Intense competition for new hires puts focus on early retention efforts

After months of searching, you have just hired a new hospitalist with impressive credentials who is excited to join your practice.

Now—even before your hospitalist reports for duty and certainly long before you sense any difficulties—is the time to start working on retaining that hospitalist, says Carol Westfall, president of Cejka Search, Inc., a physician and healthcare executive search firm in St. Louis.

Physician retention has moved to the forefront as competition heats up for new recruits and retention efforts begin earlier in the employment cycle. In high-demand specialties such as hospital medicine, the pressures on physician leaders to maintain adequate staffing are particularly pronounced.

“Retention is a major issue in hospital medicine, where there is a gross supply imbalance,” says Westfall. “There’s a growing awareness of the need to focus attention on physician retention.”

Increase patient satisfaction by improving your discharge process

As patient satisfaction surveys become a key measure of quality of care, one major concern for hospitalists is how reducing length of stay (LOS) affects overall patient satisfaction.

“There’s a popular notion that patients don’t like short length of stay,” says Paul Alexander Clark, MPA, MA, CHE, senior knowledge manager for Press Ganey Associates in South Bend, IN. Press Ganey develops patient satisfaction surveys for hospitals.

On the contrary, Clark says reducing LOS and increasing patient satisfaction are not conflicting goals.

Based on data from its patient satisfaction surveys, Clark says patients who have longer hospital stays (after controlling for diagnosis and severity of illness) actually are significantly less satisfied than patients with shorter stays.

“Ultimately, what it comes down to is that patients want to...”
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says Aaron Gottesman, MD, director of hospitalist services at Staten Island (NY) University Hospital. “The demand for hospitalists is exponential, and the supply is nowhere near that.”

According to a 2005 physician retention survey conducted by Cejka and cosponsored by the American Medical Group Association (AMGA), 58% of physician groups say they have physician retention initiatives, an increase of 10% from the prior year.

The survey also found that many groups are beginning retention efforts even before a new physician’s start date.

Build loyalty early
As soon as you make a hiring decision, work to build the physician’s loyalty to your program and maintain his or her initial high level of engagement with the organization, Westfall says.

After the high of the interview process, during which the new hire has interacted with top leaders of the hospital medicine program and the hospital, your new physician may feel let down as the attention wanes and everyone goes back to business as usual.

“A big mistake that groups make is letting a new hire get too isolated in an organization,” Westfall says. “Everyone goes about their business, leaving the new physician alone too much.”

This is a stressful time for new hospitalists, who are adapting to a new practice setting, absorbing an overwhelming amount of information, and meeting new people. In many cases, they are also adjusting to a new location and helping their spouses and children make adjustments as a result of a move.

Hospitalists develop opinions about your program during the early weeks and months of their new jobs, Westfall says. “Do I like working here? Is this what I thought it was going to be? Is it the way that they promised it would be?”

When physicians leave a group, nearly half (47%) leave within the first three years of joining, and 60% leave within the first five years, according to the 2005 Cejka physician retention survey.

Note: The 2005 survey was the second Cejka survey on trends in physician turnover, retention, and recruitment among AMGA medical groups. The results of the 2006 survey will be published in early 2007.

Elicit feedback early, especially from more reticent physicians, to avoid surprise departures later. Hospitalist leaders should check in with their new recruits, not only to ask how they’re doing, but also whether the position is what they expected and whether they’ve experienced any surprises, Westfall says.

Combat common reasons for resignation
The most common reason cited in the survey for physician resignation was practice issues (44%), followed by compensation and location issues (21% each), and spouse reasons (14%).

Among practice issues, “poor cultural fit” was cited by physicians more often than any other reason, with “work pressure and hours incompatible with quality lifestyle” cited next.

To avoid these issues, consider implementing the following early retention efforts:

- More intensive and longer orientations and mentoring programs
- Increased focus on the family and spouse
- Increased contact with medical directors and leadership
- Interview for cultural fit

Although many hospital medicine programs have orientation sessions for their new hospitalists, Westfall recommends expanding and extending those programs over a longer time period.

Consider developing orientation programs that run for six months to a year and offer brief sessions on specific topics (e.g., ethics, patient satisfaction, pa-
tient communication, etc.) to give a new hospitalist a more complete understanding of the program.

In smaller groups and programs that don’t have the resources for formalized orientation sessions, involve leaders and other physicians in general efforts to train and develop new hospitalists. This interaction creates more opportunities for relationships among the physicians, and involving leadership provides new physicians with a direct connection to the vision and direction of the organization, says Westfall. It also helps build loyalty to the organization and increases engagement.

Mentoring programs also are common, but often mentors do not contact and follow through sufficiently with the new physicians, Westfall says.

If you choose to use mentors, be sure that they receive training, are comfortable with the role, and make contact with new physicians frequently in the first year, such as by inviting the new physician to lunch and getting together with spouses for dinner.

If a mentoring program is not done well, it is not worth doing at all, Westfall says.

**Increase focus on spouse**

Like many hospitalist leaders, Chris Nussbaum, MD, CEO of the Synergy Medical Group in Brandon, FL, which provides hospital medicine services primarily to Florida hospitals, is always looking to make a good hire. Part of his recruiting strategy is involving the spouse, even if it means a second visit and interview.

“We know it’s a short distance between the spouse being happy and the physician being happy,” he says. In Cejka’s physician retention survey, 14% cited the spouse as a reason for the physician leaving the practice.

Nussbaum says if he wants to interview a candidate, he pays travel expenses for the spouse as well, including hotel bills for a few days so that the spouse can get a sense of the area. While Synergy meets with the physician, the spouse is encouraged to go out with a realtor to look at neighborhoods, visit schools, or shop with contacts from the chamber of commerce or community. The spouse may also be invited to lunch.

Nussbaum says he likes to “get a sense of the personalities involved.” When an interview with a candidate is on the schedule, it takes top priority and proceeds un rushed. “It’s our imperative for the day,” he says.

Selling the spouse on the area helped “clinch the deal” in hiring one of their hospitalists, he says. Although the physician was very interested in the position, the spouse had concerns about schooling and acceptance by the community. A Synergy nurse who moonlights as a realtor and is described by Nussbaum as a “PR genius” took the spouse house-hunting and introduced her to the neighborhoods, shopping districts, schools, and road systems. The spouse saw a “dream home that was eminently affordable,” Nussbaum says, and when she was back at the physician’s side, she told him that she wanted him to take the position.

**Start off with the right person**

Physician retention begins with a good hire, says Westfall. Interview a candidate for cultural fit, as well as clinical skills, she says.

Define your own program’s culture, Westfall says. Is it quality- and bottom-line-oriented, with a direct communication style in which there’s little hand-holding, or is it a more patient-centered culture, with an emphasis on customer service and relationships?

Once you understand your program’s culture and style, Westfall says, interviews with candidates should include behavioral questions such as the following:

- Describe talking with a patient or staff under difficult circumstances
- Give us an example of a conflict that you mediated in your practice
- Tell us about a patient who deeply affected you

Drill down to get to the core of the experience, Westfall says. Ask the candidate follow-up
New expectations: Flexibility and engagement important tools for hospitalist retention

Workload, demands, and work/life balance were cited as top concerns of hospital medicine leaders in the most recent Society of Hospital Medicine survey. These issues are also high priorities for hospitalists as they launch or build their careers.

To attract and retain hospitalists, many hospital medicine programs find that they need to be open and flexible about accommodating schedules and lifestyles.

Chris Nussbaum, MD, chief executive officer of the Synergy Medical Group in Brandon, FL, says he believes in giving hospitalists some flexibility in their schedules so that they can drop off their children at day care, go to an appointment, or run an errand later in the afternoon.

He also builds in extra capacity so hospitalists are not overloaded, but complains that some candidates seem to be looking for “a country club atmosphere.”

Nussbaum contends that restrictions on residents’ hours and workloads by the Accreditation Council for Graduate Medical Education has helped create unrealistic expectations among those who have recently completed their medical training. He cut short an interview with one physician, trained at a New York city hospital known for “delivering battle-trained residents that can handle any situation in the flick of an eye,” when she told him that she didn’t like her intensive care unit (ICU) rotation and didn’t want to work in the ICU.

“It’s a sad commentary on the willingness and state of preparedness of those coming out of training,” he says.

Aaron Gottesman, MD, director of hospitalist services at Staten Island University Hospital in New York, agrees that work/life balance is a top-priority issue for Generation Y. “Some flexibility is essential,” he says.

He tries to be sensitive to individual preferences in the work/life balance.

Some hospitalists want to work longer for extra pay; others prefer reduced hours. If a hospitalist wants to start work at 9 a.m. instead of 7 a.m. because of commuting or child care issues, the hospitalist is given the flexibility to do that, he says.

A hospital medicine program is not a “Toyota manufacturing plant,” Gottesman says, referring to the high expectations for utilization, costs, and workload that are often placed on programs.

“The limitations need to be recognized and appreciated and reinforced,” he says.

Clear expectations
To build a good foundation for retention, Gottesman says it’s important to be clear about expectations up-front. “Don’t sugarcoat it. Be honest and frank,” he says. “Don’t bait and switch.”

Gottesman says he describes the demands of the program as it currently stands but acknowledges that the situation may change.

“Change is inevitable. The only thing that never changes is change,” he says. “It is the nature of hospital medicine in general. I tell them to keep an open mind because things may be different in a few months.”

Nussbaum also emphasizes the importance of being “100% forthcoming with your teammates.” Having contingencies for sick leave, pregnancy, and other situations in which extra coverage is needed helps to “get in front of problems,” says Nussbaum.

He adds that rotating hospitalists at different hospitals helps prevent burnout and provides them with fresh perspectives.
Active participation
A major theme in physician retention is the physicians’ desire to feel they are active participants in decision-making. Nussbaum says that during the interview and hiring process, he shares with candidates his vision of the company’s future, looking ahead for the next two years, the next five, and even the next 10.

After the second year with the company, a hospitalist is offered the opportunity to buy in and acquire equity. “Most hospitalists do not have that kind partnership,” he says.

Hospitalists at Synergy participate in weekly continuous quality improvement meetings in which there is a free exchange of ideas and they often see their suggestions being implemented, Nussbaum says.

Synergy does not receive financial support from the hospitals in which it provides hospitalist services, Nussbaum says, so its physicians enjoy a professional autonomy that is a plus in recruitment.

Appreciation
Gottesman says hospitalists are “worker bees” who may often feel unrecognized and underappreciated. It’s important, he says, to provide regular feedback about how they are performing compared with their physician peers.

Gottesman likes to gather ongoing 360-degree evaluations of the program and of individual hospitalists by taking aside nurses, case managers, social workers, and other healthcare team members and asking for informal feedback about the hospital medicine program.

He says the feedback is most often refreshing and a pleasant acknowledgement of the contributions that the program has made to the hospital. He also makes a point of passing along this feedback to hospitalists, individually or as a group, so that they will have a sense of belonging to a professional community.

Sample initiatives to improve physician retention
Physician turnover not only drains time and resources due to the need to continually recruit new physicians, but it can also result in increased stress, heavier workloads, and decreased morale for physicians who remain on staff. In an effort to address these challenges, many hospitals and physician practice groups are increasing their focus on physician retention. Below are examples of some physician retention initiatives:

- More intensive and longer orientation and mentoring programs
- Assignment of both a senior- and junior-level mentor to a new physician
- Increased family and spouse focus; intermittent social events throughout the first year
- Performance reviews at three, 12, and 24 months
- Retention committee and physician satisfaction team; three-year follow-up on all new physician hires
- Flexible work schedules and job sharing
- Increased contact with medical directors and leadership
- Concierge services
- Loan repayment and salary advances (five-year paybacks)
- Involvement of newer physicians in portions of the orientation or interviews processes
- Different bonus options—vacation or pay or a mixture or sabbaticals
- Interview for cultural fit
- Prior to hiring, contract with physician candidates for a one-week locum assignment (spouses and children come with physician)
- Exit interviews with both human resources and the CEO

feel ready to leave. There’s no market demand for hospital visits,” Clark explains.

**Four elements important to patient satisfaction**

Clark says Press Ganey research has determined that four elements of the discharge process measure patient satisfaction with the process.

The following four elements also strongly correlate with overall patient satisfaction regarding the hospital’s care:

- **Patient’s personal readiness**—Do the patient and family feel that they have the appropriate understanding, confidence, and capacity to leave the hospital?
- **Speed**—Is the process of getting the patient home or to another care setting efficient?
- **Instruction**—Do the patients and family know what to do after the patient is discharged?
- **Coordination of arrangements**—How well were arrangements made and communicated for accessing home care services, medical equipment, rehabilitation care, and other postdischarge health services?

Last year, more than two million patients admitted at 1600 hospitals completed Press Ganey patient satisfaction surveys, which include four questions about the discharge process, Clark says.

Patients experience discharge as a distinct episode in their hospital care, but it also colors their perceptions of the entire hospitalization.

**Readiness for discharge**

A patient may feel rushed or not ready to leave if he or she:

- still feels sick or in pain
- doesn’t understand his or her illness
- doesn’t feel capable of self care
- hasn’t recently seen a physician
- feels that his or her illness warrants a longer stay.

Patients may also be dissatisfied with the discharge process if the hospital’s discharge procedures are not patient-centered; physicians, nurses, and specialists provide conflicting information about when the patient will go home; there are no customer service procedures around the patient’s leaving; and there is a bed shortage in the hospital.

Hospitalists, nurses, and other providers should be careful about the language they use as they prepare the patient for discharge, Clark says. The language patients hear influences how they perceive their discharge.

“If you say, ‘Medicare won’t pay, so you have to leave’ or ‘Insurance doesn’t cover you for more than three days,’ patients feel that they are being kicked out before it’s medically appropriate,” Clark explains.

It’s important to eliminate these phrases and instead communicate confidence that the patient is ready to go home, he says. Giving the patient and family a contact sheet with staff phone numbers is a simple, but surprisingly underused, way to reassure the patient that he or she is ready to go home but can get help if needed.

To avoid sending conflicting messages about the discharge, hospitalists and nurses can use whiteboards which are already in many patient rooms but are inconsistently used, Clark says. The expected date of discharge should be written on the board so that hospitalists and nurses are not giving the patient different dates.

Often, discharge plans are developed only for patients with complex medical and psychosocial issues, but Clark says one hospital that set out to improve its patient satisfaction with the discharge process set a goal of writing a discharge plan for 100% of its patients.

Taking 15 minutes to sit down with the patient and his or her family to write a discharge plan can make the patient feel ready to leave the hospital at the appointed time, Clark says. Customer service practices (e.g., cards) that convey appreciation and best wishes can also help the patient feel ready to leave the hospital, he adds.
Speed of discharge process
Although a patient don’t want to feel rushed into leaving the hospital, once the decision to discharge has been made and communicated, the patient wants the process to move quickly.

It is important to educate the patient and family about what needs to occur before the patient can leave the hospital so that he or she can appreciate all of the steps in the process, Clark explains.

The patient may even place greater value on the services that are given if he or she knows that the staff must obtain results from the lab, receive final discharge orders, and wait for information about medical equipment before discharging the patient.

Many hospitals try to adhere to a universal time for discharge, but recently some hospitals are scheduling discharge times to stagger the workload, Clark says. Time slots are assigned to patients so that pharmacy, lab, housekeeping, and patient transport are not under one deadline.

In the recently published HCPro report Patient Satisfaction and the Discharge Process, Clark recommends taking the following steps to implement scheduled discharge times:

- Establish appointment slots for each day based on the average number of patients discharged from a unit per day
- Adjust the number of slots based on the day of the week and the unit (e.g., internal medicine units may have fewer slots on Saturday and Sunday, but critical care may have more slots)
- Assign slots as soon as possible, but at least 24 hours in advance; elective surgery patients can be assigned a discharge time at preadmission
- Display a schedule of all discharges at the nurses’ and physicians’ workstations
- Schedule only one patient per slot
- Schedule transfers exactly as you would schedule discharges
- Track the percentage of patients discharged within 30 minutes of their discharge appointment time

Another best practice, says Clark, is daily rounding by case managers, facilitators, or social workers.

These practitioners should review patients’ needs prior to discharge and update patients and families on the status of all that needs to be done before discharge procedures. At admission, always ask “who will be taking you home at discharge?”

Instructions
In general, physicians and nurses tend to underestimate how much information patients need at discharge. Staff may give important instructions once, but as in all learning, Clark says, studies show that repetition and reinforcement are needed for patients and families to take in all of the information.

Healthcare professionals may perceive such repetition as excessive, but patients and families find it helpful and reassuring to hear information repeated, according to Clark.

Keep in mind that once patients are home, they and their families may forget the discharge instructions or become confused about them, which is why written materials or videotapes that they can take home are so important, Clark says.

Hospitals are not reimbursed for patient education, Clark says, and as a result, frequently there is not a lot of investment in it.

Many providers do not give patients written instructions and, if they do, the instructions are often not of high quality. Quality makes a difference in patient education materials, Clark says.

A bad photocopy from an old nursing textbook will not be as effective as a customized handout with color pictures.

Telling patients what they can expect during the course of an illness, operation, or hospital stay also helps reduce their fear and anxiety. Although hospital procedures are familiar to healthcare professionals, they are foreign and confusing to patients.

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**Patient satisfaction**

Some hospitals have patient education nurses who specialize in different areas of medicine so that “every nurse doesn’t need to know everything about every illness,” Clark says. Obtaining feedback from former patients or focus groups can help evaluate the effectiveness of patient education materials.

Remember that meeting patients’ information needs throughout the hospitalization does not necessarily mean that they will be satisfied with the discharge instructions for care at home, because they see discharge as a distinct episode, according to Clark.

**Coordination of arrangements**

One of the most effective ways that a hospital can boost patient satisfaction is to make a phone call to the patient within 48 hours of discharge.

Largely underutilized, postdischarge phone calls build loyalty to the facility and the physicians, says Clark. Some hospitals have even done postdischarge calls as a tactic to help give their patient satisfaction scores a boost.

Much of healthcare is reactive and geared toward putting out fires, Clark notes.

With postdischarge phone calls, hospitals are proactively developing and ensuring relationships with their patients by checking on their progress and clarifying their instructions, if needed.

### Best practices for improving patient satisfaction with discharge

Below are some of the best practices that hospitals have used effectively to improve patient satisfaction with the discharge process. They are listed under one of the four elements of the discharge process that correlates with patient satisfaction (both with the discharge process and the hospitalization).

#### Patient’s personal readiness
- Comprehensive discharge planning
- Patient question sheet
- Preadmission patient education
- Protocols to manage the patient’s expectations regarding length of stay
- Contact information sheet
- Improving overall patient flow
- Whiteboard with expected discharge date

#### Instruction
- Information repetition
- Written information about risks, treatments, medication side effects, symptom management, follow-up, etc.
- Unit-based case management
- Patient education nurses specializing in specific conditions
- Multimedia take-home materials

#### Speed of discharge process
- Transition coordinator
- Structures to enhance and encourage communication
- Case managers who round daily
- Standardization of day-of-discharge events and streamlined processes
- Expanded case management/social work services

#### Coordination of arrangements
- Make postdischarge phone calls
- Meet with families
- Emotionally prepare patients and families for changes in their lives
- Evaluate the emotional experiences, eliminate stressors, focus on positive emotions
- Check for financial obstacles and provide financial counseling
- Recommend hospital, health system, or community resources
IHI advocates rapid-cycle testing for spreading positive change throughout an organization

Physicians are no strangers to the terms “best practices” and “practice guidelines.” However, the Institute for Healthcare Improvement (IHI) asserts that few hospitals and practitioners are changing their patient care practices to align them with these initiatives.

The great challenge for hospitalists and other leaders is encouraging fellow physicians to close the gap between best practices and common practices, says Carol Haraden, PhD, vice president at the IHI in Cambridge, MA.

As a result of the widespread hesitation to adopt change, the IHI has developed a new area of focus—the science of spread. The science of spread examines how new practices and ideas are diffused throughout an organization, explains Haraden.

The IHI is encouraging institutions to develop a strategy for promoting the widespread adoption of best practices and practice guidelines that takes into account such factors as the organization’s infrastructure, culture, size, social system, and operational system.

In a recent visit to a hospital that had a high rate of adherence to congestive heart failure guidelines, Haraden says she and her colleagues were disappointed to discover that the hospital’s secret to success was that it hired a nurse to do nothing but ensure that the five steps of those guidelines were followed with all patients.

This strategy is not a sustainable practice for meeting goals. Spreading genuine change throughout an organization should not depend on one person, Haraden says.

Rapid-cycle testing produces local results
Haraden says that when presented with a mountain of evidence from leading researchers, physicians will still be skeptical about whether a new practice will work locally.

“Small tests of change build local support and local evidence,” says Haraden. “There are many who try to spread without first creating local success, and many who stop at the pilot and declare success without spreading.”

An important tool in creating a successful pilot and spreading change throughout an organization is rapid-cycle testing. Rapid-cycle testing allows organizations to test and refine ideas quickly and on a small scale.

Unlike more traditional quality improvement methods that involve collecting a large amount of data over a long period of time, rapid-cycle testing can produce quick feedback about the effectiveness of an intervention and allow for ongoing refinement.

Early positive results can help build momentum for spreading change and produce local data that is harder for physicians to refute.

Suzanne Dalton, RN, BS, EdM, quality improvement specialist for Healthcare Quality Strategies, Inc., a Medicare quality improvement organization in East Brunswick, NJ, says that hospitals can test an intervention on a very small scale, even with one patient.

Hospitals sometimes make the mistake of testing an intervention on a larger scale than is necessary, she says. One patient on the 3 p.m.–11 p.m. shift is enough to test a new discharge instruction form, for example. Next, the form can be tested with two patients, or with all patients to be discharged within the next hour.

This small-scale testing can produce useful information about making changes in forms before
hospital committees begin the lengthy process of reviewing and approving changes, Dalton says.

Haraden agrees testing an intervention on one patient is legitimate. “If it doesn’t work on one, why would it work on three or five?” she asks.

The results from one patient can provide valuable information about an intervention, although Haraden notes that physicians, accustomed to heeding results only from large, randomized controlled studies, tend to underestimate the amount of useful information that can be obtained from a small-scale test.

Once the intervention is working well with one patient and one physician, then it can be ramped up to involve three clinicians and their patients, then five clinicians and their patients, and so on, she says.

24-hour turnaround

Haraden recommends 24-hour turnarounds on any refinements of the intervention when doing rapid-cycle testing. For example, if you are testing a new practice and get feedback from a clinician that changes are needed on an order set, try to get the revised order set back for further testing in 24 hours, she says.

By quickly making refinements and ramping up to a few more clinicians and patients in testing the intervention, you can gather a lot of data in a two-week period, Haraden says.

As the intervention moves from one area of the hospital to another, different implementation issues emerge. In one New Jersey hospital, providers were testing interventions to ensure that colorectal surgery patients had normal temperatures within one hour of surgery, says Dalton.

They tested interventions on a Friday for one operating room (OR) and found that their interventions produced the desired outcome. But on Monday, the same interventions were used in the same OR and did not achieve the desired outcome. Staff consid-
lot of resistance,” Haraden says. She emphasizes that willingness and interest are the two most important criteria in choosing clinicians to test an intervention.

Haraden says innovators tend not to be good collaborators because “they live in their own worlds.” However, early adopters may be the most willing and interested in testing a new intervention that has succeeded elsewhere in your institution.

Although physician resistance to new practices may be unfounded in many cases, in fact, local adaptations often are needed when adopting changes, Haraden says.

As hospitals work to meet guidelines for delivering antibiotics within 60 minutes of surgery, for example, they are taking many different approaches to meeting that goal and placing responsibility on nurses or anesthesiologists, depending on different factors within that hospital.

Three questions
Before initiating rapid-cycle testing, it’s important to answer the following three questions:

- What are you trying to accomplish?
- How will you know that a change is an improvement?
- What changes can you make that will result in improvement?

The aim statement should be specific, says Dalton. “Heal all patients, all the time,” is not an aim statement, she says. Haraden adds that it’s important for everyone around the table to be headed in the same direction, noting that many committees are “driving across the country” without a map or clear destination, she says.

“Groups can be working together, thinking they share common objectives, only to discover later that many had not shared [their] assumptions with the group,” states a paper about rapid-cycle improvement by Healthcare Quality Strategies, Inc. “Working through these assumptions at the beginning is a must.”

Before initiating rapid-cycle testing, there should be a numerical measure for documenting improvement and collecting data. In diabetes patients, for example, Haraden says, there would have to be agreement on what exactly is being measured and improved.

Haraden advocates setting “aspirational goals, not dust ball goals.”

“We talk about ‘half-lives’ as benchmarks in meeting goals,” she says. “If the ultimate goal is zero, and your rate is 9.2, 4.6 is a first benchmark to celebrate.”

Meeting these half-life goals can create the energy and support that is needed for eventually meeting the ultimate goal, Haraden says.
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What questions did you ask?
- How did the patient respond?
- What was the outcome?
- How did you feel about the outcome?
- What would you have done differently?

“Examples of situations from the past and how physicians reacted are predictors of how they will behave in the future,” Westfall says.

Lack of detail in the answers, or answers that are too generic, such as “I use humor to deflect conflict” or “I let the office manager handle staff disputes,” should sound alarm bells, indicating that the candidate “hasn’t done enough thinking to come up with a specific answer,” Westfall says.

As candidates answer behavioral questions, you should be able to see their energy, enthusiasm, and passion, as well as get a sense of how well they will fit into your culture, which is one of the most important factors in physician retention.

Satisfaction

For patients who require postacute services, Clark says it is good practice to address patients’ and families’ anxieties concerning the transition to a new level of care and make a phone call to the nurse at the acute-care facility. If a nurse at the next care facility is expecting your patient and is well-informed about his or her issues, this will reflect well on your hospital and smooth the way for your patient. The nurse is likely to tell the patient that you called, he says.

The quality of the facility will also be a reflection on your services, he notes. “By arranging for or recommending a health service, you stand behind the quality of that service,” Clark writes in *Patient Satisfaction and the Discharge Process*. “To use a marketing term, this is called ‘commingling of brands.’ ”

In the minds of customers, good or bad experiences with one organization will affect their opinion of both that organization and the affiliated organization. It’s important to recognize and take responsibility for those relationships, Clark says.