Determining the right number of hospitalists for your facility

Healthcare organizations, many of which struggle to function with constrained budgets while meeting patient safety, administrative, and regulatory goals, find that it takes planning and intelligent forecasting to determine how many hospitalists their facilities need.

Although there are well-documented benefits to establishing a hospital medicine program, including saving money, increasing efficiency, and improving quality of patient care, overextending hospitalists—or maintaining a group with a workload that is out of sync with your scheduling model—can counteract benefits gained from instituting a program.

John Nelson, MD, FACP, director of the hospitalist practice at Overlake Hospital Medical Center in Bellevue, WA, and cofounder of the Society of Hospital Medicine (SHM), discussed hospitalist staffing models during the SHM annual meeting in Chicago in April. According to Nelson, deciding what level of coverage your program will provide and how you will accomplish it is a basic component in determining staffing.

How to improve productivity, efficiency

Top time management tips for busy hospitalists

As the adage goes, “If you want something done, give it to a busy person.” Chances are, the most productive hospitalist on your staff is also the one who chairs committees, teaches, publishes frequently, and is an active member of various medical societies.

So what’s his or her secret? The hospitalist is extremely busy—and prioritizes his or her time on the job.

Planning is an essential skill for today’s busy physicians, yet it’s rarely formally taught to anyone, including busy hospitalists, says Pam Vaccaro, MA, CSP, president of St. Louis–based consulting firm Designs on Time (www.designsontime.com).

A speaker about time management to healthcare professionals since 1991, she says requests for helping physicians tackle this challenge have spiked during the past five years, partially due to the ubiquity of communication technology (e.g., e-mail, instant messaging, pagers, cell phones). “No one is off-call anymore,” she says.

Managing time is a unique issue for hospitalists because of the constant pull between the
needs. His presentation, “How Many Hospitalists Are Enough? Advanced Staffing Projections,” stressed that staffing requirements are directly linked to an organization’s work schedule and that a staffing shortage might actually be a scheduling problem.

“There are formulas to use as a framework in finding the number of hospitalists you need, but if yours is a practice with on-site presence 24 hours a day, you’re probably going to need more doctors than you would calculate based on one metric—for example, patient volume—alone,” Nelson says. Likewise, he noted that a small organization with a low number of admissions might appear to need the services of only one hospitalist. However, even without offering night coverage, the facility would need more than one hospitalist on staff to avoid having the physician constantly on call.

Variables
Although it’s acceptable to use national data as a starting point in calculating the number of hospitalists your facility will need, Nelson says that individuals tasked with staffing a program should also consider the unique features of their organization. Using only one variable (e.g., daily census) would be a mistake, he says.

“I also would not calculate staffing based solely on the number of referrals because that fails to take into account whether your hospitalists see a lot of very sick patients or do a lot of work in the [intensive care unit]. You should calculate the number of hospitalists based on several metrics,” he says.

Nelson suggests that organizations consider the following metrics when determining the number of hospitalists they will need to run a successful program:
- Patient volume/referral volume
- Number of admissions/consultations
- Scheduling format (e.g., shift- or call-based, rotating, etc.)
- Staff turnover
- Daily census
- Availability of night coverage
- Hospital-specific issues (e.g., a Florida hospital may see significantly higher patient volumes in winter because more elderly people reside there for several months)

Nelson also recommends that organizations consider relative value units (RVU) when tackling the issue of hospitalist staffing. He explains that every service a physician performs has a predetermined RVU value. According to Nelson, hospitalists generate roughly 3,000 RVUs annually.

Mission
Kenneth G. Simone, DO, administrative director for Northeast Inpatient Medical Services, which serves St. Joseph’s Hospital in Bangor, ME, and founder and president of Hospitalist and Practice Solutions in Brewer, ME, also sees patients as a primary care physician (PCP)—a dual role that provides a unique perspective from both the hospitalist and the “consumer” (i.e., referring physician) points of view.

According to Simone, coverage considerations are important, but an organization’s mission is the true cornerstone for determining staffing numbers.

Although many programs start with one or two hospitalists and simply collect more as needed, he says a hospitalist practice should first establish a mission by looking at the
- community’s needs
- organization’s overall mission
- healthcare competition in the region
- people whom the program aims to serve

To illustrate this point, he explains that St. Joseph’s mission is threefold. “We wanted to provide services for patients who have no insurance, many of whom are unassigned [to a PCP] or are indigent. When we looked to the administration for funding, [it was] willing to commit the additional resources [to serve this population] because it fit in with the institution’s mission in the community,” he says.

The second part of the mission is to support commu-
nity physicians because, in Simone’s view, “if they get burned out, they’re going to leave town. Fewer PCPs and specialists in the community translates into overworked physicians; decreased provider accessibility for patients; sicker, more acute patients—and the quality of care deteriorates, along with our referral base.”

Last, the organization had a mission to develop a more efficient, cost-effective medical model emphasizing teamwork. “We want our hospitalists to be the spokes of the wheel, working with PCPs, patients’ families, social services, discharge planners, and others,” he says.

**Coverage**

It’s important to consider how coverage determinations will affect an organization’s staffing model, Simone says. For example, a staffing plan should take into consideration whether hospitalists will work seven days on and seven days off, follow a 36-hour shift model, work in block schedules, or use another arrangement, he says.

Although fewer hospitalists are typically needed at night and on weekends—in part due to decreased utilization of services and fewer admissions during these times—staffing depends on the average number of admissions or average daily census during periods when full coverage isn’t necessary. “Some practices use a ‘float’ to cover hot spots in a schedule, such as 2 p.m. to 10 p.m,” Simone said, while other practices rely on a backup physician. A float fills in and helps out when and where needed (e.g., covering nights or helping with admissions).

With regard to increasing coverage hours, Simone recommends beginning your hospitalists’ program with a 7 a.m. to 7 p.m. schedule and expanding hospitalists’ availability as more physicians refer to the program.

“You don’t want to overextend yourself and fail to deliver the quality services you offered. It is essential to develop a timeline and strategic plan to grow and appropriately staff your hospitalist program,” Simone adds. Such incremental steps also may help garner funding.

**Note:** Avoid overextending hospitalists—yet another retention challenge. Doing so can jeopardize patients’ safety, decrease the quality of patient care, and lead to staff burnout. In addition, as hospitalists’ workloads go from light to busier, they reach an optimal level beyond which they become less efficient, according to Nelson. “Exactly where that threshold lies, no one knows precisely. I think if one doctor is seeing more than about 20 patients in a given day, you’re probably getting there.”

**Recruiting and turnover**

According to Nelson, a healthcare organization with a hospitalist program should never stop recruiting new hospitalists because new hospitalist practices typically experience high turnover rates.

Forecasting staffing needs can be challenging. According to Nelson, referral volume for new hospitalist programs can increase more rapidly than initially anticipated, and the surge can happen in a matter of weeks, rather than months or years. As a result, he recommends erring on the side of hiring more hospitalists than the facility anticipates needing.

In Simone’s experience, an organization’s approach to scheduling can have a significant effect on recruitment and retention. St. Joseph’s went from a block schedule that required hospitalists to work days (with one hospitalist working nights and weekends) to a seven-day on/seven-day off model. “This was great for recruitment and retention because the providers love the continuity this model provides, and it has improved their lifestyle,” he says.

Simone adds that on paper, the program is slightly less efficient on a seven-day on/seven-day off model because at any given time only half of the eight staff hospitalists are working. However, “when we added it up dollar for dollar, this model fit for what we were trying to do, which is recruit and retain physicians who might not want to come to Bangor, ME, where the pay is traditionally lower than the national trends and where the weather can be extreme in the winter,” he says.

**Note:** Determining staffing requirements takes more work for organizations with no track record (i.e., programs or facilities that do not yet exist or are...
Hospitalists

not yet open) because they must take the extra step of projecting the expected number of referrals, Nelson says. “You can assess the number of referrals from unassigned patients, add it to the number of referrals from area [PCPs], and then consider other components like consults from surgeons and what procedures hospitalists might be doing.” Adding up these factors can provide a volume of work from which to decide how many hospitalists will be enough, he says.

Added-value services
In addition to addressing average daily census, coverage considerations, and mission when calculating staffing requirements, “It is essential to factor in the added-value services that hospitalists provide,” Simone states. “Any extra activities affect hospitalists’ schedules and the amount of time they have to see patients, and someone has to cover for them.”

As a result, he recommends that organizations take into account whether they will expect hospitalists to
- staff rapid response (or code) teams
- serve on or chair various hospital committees
- provide training and education to key hospital personnel (e.g., nurses, technicians, etc.)
- cover patients at more than one hospital or site

In addition, Simone points out that hospitalists may be involved in oversight of utilization data, improving program efficiency (e.g., length of stay, patient flow, readmission rates), or developing clinical protocols.

One area of debate related to added-value services is whether hospitalists who have teaching responsibilities should be afforded more or less time to see patients and whether this significantly affects staffing needs. Nelson says he believes it’s a little of both. On one hand, although medical residents may relieve a hospitalist of being on-call at night, it may mean moving more slowly through rounds during the day.

Hospitalist staffing formula

Hospitalists Jon D. Lurie and Robert M. Wachter created a widely disseminated formula for calculating the number of hospitalists a program needs (published in the May/June 1999 Effective Clinical Practice). The calculation first converts a facility’s commonly reported admissions and length of stay (LOS) figures into an average daily census figure using the following formula:

\[
\text{Annual admissions} \times \frac{\text{LOS}}{365} = \text{average daily census}
\]

Next, the number of hospitalists needed is calculated by dividing the average daily census by the number of patients per hospitalist. An extra hospitalist is then added to account for night coverage.

Note: The figure used for the number of patients per hospitalist is an estimate based on a Society of Hospital Medicine membership survey. A low estimate of 10 patients per hospitalist was used to account for the extra coverage needed for vacations and other time off:

\[
\frac{\text{Average daily census}}{\text{patients per hospitalist}} + \text{one extra hospitalist for night coverage}
\]

Sample calculation:
Admissions: 3,000/year
Average LOS: Five days
Average census: \( \frac{3,000 \times 5}{365} = 41 \text{ patients/day} \)

Ten patients per hospitalist = four hospitalists
+ one to help cover nights and weekends
= five full-time hospitalists

Based on Lurie and Wachter’s formula, a hospital with 3,000 admissions per year and an average LOS of five days would have an average daily census of 41 patients and would need five full-time hospitalists.
According to the Society of Hospital Medicine’s (SHM) published guidance for determining the number of hospitalists a facility needs, “Determining staffing requirements can seem to be a complex issue, and each site can have different workforce needs. But there is also enough similarity among programs that you probably will not have to reinvent the wheel.” According to the society, there are ample formulas and models for determining staffing needs.

The SHM also advises that staffing estimates should provide hospitalists enough time to see each patient approximately twice per day. Other considerations include providing hospitalists enough time to conduct appropriate admissions/discharges, review ancillary data, meet with family members, communicate with primary care doctors and other specialists, and complete paperwork.

As a result, the society makes the following recommendations for determining the appropriate number of hospitalists:

- Decide what level of coverage the practice will provide (e.g., 24/7 coverage, days only, nights only, weekends and holidays)
- Know the community, including local referral sources (e.g., primary care physicians and others who may see hospitalized patients at your hospital)
- Consider all of the responsibilities hospitalists will have at your facility (e.g., teaching, administrative duties, case management involvement)
- Identify seasonal, organizational-specific, or other unique issues affecting demand for hospitalists’ services (e.g., whether the hospital is in a region where flu season hits particularly hard)
- Determine how your facility’s scheduling format will affect the number of hospitalists needed (e.g., 10-hour versus 12-hour shifts; five-day versus 14-day shifts)

**Time management**

human and business sides of healthcare, according to Vaccaro. “They don’t have control over things like the timeliness of discharge reports or other administrative paperwork.”

At the same time, patient demands on the hospitalist’s attention during any given shift are enormous, she adds.

In addition to striving to provide top-notch care, hospitalists are under pressure to help the hospital maintain a competitive edge—the edge the organization hoped to gain by adding a hospitalist program.

“I tell physicians that they’re in the marketing business now because many don’t realize it,” she says.

As a result, she speaks to physicians about focus management rather than time management. Vaccaro says the distinction lies in reframing the way hospitalists view their schedules.

“When you’re asked to do yet another thing during the day—and the list keeps growing—you have to realize that you can’t do it all. Ask yourself, ‘What’s my most important 20%?’” Vaccaro recommends.

“It’s more about determining how they’ll focus their attention—which is under their control—as opposed to finding more time, which is not. There is nothing more valuable today in the healthcare field than the reputation that you pay attention to people, and that takes focus,” she says.

**Robert Houser, MD,** a hospitalist with the Sioux Valley Clinic in Sioux Falls, SD, says there is a lack of resources for hospitalists seeking to improve their time management skills. As a result, he began...
Time management

researching and compiling information about time management to help colleagues avoid burnout and other stressors, such as managing new technology and the growing number of administrative functions that are part of a hospitalist’s job.

“The number one thing I hear when I talk to hospitalists about time management is that they feel they don’t have enough time with patients—and I felt the same way. I felt my stress levels start to creep up,” he says.

For most hospitalists, seeing patients and starting them on an effective treatment plan is the most important element of the job, Houser adds. Keeping a log can help them prioritize and identify the most time-consuming activities (e.g., discharge summaries, intensive care unit, etc.), and then tailor their schedule as needed.

Houser says many hospitalists join new or recently established hospitalist programs where they are expected to balance a large volume of patients (15–18 is typical in a medium-sized program) in addition to performing various other duties.

Houser recommends that hospitalists start managing time by keeping a log. “If you monitor where you spend most of your time each day, you can begin to see where you need to make improvements.”

As opposed to monitoring a Monday or Friday, Houser suggests logging time midweek, when the hospitalist service flows in a regular pattern.

For example, if I’m late rounding on a particular patient, I call to let them know the approximate time I’ll be there and provide them with any new information (e.g., test results, discharge plans) during the call. This helps keep patients and family members in the loop and lessens their frustration in waiting for new data. If discharge is to occur that day, it helps everyone—especially family—better allocate their time and plan their day.

I’ve found it to be useful not only in managing my time, but in making patients happier and allowing them to better manage their own, and their family members’, time.

J.D. Wright, MD, a hospitalist at Provena St. Joseph Medical Center in Joliet, IL, shares the following advice:

The nine-story hospital where I work has more than 400 beds, so I do a lot of running around. One way I’ve found to be more efficient while improving patient/family satisfaction is to call patients in their rooms to update them about their cases.

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Reader tip: Improve efficiency and patient satisfaction

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I’ve found it to be useful not only in managing my time, but in making patients happier and allowing them to better manage their own, and their family members’, time.
Years of speaking to healthcare providers have helped Pam Vaccaro, MA, CSP, president of St. Louis–based consulting firm Designs on Time, develop the following time-tested advice on coping with hectic schedules:

1. **Find your most productive time of day.** Although physicians know the body well, few likely know how to capitalize on their best times of day—the three- to four-hour periods during which they’re the most alert mentally and physically, says Vaccaro. “Research shows that each of us can determine our chronobiological time,” she says. Our peak periods are followed by a slump and then repeat during the day, she says.

   **Note:** Chronobiology is a developing field that studies biological rhythms and timing mechanisms, such as sleep-wake cycles and heart rate.

   According to Vaccaro, using your best times of day as a basis for creating a work schedule can boost productivity significantly. “Be cognizant of them, do the one or two things you know are high priority, guard them very closely, and you’ll feel like you get more done at the end of the day,” she says.

2. **Capitalize on snippets of time.** Interactions with many patients, primary care physicians, specialists, and other healthcare providers during the day can splinter even the most flexible schedule. Like many other specialists, hospitalists rarely have blocks of time during which to accomplish tasks, but they do get occasional snippets of time, which Vaccaro identifies as seven- to nine-minute segments. “You might initially discount these because there isn’t enough time to do something. But if you capitalize on them, you’ll be surprised by how much you can get accomplished,” she says.

3. **Get adequate rest and take breaks.** Many studies have shown the negative effects of sleep deprivation and fatigue. Among them is a report published in the October 2004 *New England Journal of Medicine* that found that residents who worked more than 80 hours a week made 36% more serious medical errors than those who worked 65 hours a week.

   In addition to getting adequate sleep, Vaccaro says the human body occasionally needs a short recess. “Often, all that recess needs to be is a break in the physician’s focus. This is especially important because it’s not so much the hospitalists’ time that we need, but their focus.”

4. **Prescribe to the 80/20 theory.** In the late 1800s, Italian economist Vilfredo Pareto created a mathematical formula to describe the unequal distribution of wealth in his country after he noted that 20% of the people owned 80% of the wealth. Along the way, management experts began applying “Pareto’s Principle,” as it became known, to the way people managed their time. Although it may be misnamed, the theory that 20% of what you do produces 80% of the results you want can be useful for hospitalists and other healthcare providers striving to maximize their time and focus on the job, Vaccaro says.

5. **Manage technology.** A large part of time management in today’s increasingly high-tech hospitals is managing all forms of technology and the related stress that results from having to learn yet another program or procedure. Vaccaro says inefficient people aren’t automatically aided by technology itself. In fact, she believes it can make them inefficient faster. As a result, she recommends that hospitalists start with the basics—good planning—even if that means using an old-fashioned paper planner in lieu of a flashy personal digital assistant.

   In this regard, she says the 80/20 theory comes into play again. “Plan by the week, adjust by the day, discern hourly, and make those adjustments in favor of the best 20%.”
Recruit and retain hospitalists in a candidate’s job market

The job postings sections of hospitalist-targeted publications provide ample anecdotal evidence that the demand for these professionals outweighs the supply.

However, it’s the hard numbers from the Society of Hospital Medicine (SHM) and a growing cache of studies (e.g., Health Care Market Trends and the Evolution of Hospitalist Use and Roles, published in the February Journal of General Internal Medicine) that prove that the proliferation of hospital medicine programs is stretching the supply of hospitalists nationwide (see sidebar on p. 9).

Whether yours is a well-established hospitalist program that continually recruits to meet growing demand or one that’s just getting on its feet, chances are good that your organization has found recruitment and retention a challenge in today’s hot job market.

In-house recruiters vs. search firms
Hospitals most often take one of the following tasks to recruit hospitalists:

- Using in-house recruiters or other staff to locate candidates
- Contracting out the task to a third-party firm that specializes in placing hospitalists

Tip: The National Association of Physician Recruiters (NAPR, www.napr.org) is a good starting point for programs that want to explore using a search firm. NAPR consists of over 400 physician recruiting firms that conduct physician searches, place locum tenens physicians, and train in-house recruiters. The Association of Staff Physician Recruiters (ASPR, www.aspr.org), which represents more than 700 members with the role of recruiting physicians and other providers to the hospitals and healthcare organizations where the members are employed, is another option.

Four years ago, Brett Walker, director of physician recruitment at Indianapolis-based Clarian Health Partners, established the system’s in-house physician recruiting program. The program staffs Methodist Hospital, Indiana University Hospital, Riley Hospital for Children, Clarian West Medical Center, and a fifth facility, Clarian North Medical Center, slated to open in late 2005.

He says a national shortage of physicians—particularly hospitalists—is creating a competitive environment. However, he also notes, “We’re in a period where the face of medicine is changing, more hospitals are being built, and demand for healthcare in general is going up.” Walker and his team have placed six hospitalists into two new Clarian hospitals during the past year, but he says there is a need to hire more.

Germaine Lorbert, senior search consultant for St. Louis–based Cejka Search (www.cejkasearc.com), a nationwide firm specializing in physician recruitment and staffing consultation, says she has also found that the high demand for hospitalists has led to a shortage of qualified candidates.

As a result, “many organizations appear to be more open to hiring new residency-trained graduates, even though they know these individuals will need more mentoring. There are just not as many practicing hospitalists as there is a need,” Lorbert says.

The following tips can help you improve your organization’s recruiting and retention efforts:

1. Look for geographic ties, and capitalize on size.
Large hospitals in urban areas and small facilities in rural areas face different recruitment challenges. For example, a big teaching hospital in Chicago may have the advantage of drawing on a ready pool of residents seeking hospitalist positions. Meanwhile, a hospital in remote area of Maine may have to work harder to attract or keep job candidates.

According to Walker, part of the solution for small rural hospitals may lie in targeting hospitalists who are connected to the area in some way. In fact, he says his clients (i.e., the in-house physician groups) prefer it that way. “In following up with our new
physicians, we’ve found that if they had some tie to the rural area—perhaps they did their undergraduate studies nearby or have family in the region—retention tends to be a lot higher,” he adds.

Likewise, facilities in coastal areas or near the mountains often find success landing candidates when they tout their geographic strengths. However, small rural facilities aren’t always at a disadvantage. Remember, not all hospitalists want to work at a busy urban hospital.

**Tip:** When working with an in-house or third-party recruiter, tap into his or her expertise on how best to concentrate advertising and recruitment efforts in ways that will reach candidates (e.g., local medical graduates, beach lovers, ski enthusiasts) most likely to join your facility and community. Doing so can increase the chances they’ll get what they expected and want to stay long-term.

2. **Use physicians on staff.**

Recruiters admit that there is only so much they can do when it comes to wooing a candidate and assessing his or her clinical competence. That’s where a hospital’s medical staff comes in. Walker, who has been recruiting and placing physicians for 10 years, says, “I’ve learned that our practicing physicians are without a doubt the best recruiters. We can put candidates through an intense interview process and make sure they fit well in the organization and the community, but we rely on our current physicians to hammer down the medical portion.”

A good recruiter will cover all the bases in terms of explaining to the hospitalist

- what the job opportunity entails
- the hours
- the call schedule
- the process for following up with another physician’s patients

But consider using staff physicians to show candidates what it’s really like to live and work in your community, in addition to having them do the typical rounds with physicians.

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### Figures driving the demand for hospitalists

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<thead>
<tr>
<th>Number</th>
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<tbody>
<tr>
<td>7,569</td>
<td>Number of hospitals nationwide</td>
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<tr>
<td>10,000</td>
<td>Number of hospitalists</td>
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<td>45%</td>
<td>Percentage of U.S. hospitals with 100+ beds that have hospital medicine programs</td>
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<td>50%</td>
<td>Percentage of U.S. hospitals with 200+ beds that have hospital medicine programs</td>
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<td>71%</td>
<td>Percentage of U.S. hospitals with 500+ beds that have hospital medicine programs</td>
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<td>539,000</td>
<td>Number of hospital inpatients on any given day</td>
</tr>
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<td>33.7 million</td>
<td>Number of hospital inpatient discharges in 2002 (most recent data)</td>
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information, however. “Some of the programs give actual schedules and enable us to say specifically, ‘You’ll be working day shifts for the next six months until we hire the next person,’ ” she adds.

Others, such as startup programs, might only know that they need a hospitalist who is willing to occasionally work nights.

However, the important thing is to provide the hospitalist candidate with whatever information you have about the position so he or she can make an informed decision and your staff can avoid replacing the hospitalist in three months when it doesn’t work out.

Communication also entails listening. “One of the reasons physicians change jobs is because they feel they weren’t being heard by administration,” Lorbert adds.

Walker also believe basic correspondence is key to retention. He recommends checking in with the new hire, asking how his or her practice is going, and inquiring about his or her progress, noting that a little attention goes a long way.

**Tip:** Clarian tracks every physician they’ve recruited and sends them a Doctors’ Day card, a simple act that physicians appreciate, Walker says. The United States House of Representatives adopted a resolution first commemorating the day on March 30, 1958, and it is observed on that date each year.

“Because we reach out to physicians even after they’ve joined the organization, nine times out of 10 when there is a problem, they’ll come knocking on our door because they have that comfort level,” he says.

4. **Question candidates with retention in mind.** Successful recruiters know that employee retention begins long before a candidate is hired. A particular strength of recruiters is their adeptness at monitoring the warning signs of a physician’s comments and questions during the interview process.

“If all of a candidate’s questions are about compensation and vacation, it’s usually a red flag to us,” says Walker.

Examples of the inquiries he says that recruiters want to hear include the following:

- What are the physicians in the group like?
- How long have they been there?
- What is the rate of turnover?
- How are the group dynamics?
- What is the diversity of cases I can expect?
- What’s the average patient population?
- What is the scheduling on-call model?

On the flip side, says Walker, recruiters working to find you the best candidate should ask

- why are you thinking about making a move?
- what’s important to you in your career?
- why are you interested in being a hospitalist?
- what are your subspecialty interests?
- what is your preference for scheduling?
- how flexible are you in terms or coverage hours/scheduling?
- would you be opposed to working nights?

5. **Consider the “fit” factor.** Medical staff and medical services professionals often tell those charged with screening new physician candidates to seek individuals who fit well with the group.

In addition to being competent and well-qualified, the new hire should also share with the current medical staff similar work habits, scheduling preferences, and other work-related beliefs or philosophies.

“If your organization has a specific culture and you know that the group of physicians needs to have a specific personality, this should be taken into consideration,” Lorbert says. She adds that because physicians work as a team, often covering for one another and caring for each other’s patients when they go off-duty, the new physician must fit in well
with the current staff.

Each institution must determine what skills, characteristics, and philosophies the new recruit should possess to fit into the organization’s culture. However, Lorbert cautions that regardless of what criteria a facility comes up with, the same procedure and standards should be applied to all candidates.

Fit also goes back to the importance of communication, she says. “The candidate needs to find out as much as they can as well, to see if they are going to be the right fit for that organization.”

6. Compensate competitively.
According to Lorbert, compensation is a critical factor not to be overlooked in today’s hot hospitalist job market.

“It is essential for healthcare organizations—especially those starting a new hospitalist program—to ensure that their compensation is at market level. To attract and retain physicians in a growing field, one must be highly competitive,” she says.

Lorbert advises healthcare organizations in the market for hospitalists to regularly

- research compensation trends
- consult organizations like SHM to determine what the current market rate is
- offer at least that rate to prospective physicians

7. Be flexible.
For any hospitalist to succeed, he or she must demonstrate critical inpatient skills and a high level of comfort in the intensive care unit. However, Lorbert says that good hospitalist candidates often come from a clinical background that is more outpatient-based. If they have the skills and desire to switch over to an inpatient role, she advises organizations to keep an open mind in considering them. “Although staying open and flexible to physicians’ backgrounds, the recruiting team must keep their standards of screening and referencing high,” she adds.

According to Walker, it’s a plus when physician groups at Clarian are actively involved in seeking out candidates. However, he finds that he often has to balance expectations—especially in today’s job candidate’s market. “Nine times out of ten, our in-house physician groups will give us guidelines that say, ‘This is the ideal candidate.’ We follow that but encourage them to have an open mind,” he says.

Finally, Walker notes, “Recruiting is really a team effort, from the practice manager to the physician recruiter—and especially the physicians in the group, because they know what’s best.”

Hurricane Katrina displaced 6,000 physicians

A study released September 26 by the University of North Carolina’s (UNC) School of Public Health found that approximately 6,000 physicians along the Gulf Coast were displaced by Hurricane Katrina—the largest displacement of healthcare providers in U.S. history. Notably, this number includes only those physicians providing direct care to patients, not medical doctors involved primarily in administration, research, or education.

Demonstrating the magnitude of the displacement, one of the study’s authors, Thomas C. Ricketts, MD, a UNC professor of health policy and the deputy director for policy analysis at the University’s Center for Health Services Research, stated in a UNC press release that the 6,000 figure represents more than 25% of the total number of new physicians who start practice in the United States annually.

Other specific findings of the study included the following, according to the press release:

- More than two-thirds (4,486) of displaced physicians were from the three central New Orleans parishes that were evacuated
- The majority (2,952) of the displaced physicians were specialists, with 1,292 in primary care and 272 in obstetrics and gynecology
- Nearly all of the health records were destroyed in the community health centers within the poorer neighborhoods of New Orleans

The researchers reached their conclusions by analyzing American Medical Association and Federal Emergency Management Agency data, as well as other records.

It is unclear how many of the practitioners will return to the area to reopen their practices. Ricketts is quoted in the press release as saying, “Likely a very substantial number of physicians will permanently move away from the area. This is both an opportunity for places that need physicians as well as a dire problem for the population that will remain.”

To access the press release, go to www.unc.edu/news/archives/sep05/ricketts092605.htm.