanks with how they think the service should be structured,” says Mathews. “The best idea is to include a small group of decision-makers. You don’t have to make it a free-for-all and invite everyone to the table.”

Decide what the hospital’s goals are and take that information with you to the marketplace and the recruitment process.

You should also consider where to search for your candidates. Look in all of the traditional places, such as internal medicine or family practice residency programs, and try to identify candidates from your own medical

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staff. Also search Web sites where candidates post their résumés. “You can’t leave any stone unturned,” says Mathews. “Increasingly, we are finding physicians that are sick and tired of the hassles of an office-based practice.”

Hire the right candidates

Before you hire anyone, understand that it takes a minimum of six months to determine whether you made a good hire, says Mathews.

“You have to come to grips with that,” he says. “Sometimes, in the worst scenario, you might know right away that you have made a bad hire. But anyone can be on their best behavior for six months.”

When you conduct your interviews, there are big-picture factors you should consider. Mathews suggests asking the following questions:

➤ Why do you want to work in hospital medicine?
➤ What things are you looking for from a community?
➤ What type of community is most attractive to your family?

“What the candidate provides for answers will let you know whether they are going to be a good match,” says Mathews.

Know what variables exist

There are three additional variables that Mathews suggests investigating. Try to determine whether the candidate possesses the following:

➤ Good clinical skills. A candidate’s clinical skill is the most difficult quality to ascertain during an interview. It may take some legwork, but it’s obviously an important factor in your decision.

“Do your background checks, talk to people, see what others say about [the candidate],” Mathews says. However, keep in mind that there is also an inherent flaw built into the system, which Mathews says you should take into consideration. “I don’t recall ever speaking to a [candidate’s former] program director who said he or she is not a very good physician. If the physicians made it through the director’s program, then the director will almost always say [he or she] is a good physician.”

Tip: Don’t settle for the director’s initial response. Ask more questions. Listen to the adjectives the director uses. Is the candidate a good physician, or a great one? Make note of hesitations. Is the director thinking how to respond? Probe a lot, Mathews says, and try to glean as much information as you can.

➤ A service mentality. Start by asking the candidate if he or she does any volunteer work. If the response is just “Yes,” he or she may not be passionate about this service. If the answer is “Yes, I take a lot of medical missionary trips,” you’ve got a better feel for the candidate’s approach to service.

“You’re not so much looking at their specific volunteer work, but their reaction to the question,” Mathews says.

Another way to uncover information is to determine whether the focus of the candidate’s remarks is about himself or herself. “They may ask if they have to work weekends. It’s an important thing for the candidate to know, so don’t automatically declare them selfish,” he says. However, it’s a telling question for the line of the work the candidate is pursuing.

“We don’t have patients unless someone else sends them to us. We are serving the patients and also the people who sent us those patients,” Mathews says. “Many of our patients come from a physician whose patient has put their trust in them for many years. But they are now referring them to our care. So a service mentality is an important quality to have.”

➤ Proactive communication abilities. Communication is a huge part of a hospitalist’s job. If the candidate is someone who is difficult to draw information out of, that’s not a good sign, says Mathews.

“You’re not necessarily looking for someone who rambles, but someone who is articulate and can explain
Avoiding hospitalist burnout starts with the right approach

The constantly evolving role of today’s hospitalist can open the door to a wide variety of opportunities and responsibilities that make the physician’s role dynamic, challenging, and interesting. But new roles and responsibilities can also lead to more work than a hospitalist can handle, and that can eventually result in burnout.

“There are a lot of reasons why some hospitalists are starting to get burned out,” 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. “Unreasonable expectations in terms of daily clinical load may be the primary reason, though.” Amin says other reasons for burnout include:

➤ Competing activities or interests
➤ Balancing clinical work and educational roles
➤ Time spent in committees that isn’t built into the hospitalist’s normal schedule
➤ Low staffing levels

Fine-tune your retention strategy

The most important and most effective strategy to reduce turnover and maintain employee satisfaction is to be honest from the get-go about the specifics of the job you are offering, says Mathews. “If you tell them it’s going to look like this, and it’s really like that, you won’t be able to keep them,” he says.

After you’ve hired the hospitalist, maintain good communication. “Never stop recruiting them, even after they become your employee,” Mathews says. Keep an open-door policy, and schedule regular informal visits to chat about any concerns the hospitalist might have. “That way, if there are any problems, you can address them before they reach a critical level,” he adds.

Finally, continually monitor your staffing model to make sure it still works. Many hospitals underestimate the rate at which their program will grow, Mathews says, and the changes that may come with that growth.

Editor’s note: For more information, look for Mathews’ upcoming book about hospitalist recruitment and retention, Practical Guide to Hospitalist Recruitment and Retention (published by HCPro, Inc., July 2008) on www.hcmarketplace.com under the Medical Staff tab. Check the July HMA for a professional reference verification form you can customize for your program.

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In a 2002 study by Hoff et al, published in the Journal of Social Health and Behavior, the authors found that factors associated with burnout included:

- Perception of restricted autonomy
- Poor occupational solidarity
- Poor integration with nonphysician coworkers
- Poor recognition by patients/families for a job that is well done
- Inability to treat the entire range of patient problems

Whatever the reason for burnout, if you don’t address it in your hospitalist program, you’ll most likely start to see its effects at some point. In the worst cases, hospitalists may flee the specialty and pursue positions that allow them more flexibility or freedom, says Amin.

Address staffing and scheduling needs

Because there’s not just one reason for burnout, lessening the burden on hospitalists isn’t as simple as just making one or two changes. “You need to look at your individual program and discover where your deficiencies are and talk to your hospitalists. Do not just assume that you, as the director, know what might be leading to any exhaustion, cynicism, and ineffectiveness they may feel,” says Sylvia Cheney McKean, MD, FACP, medical director at Brigham and Women’s Faulkner Hospitalist Service in Boston and associate professor of medicine at Harvard Medical School in Cambridge, MA.

Consider taking the following steps:

- Examine the needs of the whole program. A lot of programs focus on addressing the needs of the individual physician, says McKean, even though that’s not always the most successful or effective way to tackle burnout concerns. “Like healthcare in general, changing the healthcare system or organizational structure potentially has more value, even though it is harder to do,” she says.

However, such structural changes require strong and dedicated leadership that can address the needs of the program as a whole, says Amin. Two important factors are crucial to that success: time and money.

- Spend time and money wisely. “Putting money into ... a full staff is essential,” Amin says. “When staff goes on a vacation or has to miss a day of work, a hospital can’t just cancel appointments or reschedule. If that extra patient load is just handed off to other hospitalists working that day, it leads to too large of a case load many times.”

This means your program must hire the appropriate number of hospitalists to cover nights, weekends, staff member illness, and any other contingency that may arise, says Amin. Sometimes, you may need to be creative with your staffing solutions to achieve the desired result. “Maybe you have one or two people whose primary roles aren’t patient care, but who can fill in during times of need,” he says.

- Allow for individual growth and flexibility. Building an adequate staff isn’t just about covering your program’s basic needs—it’s also about allowing room for your hospitalists to pursue opportunities, and that flexibility can help combat potential burnout.

“By having a large enough staff, you can also work in time in hospitalists’ schedule for their own personal growth and projects,” Amin says. “You can’t just expect all their allotted time to be spent on patient care, and then they have to find extra time for committees, education, teaching, project work, and administrative work.”

McKean and Amin say diligent scheduling is another tool to keep your hospitalists satisfied.

“Flexibility in scheduling is key to address the diverse needs of hospitalists, and building redundancy into the schedule is necessary in anticipation of inevitable absences,” says McKean.

“Unlike in the outpatient world, hospitals have a varying patient flow,” Amin says. It’s inevitable that, in a setting without appointments, some days will be slower or busier than normal. Having the ability to adjust to that flow can make things run much more efficiently.
Clearly define hospitalists’ roles

“Setting up processes for dealing with the daily fluctuations in patients and the increasing roles of hospitalists is essential,” says Amin.

Hospitalist programs are often spread throughout the hospital, dealing with different nursing units, floors, and patients. If it’s not clear what each hospitalist is responsible for, confusion and inefficiency will become prevalent.

“The less nonphysician tasks a hospitalist is responsible [for], the better,” says Amin. For example, hospitalist programs should take advantage of pharmacists for medicine reconciliation and case managers for discharges. If case managers are also calling insurance companies and determining next levels of care for the physician, that’s another task that can be taken off a hospitalist’s plate.

“Consider taking a look at whether a unit-based strategy or a service-based strategy is better for your program,” Amin says. A service-based system, in which the same hospitalists work with the same nurses, case managers, etc., works best for Amin’s hospital, he says. It enables the support staff to get to know the hospitalists’ needs, and allows hospitalists to teach staff members what their quality measures are.

A unit-based strategy, in which the hospitalist sees patients on different floors, means he or she will be working with a different set of nurses and other staff members who may not be as familiar with the hospitalist’s style.

“But plenty of other hospitals have had success with the unit-based strategy,” says Amin. Which is the best setup is seemingly always in debate in the rapidly changing world of hospitalist programs, he adds.

Create a dedicated space

In a private physician’s office, every physician would expect to have his or her own office in which to work or relax when not caring for patients. That’s not always the case in hospitals. “The importance of the physical environment cannot be minimized,” says McKean. “Hospitalists need office space, places to sit while they write notes, space to teach, talk to their colleagues, and relax. But environment isn’t just office space. We are all working within a community of physicians in the hospital network. How we interact with each other defines our professionalism and satisfaction with the hospital as a place to work.”

In addition, physicians are human beings who have lives outside the hospital, says McKean. Sometimes, hospitalists may experience unpredictable personal issues—they may go through divorces, have children, or care for sick family members.

“By allowing physicians the flexibility in their workload and schedule to address personal challenges, it’s much more likely they’ll respect the organization and be able to focus when they are working,” says McKean.

Find the right fit

A hospital is somewhat like an airport, says Amin. In some airports, planes land on the runway, and passengers take a bus or walk to the terminal. In other airports, planes pull right up to the terminal for faster, more convenient transfers. For a hospital, the type of setup similarly determines the time and resources it needs and affects its overall systematic operations.

Hospitals are still trying to figure out the most efficient way to deal with patients, but finding the right design to meet patient and physician needs goes a long way toward creating a better process.

“Some of the responsibility does fall on individual hospitalists, however,” says McKean. “Entering a hospitalist program that best fits his or her goals will also help stave off job dissatisfaction and, ultimately, burnout. Hospitalists should identify mentors and work toward finding a niche of expertise within the group and receive recognition for their work from the larger hospital community.”
Don’t just use job descriptions for recruitment
Regular updates will help keep your program focused

Whenever you’re recruiting new hospitalists, you’re bound to create a job listing that contains an ideal description of the role you’re looking to fill. But how accurately does that description reflect the actual roles and responsibilities of your hospitalists?

Job descriptions are essential in defining what your hospitalist program is all about, says Jeffrey R. Dichter, MD, FACP, partner at Medical Consultants, PC, in Muncie, IN, and former president of the Society for Hospitalist Medicine. “Job descriptions help define your program’s mission and what an individual’s goals should be,” Dichter says.

But before writing or editing a job description, it’s important to know who your customer is and what you want the priorities to be, says Dichter. Because these things can change with relative frequency, it’s important to review your job descriptions at least once per year and update them as appropriate.

Describing the job

A hospitalist job description will vary at every hospital and will differ within the program based on the different roles that exist. A leader or manager’s job description may be quite different than a staff hospitalist, even though every physician in the same facility will have many of the same tasks defined in their role, says Dichter.

Hospitalist programs should always keep their job descriptions simple and, whenever possible, fairly general, says Dichter. A job description of one to two pages is ideal because it’s easier to keep up with, but often it has to be longer. Although the details may vary, there are several items that most good job descriptions feature, including:

- Supervisor (i.e., to whom the employee reports)
- Supervisory responsibilities of the employee
- Essential job functions
- Expectations
- Knowledge, skills, and ability requirements
- Typical work conditions
- Typical physical demands
- Education and experience requirements
- Specific tasks and roles you may want to mention include:
  - Maintaining privileges
  - Working with specialists
  - Communicating with patients and family
  - Transitioning patients’ care in and out of the hospital
  - Documentation and coding procedures

Job descriptions should be set up uniformly so it’s easier to distinguish any differences between roles, says Dichter. Doing so also makes it easier to make those roles a part of the evaluation and promotion process. For example, you can make it clear what tasks or roles the hospitalist needs to take on to earn a promotion.

Updating your descriptions

The onus of looking at job descriptions mostly falls on hospitalist group leadership and/or hospital leadership, especially in the case of job descriptions for hospitalist management personnel. “It’s easy to overlook job descriptions sometimes, but I believe that no matter how busy your program is, it’s time well spent,” says Dichter.

It’s essential to have a process for updating and changing job descriptions, Dichter adds. Without a written process, it’s less likely that you’ll actually make the updates, and it’s more likely that individual hospitalists won’t be happy with the changes. A formal procedure will help you avoid confusion in the department.

Questions? Comments? Ideas?

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Your staff members should know how the process is done and be involved with any changes that will affect their duties and responsibilities.

For example, Dichter says, if some hospitalists will now be part of a comanagement process with another department when they previously served as consultants, you should discuss with the hospitalists involved what the main changes will be and whether the expectations are appropriate.

When updating or creating new job descriptions, consider taking the following steps:

1. Educate current hospitalists and other appropriate medical staff members about the need for a written job description or policy.

2. Appoint a task force to draft an initial set of hospitalist performance expectations. In essence, this task asks hospitalists to personally define what it means to be a member of the team.

3. While it is still in draft form, make the job description or policy an explicit agenda item for discussion in a medical staff meeting (for each relevant department). Regardless of the approach your department or staff members take, hospitalists’ expectations must be shared with all medical staff members. Seek opportunities to discuss the draft with hospitalists in the hallways, in the operating room lounge, and even in social settings.

4. Implement the expectations, ensuring that all hospitalists currently on staff have a copy of the job description or policy. Include a copy in the orientation materials of incoming hospitalists as well.

**Recruiting and hiring**

Although every facility may not use job descriptions to keep current employees on track, job descriptions are always an important part of the recruitment and hiring process, says Dichter.

“When a person comes into my program, I show them exactly what the job is and what my expectations of them are,” he adds. “You want your job description to give the potential employee a good idea of how your program functions, so there are no surprises when they start.” A well-written job description that aligns with a clear mission statement should help you recruit, because it brings up talking points and should separate you from the pack of other hospitals looking for physicians, Dichter says.

“It gives a potential employee an idea of what your values are and how you understand what a hospitalist does,” says Dichter. A thorough job description will also help avoid hiring physicians who may not fit into your system.

**Sample hospitalist job description**

The following is a sample of a general hospitalist job description from the HCPro, Inc., book, *Tools and Strategies for an Effective Hospitalist Program*:

- Perform rounds Monday through Friday, taking full ownership of the general internal medicine inpatient service during weekday business hours
- Perform internal medicine consultations
- Participate occasionally in the ambulatory clinic, which may include private practice, preoperative clinic, same day, urgent care, posthospital follow-up, procedure, and/or clinic attending responsibility
- Attend regular meetings with the executive director of the hospitalist program
- Attend/participate in the monthly hospitalist program faculty meeting
- Attend/participate in the department of medicine faculty meetings
- Attend/participate in the division of general internal medicine meetings
- Become actively involved in various administrative committees and projects as determined by the executive director of the hospitalist program
- Follow the hospitalist program policies on patient care, availability, medical education/teaching, and academics
- Become an integral part of the hospitalist team and be willing to provide backup as needed
- Participate in evening and weekend call as scheduled by the hospitalist program
**Recruiting tip of the month**

**Use Web technology to your advantage**

The demand for primary care positions significantly outweighs the current supply, which makes recruitment a struggle. Because primary care physicians are especially important for the aging population, hospitals and medical groups must adopt creative recruitment strategies.

A nonprofit regional health system in eastern Texas launched a search to recruit 15 family practice physicians this year. This health center operates more than 20 area clinics, for which primary care physicians are always in high demand. The health center enlisted Cejka Search experts to help strategize this search.

**Strategy**

Realizing the importance of cutting-edge technology and outreach, Cejka Search made recommendations on how to best leverage technology based on current trends.

For example, a greater percentage of recent medical school graduates use mobile devices and MP3 players than their predecessors. As these technological tools gain popularity, both young and experienced doctors are becoming more tech-savvy. Therefore, the health system can utilize more technology in its efforts to recruit top physician talent.

Effective uses of technology can be as simple as frequently updating the health center’s Web site, producing podcasts (audio recordings of available positions), or creating a blog to encourage discussion between candidates and others in the health system.

Web site updates are important when candidates consider joining a health system or medical group. They will likely first turn to the organization’s Web site to find information and to validate their interests in the opportunity. Updates may include news about the health system, such as recent awards, new treatment centers, and announcements welcoming new physicians.

**Results**

The Texas health system found that:

- **Podcasts draw applicants.** Podcasts are a particularly progressive advertising opportunity as an additional outlet for physicians to find job postings. When Cejka Search began posting job openings via podcast, the podcast was downloaded 72 times in just 24 hours.

- **Blogs provide an outlet.** Another avenue for recruiting, as well as retention, is the use of social networking through a Web log, or “blog.” From a recruiting perspective, it gives candidates a window into the organization’s culture. Candidates can read how new and experienced physicians interact and discuss issues with one another. Additionally, as an outlet to talk about trends and to ask questions, the blog provides a consistent dialogue among physicians at all points in their careers, which is good for retention.

Although it is still early to accurately measure results for this year, the feedback from the Texas health system thus far has been positive. Even though these positions are in high demand across the country, the search is currently on track to fill all 15 positions as planned.

Because there are more candidates who use the Internet than journal ads to find job opportunities, the podcast and the blog make job postings even more accessible. Like Web 2.0, recruiting is in its next phase, and Internet tools can be used to seek the best physicians for hospitalist care.

*Editor’s note: This month’s recruitment strategy was submitted by Pam Kinsella, senior search consultant at Cejka Search. This data was pulled from the American Medical Group Association (AMGA) and Cejka Search 2007 Physician Retention Survey. Forty-three members of the AMGA, which collectively employs more than 14,705 physicians, completed the survey. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.*