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Hospitalist Management Advisor

—INSIDE—

A look at literature

Read what published literature has to say about the role of clinical pharmacists in inpatient care to decide whether it is time for your hospitalists to partner with these providers on p. 6.

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Lessons learned: Strategies for leading a hospitalist program

You're mastering the art of medicine and feel comfortable in your clinical abilities. The next thing you know, you are chosen to lead a hospitalist program, and suddenly you feel just like you did when you first left residency.

What can you do to ensure that you are as successful in a hospitalist director role as you are as a physician? **Hospitalist Management Advisor** asked several experienced hospitalists what they wish they knew when they took on their first job as a director and what they think every hospitalist

aspiring to a leadership role should learn. Following is their top 10 list:

1. **Learn to manage people.** **Richard Rohr, MD, FACP**, director of the Milford (CT) Hospital hospitalist program, says that medical education is lacking in regard to training physicians to work collaboratively and manage people. "A hospitalist program director has to work hard to promote teamwork and cooperation," he says. "Business schools put a great emphasis on this, but medical schools don't." **> p. 2**

Pharmacist, hospitalist cooperation can aid medication reconciliation

There has been an increased emphasis on the issue of medication errors by The Joint Commission that now requires hospitals to demonstrate their medication reconciliation programs as part of the accreditation process.

But beyond implementing a sound reconciliation process, what can a hospital do to ensure that inpatients don't experience medication errors during their stay or immediately afterward?

At Brigham & Women's Hospital in Boston, **Jeffrey Schnipper**,

MD, MPH, director of clinical research for the hospitalist service, and his colleagues devised a collaborative approach—they ensure that the hospital pharmacists are involved in the medication reconciliation process. The program, started four years ago, focuses on the discharge process.

As most hospitalists know, discharge can often be rushed as the physician turns his or her attention to incoming, acutely ill patients and focuses less on the patients who are healthy enough to leave the hospital. **> p. 5**

Lessons learned

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Learning how to hire, how to set expectations, how to manage behavior—both positive and negative—how to reward and recognize people, and how to take corrective action when necessary are skills that many physicians lack, says **Russell Holman, MD**, president-elect of the Society of Hospital Medicine and chief operating officer of Cogent Healthcare. He also says knowing how to manage conflict and effectively run a meeting are important skills he wishes he had when he started out in 1996.

There are plenty of programs you can attend to learn these skills, Rohr says. The onus is on the hospitalists to seek out education opportunities.

For example, **Bill Ford, MD**, program medical director at Cogent Healthcare's program at Temple University Hospital in Philadelphia has been in his first hospitalist director position for just nine months. He completed a leadership fellowship before he took on the managerial role, which prepared him to carry out his responsibilities.

Hospitalists can also learn these skills by taking classes at local colleges and universities that don't demand as much time as a fellowship program or an MBA. An example are the courses available through the Harvard School of Public Health and Harvard Business School in Cambridge, MA, says **Sylvia Cheney McKean, MD**, medical director of the BWF Hospitalist Service at Brigham and Women's and Faulkner hospitals in Boston.

She asserts that programs that provide young physicians the chance to think about issues such as leadership development, networking, thinking critically about career trajectory, and setting and achieving goals are essential. "The only challenge with all of these programs is finding the time to take advantage of them," says Cheney McKean.

2. Read, read, read—in moderation. Holman says with such a large number of books about leadership and management, it is best to select a small number and delve deeply into them. Jot notes

in the margins, and be sure to find your highlighter—or buy a new one if the old one dried out during your final year of medical school. Return to these resources again and again, he says.

3. Know your job description. Holman was one of the first people to take on a hospitalist director role 11 years ago. "I wish I had someone more clearly outline the expectations for my role," he says. "It was very ambiguous, and I had to create my job description as I went."

Holman says he had no defined measures of success, "so I took a significant leap of faith that my definition of success would align with those who had authority over the program."

4. Understand the expectations. **Jeff Dichter, MD, FACP**, partner in the consultancy Medical Consultants and director of hospitalists at Ball Memorial Hospital, both based in Muncie, IN, says that beyond a job description, there is a need to know the goals the hospital has for the program and for you as director.

"I wish I had a better sense of a road map of how the program should look when I started, after a year, and after three years," says Dichter. He wanted to know more about several issues, including:

- Prioritizing processes and protocols
- How to realistically assess finances (e.g., appropriate coding and diagnoses, as well as knowing the billing, collection, and denial rates)
- How the hospital administrator views the program
- What the director needs to teach a hospital administrator in order to make him or her a better partner
- How to educate hospitalists on the priorities for the program, and what the program needs from each of them

5. Seek general business knowledge. **Ken Simone, DO**, a former hospitalist program director, a working primary care physician, and president of Hospitalist and Practice Solutions, a consultancy in Brewer, ME, says that a good director will

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know how to read and interpret profit-and-loss statements, and monthly financial reports.

Ford says taking a single healthcare business course could be helpful in getting a handle on the lingo you'll need to know in a managerial position.

In addition, Ford says many new hospitalist directors lack experience negotiating and communicating ideas to administration and hospitalists. "I think my weakness was in those areas more than any other," he says. "It might seem obvious that you should know this stuff, but you don't think of it until you are in the situation." He's also struggled with how to give criticism and feedback.

6. Find a mentor—better yet, several. Holman says he wished he had someone he could have talked to about the new role and his reasons for taking the position. That way, he would have had a better idea whether the rewards he was looking for were realistic.

He does assert that he did benefit from guidance gleaned from more experienced colleagues. "I have been blessed by having had several terrific mentors, each with diverse strengths and backgrounds," says Holman. "Whereas this informal type of development is arguably the most powerful, it is also the most challenging to establish."

He notes that research has shown that the best mentoring relationships are those that come about naturally, rather than those that have been engineered. There is also evidence that having access to several mentors works better than having just a one-on-one relationship.

"I encourage people to look broadly within their healthcare organization," he says, noting that mentors do not all have to be physicians. Look outside and work within your community.

"In some cases, I have recommended that the individual consider a more robust variant of mentorship by engaging a professional coach," he adds. "While professional coaching is expensive and time-inten-

sive, it is a tremendous investment in one's future that can render a depth of development well beyond other means."

7. Understand the importance of quality. "Simply knowing what quality in healthcare actually means" is a start, Holman says. Beyond that, you should understand common methodologies for improvement and measures commonly used for determining hospitalist quality of care as well as how to create a program with a culture of quality and safety. He says a good place to learn about quality is by attending the Institute of Healthcare Improvement's national forum this December in Orlando, FL (www.ihl.org/IHI/Programs/ConferencesAndSeminars/19thNationalForumonQualityImprovement.htm).

8. See the big picture. Do you understand trends in Medicare and Medicaid? Do you know what third-party insurers are prioritizing? Does the term pay for performance mean anything to you? Holman says knowing about hospital business drivers would have assisted him in putting the hospitalist program's goals into proper context.

Similarly, a good director should understand issues of general practice management such as scheduling, risk management, and compensation.

9. Don't overestimate your ability. "The hardest thing is not necessarily relying on the skills that make you a good clinician to also make you a good leader or manager," Holman says. "In many cases, a physician leader is appointed to a leadership role because of exemplary clinical abilities. Having excellent diagnostic and clinical decision-making skills is a key part of what engenders respect and admiration from peers and coworkers, and results in a physician being identified as a potential group leader. These skills are based on natural talent combined with learned behaviors and knowledge during medical training and clinical practice, and include things such as the ability to make independent decisions, react to abrupt changes in a patient's status, achieve results through personal intervention, and base decisions on scientific evidence whenever possible." **> p. 4**

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Lessons learned

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Although these are important clinical skills that are “seared into our brains during every step in our professional development,” Holman says, they are often at odds with the skills needed by an effective leader. “Leadership requires one to make decisions based on the collective input of a team, and to be proactive in anticipating future problems and trends,” he says.

“Management achieves results through the work of others, necessitating the ability to delegate, hold others accountable for performance, and gain vicarious rewards from the team’s accomplishments. Finally, much of leadership is based on possessing and communicating a future vision. But as many leaders learn, the path to achieve a vision is forged far more by art, instinct, and improvisation than scientific evidence,” he adds.

Ford says it was a revelation to him how much time directors spend in meetings. Before taking on the role, he used to poke fun at the director of his program for spending so much time in meetings. Ford assumed it would be different for him when he was a director. It wasn’t. Indeed, it was so different than what he anticipated that he called his old director and apologized for mistaking his managerial prowess.

10. Don’t panic. Many of the skills that benefit a director are things that young physicians have not yet acquired. Simone says a good director should have experience with the following:

- Running a multi-provider practice
- Serving in a medical staff leadership position
- Working with hospital administration
- Working within a multisystem organization
- Addressing performance and compliance issues
- Analyzing clinical and financial performance and data as they relate to hospital systems and the clinician forging collaborative relationships and championing various initiatives

These are not skills a physician is likely to have when assuming his or her first directorship role.

But these experiences do make the transition into a director’s role an easier one. The good news is that just about every skill you need can be learned through experience or formal course work, says Holman. Make use of the resources around you, be they classes, books, or mentors.

And Ford’s best advice for those taking on leadership roles? Be honest and open, and don’t be afraid to ask questions. ■

“Finally, much of leadership is based on possessing and communicating a future vision.”

—Russell Holman, MD

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Cooperation

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Schnipper and his colleagues took a hard look at the program they implemented at Brigham & Women's in a study published in 2006 by the *Archives of Internal Medicine*. The group examined the discharge process followed by 178 patients. A portion of these patients were counseled by a pharmacist at discharge and received a follow-up phone call three to five days later. For patients who were assigned a pharmacist, the discharge discussion focused on:

- Medications the patient was taking
- How that medication was different from what the patient may have taken before
- When and how to take the drugs
- Potential side effects of the medication
- Signs and symptoms of side effects
- Screening for patients who might not be compliant with medication regimens

The study found that out of the 91 patients who had pharmacist intervention:

- 45 had at least one unexplained discrepancy between what they were taking before admission and what they were prescribed on discharge
- 23 had at least one unexplained discrepancy between what they were supposed to be taking at discharge and what they reported taking once home
- 29 experienced possible medication side effects
- 18 did not adhere to their medication program
- 14 had trouble getting prescription refills
- Nine reported problems paying for their prescriptions

Collaboration and confirmation

When the program was first implemented, Schnipper and his colleagues assumed the patient education component of the program would have the biggest effect. However, when studying the effect of the program after implementation, he learned that medication reconciliation made the biggest difference. "The pharmacists were making sure that the regimen made sense," he says. Four out of 10 reviews by pharmacists prompted a discussion between the pharmacist and the hospitalist working on the case to ensure that the patient was assigned the proper medication.

Schnipper's review of the program also found that after the three- to five-day period, patients were often taking a different list of drugs than those prescribed by the hospitalists. "[The patient] would be confused and would take something they used to take but that we wanted them to stop taking," says Schnipper.

Note: The Joint Commission–mandated reconciliation programs are designed to identify errors that occur before patients are discharged. However, Schnipper asserts that hospitals must take steps to check up on patients after discharge. "Sometimes, reconciliation has to happen again," he says.

High-cost for high-risk patients

Overall, the program resulted in a 10% absolute risk reduction of adverse events, Schnipper says. But that reduction didn't come cheaply—there was a pharmacist who worked on the program full-time. To help decrease costs, the hospital is researching a way to determine which patients will benefit most from the program. As part of this effort, the hospital reviewed medication errors and found that three-fourths of these errors were the result of physicians taking incomplete medication histories. Therefore, education could play a role in reducing such errors.

However, pharmacist involvement is essential for high-risk patients—the elderly, patients with low health literacy, patients who take a lot of medications, and patients who are prescribed high-risk medications. The trick is to determine where you can effectively fit the pharmacists into the process.

"Only 5% of hospitals have pharmacists taking medication histories now," Schnipper says. "It could be that you will have to tailor that kind of intervention to the people who need it most. You will end up spending more money, but you could be preventing errors, readmissions, and even deaths."

Note: Schnipper just finished a different study that found that out of 4,000 unexplained medication discrepancies examined, nearly 3,500 had the potential for harm. With numbers like that, hospitalists > p. 6

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Cooperation

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should think about getting pharmacists involved in their programs. “They shouldn’t just have a dispensing role. They have a great ability to counsel patients and follow up with them. It would be great for patient care and would also create a more interesting work environment for them,” says Schnipper, who hopes to see his study published within the next year.

Pharmacists are just one of the resources that can aid a medication reconciliation program, but Schnipper believes they are also the key to develop-

ing a wide array of other programs. “They are a great untapped resource,” he says. “Three-quarters of the time, the problems arise from a poor medication history. It’s good to have someone help you figure out what the patient or family isn’t telling you. You need someone who can call the pharmacy or call the primary care physician. It is a detective hunt, so have them do more—tap the resource.” ■

Editor’s note: For more information about this topic, contact Schnipper via e-mail at: jschnipper@partners.org.

Literature review: Pharmacists’ role in inpatient care

A literature review published in the May 2006 *Archives of Internal Medicine* looked at how clinical pharmacists have been used in inpatient care. Thirty-six studies examined by Peter Kaboli, MD, MS, assistant professor at University of Iowa Healthcare, and his colleagues introduced research on including pharmacists on rounds, medication reconciliation programs, and drug-specific pharmacist services. They concluded that using pharmacists in an inpatient setting does improve quality, safety, and efficiency of care, and pointed to a study by C.A. Bond, PharmD, FASHP, FCCP, of Texas University Health Services Center in Amarillo, and his colleagues published in the February 2001 *Pharmacotherapy*.

The Bond study reported that the only pharmacy variable positively associated with four outcomes—mortality rates, drug costs, total cost of care, and length of stay—was the number of clinical pharmacists per occupied bed. As they increased from the 10th to the 90th percentile—0.34 pharmacists per 100 occupied beds to 3.23 pharmacists per 100 occupied beds—hospital deaths decreased from 113 to 64 per 1,000 admissions, or 1.09 fewer deaths per day in the 90th percentile versus the 10th, or \$320 of pharmacist salary per death averted. The study further found that pharmacists’ participation in medical rounds led to lower lengths of stay.

A follow-up study conducted by Bond and his colleagues, which was published in the April *Pharmacotherapy*, found that the following six services were associated with reduced mortality:

- Pharmacist-provided drug use evaluation
- Pharmacist-provided in-service education
- Pharmacist-provided drug protocol management
- Pharmacist participation on the cardiopulmonary resuscitation team
- Pharmacist participation on medical rounds
- Pharmacist-provided admission drug histories

Other work by Bond and his colleagues focused on particular drugs and diagnoses that are most likely to lead to adverse drug events in hospitalized patients:

- Cardiotonic glycosides
- Adrenal corticosteroids
- Antineoplastic agents
- Anticoagulants
- Analgesics and diagnoses of hypertension
- Congestive heart failure
- Atrial fibrillation
- Volume-depletion disorders
- Atherosclerotic heart disease

Hospitalists and pharmacists may find the list useful to develop programs to reduce medication errors.

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Strategies for recruiting and retaining top hospitalists

Twenty tips from hospitalist leaders

Early this spring, **Robert Bessler, MD**, director of Sound Inpatient Physicians of Tacoma, WA, and a member of the **Hospitalist Management Advisor** editorial advisory board, joined with **Aaron Gottesman, MD**, director of the hospitalist program at Staten Island (NY) Hospital, to talk to hospitalists, hospitalist program directors, and other hospital executives about recruiting and retaining hospitalists during the HCPro audioconference “Best Practices for Recruiting and Retaining Top Hospitalists.” (Go to www.hcmarketplace.com/prod-4973.html for more information.) Following are 20 things they said can help you find and keep the best physicians.

1. Understand your turnover. Bessler said there is a difference between a hospitalist who leaves so his or her spouse can pursue a job elsewhere and a hospitalist who leaves your program to join the hospitalist group across town. Whereas the former situation may be an ordinary occurrence, the latter may signal that something bad has happened. Knowing why people are leaving your program is key to figuring out whether your program is experiencing retention problems.

2. Know your potential pool of candidates. There are 122,000 physicians in internal medicine in this country, 85,000 of whom actually practice internal medicine. Of those, 62,000 are board certified. There were 6,400 residents who graduated from internal medicine residencies in 2006. “That’s your pool,” said Bessler. In some regions, there will be a tiny number available. For example, there are fewer than 300 internal medicine physicians in Montana, where Sound Inpatient Physicians has two hospitalist programs. If they want to grow their business in that state, they may have to find candidates outside of the state. California, on the other hand, has twice as many physicians as any other state.

3. Know your community. Your recruiters need to know about more than your hospital and hospitalist program. When Bessler’s recruiter starts seeking candidates for one of its 16 practices,

he or she sets up a practice profile that includes information about everything from local schools, housing, and job prospects for spouses, to airport locations.

4. Put the entire practice on the recruiting team. Another reason why Sound Inpatient Physicians has been successful—they hire about seven hospitalists per month and have a low turnover rate—is that they get all of their team members involved in the recruiting process, said Bessler. The recruiter and all physician leaders screen candidates. When a candidate makes it past the initial screen and comes out for a visit, he or she spends the day with the entire team with which he or she will work.

However, if you use more than one person to sell the physician about your practice, make sure they all give the recruit the same information.

It is self-serving for everyone to be involved in ensuring that the best person joins the team, he said. “If they are engaged and don’t view [recruiting] as someone else’s problem,” the team will be the better for it.

5. Present information first. Bessler said his recruiters have told him that they often feel like career counselors. Their first job is to answer questions about the opportunity, not sell the position—at least not at first. Present the opportunity and provide information first, he said.

6. Check more than the usual references. Along with the usual reference checks, Bessler said that his organization always checks nursing references. It also does a complete background check “so we don’t miss something important,” he said. These references give the hospitalist practice a complete picture of the recruit.

7. Use a variety of strategies to recruit. The Internet has transformed the way > p. 8

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Recruiting hospitalists

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practices recruit physicians, but there are some effective old-fashioned recruiting techniques your program should continue to employ. For example, don't abandon traditional mailers, professional conventions, and meetings.

8. Don't skimp on relocation costs. This isn't the place to save money, Bessler advised. "You are asking people to move across the country."

9. Beware of long delays. Bessler said his hospitalist practice has learned that the longer the time period between a job offer and an acceptance, the more likely it is that a candidate will say no. And if he or she says yes after a long period, there may be issues. It should raise a red flag.

10. Don't rule out new blood. Gottesman said that although urban areas with large teaching hospitals have a larger pool of potential recruits than smaller communities, the tendency to recruit fresh graduates has pitfalls.

Novel approaches and points of view from people who have not been a part of your institution can be valuable, he said. You need to create a balance between people who have great inside knowledge of your facility, its policies, and its procedures, and the value of second opinions from those who have worked outside of your institution.

Bessler said he has taken over failing hospitalist programs in which one of the mistakes was hiring all of the local people in town to "do the things they have always done." Although local people can provide instant credibility, it is important to also have people who can provide fresh eyes.

11. Know the pros and cons of your schedule model. A schedule based on rounding maximizes daytime coverage and minimizes volume surges, said Bessler. Continuity of care is good, but you have high relative value units (RVU) per full-time equivalent per year, a high number of days worked per year, and trouble getting weekend

coverage. The need to take call can lead to situations where someone has to be up and then work the next day.

"Then you are back to a 36-hour shift, like residency," he said. If one of the hospitalists wants to take a day off, the volume for the remaining doctors increases. It can reach unacceptable volumes if two or more want or need a day off. And nevermind trying to schedule vacations.

Shift work provides predictability and has a great upside for both recruitment and retention. There is no call. There is reasonable continuity of care if there is a seven-on, seven-off schedule or some permutation of that. However, rigidity is a problem.

There also are issues with the switch day. Monday morning is common, but that is the worst day, said Bessler, as the hospital is often loaded with weekend patients who couldn't get into long-term care or rehab facilities over the weekend. In addition, there are significant financial costs of covering nights, when there is much less revenue generated.

12. Review your compensation program. Gottesman said there are three formulas for compensation: pure productivity, pure salary, or a hybrid of the two. There are issues of concern with the former two.

In the first, physicians are encouraged to worry about RVUs, not necessarily quality. In addition, there isn't any impetus for the physician to move the patient through the institution—the longer he or she is there, the more RVUs. In the second case, pure salary, physicians may think that they have to see only their set allocation of patients and may not be willing to stretch beyond that. There is no financial incentive for them to do so. Thus, a hybrid program is best.

But how you balance out the guaranteed salary and the part that is productivity-based will depend on a variety of factors. In general, you should try to keep

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the number of variables for getting a bonus small and ensure that they are measurable.

13. Remember the nonfinancial compensation. Don't forget that compensation is more than just the money the physician is paid each month. Vacation time, how much the program pays for the physician's continuing medical education, and other nonmonetary perks are also part of the compensation package, said Gottesman.

14. Don't try to meet everyone's needs. Bessler said no program can create incomes and lifestyles to meet the desires of all hospitalists. What is important is that you have a transparent program that gives hospitalists a clear and understandable path to reaching their bonus, and that the path is not complicated and involves measurable criteria. Make the measurement timely.

Bessler noted that his organization has done away with bonuses that cue up from the prior quarter. "If you worked hard in January because it is our busiest month, then on March 1, you will be rewarded for that," he said.

15. Beware of survey data. There will always be someone who wants to quote a compensation number from a survey. There are many salary surveys out there, and they all differ. Gottesman said you should take the numbers with a grain of salt, don't hang your hat on them, and understand their limitations.

16. Watch for burnout. Understand the potential for staff burnout, said Gottesman. If your hospitalists don't feel that they have the ability to push back or argue against something with which they don't agree; if they are attacked and abused, particularly by people whom they don't view as having any authority over them; or if they feel powerless, they are in danger of burnout.

Keep in mind that burnout is more than a hospitalist seeing too many patients day after day. Burnout can also result from a hospitalist's sense that he or she has lost autonomy, is viewed as a "super resident" rather

than an attending physician, is not being given the opportunity to contribute, and does not feel part of the team.

17. Show appreciation. People never get tired of being appreciated, Gottesman noted. "There should be no sense that your bank account of 'thank yous' is depleted." Many physicians feel grossly underappreciated. Your ability to let them know you appreciate their efforts will be rewarded. "People outside healthcare view us as having achieved something," he said. But internally, this isn't the case.

18. Pay attention to the needs of the group leader. In a 1999 article for the *Harvard Business Review*, authors Peter Frost and Sandra Robinson came up with the notion of the Toxic Handler—a person who runs interference between multiple stakeholders and often takes the heat from multiple sources about multiple issues. This is a critical role for an organization, but a difficult one to be in, particularly because there is little training that can prepare one for it, said Gottesman. Natural abilities will only carry one so far, he added. This person needs to be encouraged to find an outlet for any frustrations. "Don't expect them to just suck it up," he said.

19. Create a sense of ownership. Gottesman said one of the best ways to make something speak to a physician is to show them data. Give them information about their performance and the performance of the group. Make the information transparent. "Physicians respond well to this," he said.

20. Be flexible, but stay within limits. Although flexibility is fundamental to the health of an organization, nothing can function if there are no standards. "Only flexibility and no standards create nothing but dysfunction and confusion," said Gottesman.

Some flexibility is necessary, but you can't bend over backward for every person, on every issue, every time. ■

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Recruiting tip of the month: How to determine whether your candidate is a good fit for your organization

How well a physician meshes with the current culture of an organization influences the length of the physician's stay. According to the Cejka Search and American Medical Group Association (AMGA) 2006 *Physician Retention Survey*, which was completed by 92 members of the AMGA who collectively employ more than 16,833 physicians, "poor cultural fit with the practice" is the single most frequently mentioned reason for voluntary separation.

Because recruitment and retention are directly related, focus on attracting candidates who will quickly acclimate to your group's culture. To do so, recruiters must first clearly understand the culture of the organization. By identifying your organization's values, you can more accurately recognize traits in candidates that will blend with the current staff. One of the most effective strategies for assessing whether a candidate will be a long-term cultural fit is through behavioral interviewing techniques. Ask candidates the following during the interview process:

- Describe an experience that required talking with a patient or staff member under particularly difficult circumstances.
- Tell me how you have created an environment where staff members or patients are comfortable

approaching you—even with bad news.

- Describe a time when you provided recognition of a staff member.
- Describe a time when someone wasn't performing up to your standards.
- Tell me about your relationships at work. Describe a favorite relationship and a difficult relationship.
- Give me an example of where you had to mediate conflict in your office, department, or organization.
- Describe a patient case or encounter that generated a particular sense of compassion in you.

Such questions will assist in determining whether a candidate is a long-term cultural fit for your organization. Additional strategies include peer interviews, spouse participation in interviews, job shadowing prior to the offer, and offering a locum assignment for a probationary period. ■

Editor's note: This tip was submitted by Paul Smallwood, vice president of physician search with St. Louis-based Cejka Search, a nationwide firm specializing in physician and healthcare executive recruitment. For more information about recruiting and retaining hospitalists, go to www.cejkasearch.com or call 800/678-7858.

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Ask the expert

Q: I discharged a patient last month, and now he is asking for a refill of his medications. What is my obligation?

A: The obligation depends on what you told the patient when he or she was in the hospital. In general, once you accept a patient for treatment, you must continue treatment until the disease is cured or another physician accepts the obligation. If you do not respond to the patient's needs, you could be sued for abandonment (not covered by most professional liability policies). You can terminate the patient-physician relationship unilaterally, but the patient must be given 30 days to find a new physician, and you must provide treatment in the meantime. The best way to prevent this problem is to determine at the time of admission whether the patient has another physician who will take over subsequent management. If this is not the case, tell the patient prior to discharge that you will not provide treatment more than 30 days after hospitalization. Put this information in your practice brochure.

Make all reasonable efforts to help the patient find another physician. Provide the patient with a 30-day supply of medications. Give no more than 30 days of medication and no refills—otherwise you have signaled your intent to continue the relationship. During those 30 days, the patient is entitled to your

help with any complications that may arise, but you are never obligated to provide telephone treatment—and you should not do so—and you may insist that the patient come to your practice location for examination.

*This question was answered by **Richard Rohr, MD, FACP**, Director of Hospitalists at Milford (CT) Hospital. Contact him at Richard.rohr@milfordhospital.org.*

Q: How do you handle handoffs in a department that normally closes for the night?

A: Hospitals accredited by The Joint Commission were expected to comply with the 2006 National Patient Safety Goals (NPSG) by January 1, 2006. Among those goals was a mandate to implement a standardized approach to handoff communications (NPSG #2E).

The handoff is the responsibility of the individual who is in charge of the patient's care. In the situation described above, the pharmacist should communicate the information to the physician or nurse in charge of the patient's care.

*This question was answered by **Della Lin, MD**, and **Glenn Krasker, MHSA**, during the HCPro, Inc., audioconference, "JCAHO's Patient Safety Goals for 2006: Tips and recommendations for compliance." ■*

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Preparing for a leadership role, one step at a time

If you're not yet a director, but you aspire to be one, get as much experience in leadership as you can now, suggests **Russell Holman, MD**, president-elect of the Society of Hospital Medicine and chief operating officer of Cogent Healthcare. Volunteer for committee assignments, quality improvement activities, and practice management jobs. The caveat: Don't bite off more than you can chew, but take small portions over time.

"[Physicians] will learn the nuances of interpersonal dynamics and how to negotiate and build consensus," says Holman.

"They will learn the value that others—particularly nonphysicians—bring to the group, and incorporate broad views and skills into the particular activity," he adds. "Over time, the physician will gain confidence in his or her abilities by building a track record of success, and also by having learned important lessons through failures along the way. The pitfall here is to avoid the temptation to take on more responsibility than one is ready for, or to be

accountable for results in a project without adequate support, training, or time."

When you assume a leadership position, don't be surprised if it is different than what you suspected, warns **Bill Ford, MD**, program medical director of Cogent HealthCare at Temple University Hospital in Philadelphia. His job is supposed to be 80% clinical and 20% administrative, but Ford was shocked when he started at how much time it takes to get all of the administrative tasks done. He tries to do his meetings in the afternoons, and he still manages 15 shifts per month.

"I still find it hard to divorce myself from the clinical aspect of my work as a hospitalist," he says. "And I don't think you should. I think you should do the same kinds of shifts that your staff takes—that means the occasional night shift. That way, you don't lose respect of the other hospitalists, and it gives you more credibility when you go to administration or when you come back from them with a new program or policy." ■

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