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Medical Staff Briefing

A TRAINING RESOURCE FOR MEDICAL STAFF LEADERS AND PROFESSIONALS

Special report

Despite barriers, more inactive physicians seek to reenter work force

The Association of American Medical Colleges has recommended a 30% increase in total medical school enrollment during the next decade to help stunt the ever-growing physician shortage.

However, that goal may be difficult to achieve, says **Ethan Jewett, MA,** codirector of the multiorganizational Physician Reentry into the Workforce Project.

"It takes a lot of extra resources in terms of expanding the capacities of medical schools and residency programs," says Jewett.

Although increased medical school enrollment will help meet future healthcare needs, several organizations, including the AMA and the American Academy of Pediatrics, are focusing their efforts on helping inactive physicians reenter the work force.

Roadblocks to reentry

Retraining inactive physicians costs less than sending a new physician through medical school and takes a lot less time—a few weeks to several months, compared to the seven to 10 years required to train new physicians.

However, physicians are faced with several challenges when attempting to reenter the work force. First, only a handful of physician reentry programs exist in the United States, and not all offer local training options. Having to uproot for several weeks to attend a retraining program could disrupt a physician's family life and cause financial strain.

> **"Boards of medicine are saying one thing and credentialing bodies are saying another, and neither is communicating with the other."**
>
> *—Nielufar Varjavand, MD*

Second, physicians often incur the expense of participating in a reentry program. Depending on how long a physician has been out of practice and the level of education needed, he or she could be required to spend tens of thousands of dollars.

"Because they haven't been practicing, they don't have the kinds of resources that a practicing physician would have," says **Beth Korinek,** executive director at the Center for Personalized Education for Physicians (CPEP) in Denver.

Third, physicians often hit a wall when they attempt to meet medical staff credentialing and privileging requirements. Eleven state medical boards have established reentry requirements (see "State medical licensure requirements" on p. 5), but some medical staffs set the bar a notch or two higher to avoid potential patient safety issues related to accepting reentering physicians.

"Boards of medicine are saying one thing and credentialing bodies are saying another, and neither is

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communicating with the other," says **Nielufar Varjavand, MD,** program director of the Drexel Medicine Physician Refresher/Re-Entry Course in Philadelphia.

For example, some medical staffs may require physicians to be active for two of the past three years, which may make it difficult for those returning to practice. Medical staffs may also require physicians to have completed a specific number of procedures, which creates a catch-22, as physicians who have been out of practice for an extended period are often not allowed to perform procedures.

Fourth, physicians may simply lack the confidence to return, says Varjavand. Not having a clear pathway to reenter clinical practice can be so daunting that some physicians choose not to reenter after their initial attempts.

Economy cutting retirement short

Despite such barriers, the need for effective reentry programs and clearly delineated reentry standards is increasing as more physicians wish to return to clinical practice. Varjavand says she receives at least five phone calls per day from physicians inquiring about Drexel's reentry program, and enrollment at CPEP is up 300% this year from 2008.

Much of this increased enrollment is due to physicians coming out of retirement, possibly as a result of financial pressure. In an analysis of data from 62 participants in its reentry program, CPEP found that 22.6% of physicians returning to clinical practice were coming out of retirement or had left practice to pursue a different career path.

"Lots of people are calling us now that their retirement savings or their spouse's job has been affected," says Korinek. "They need to get back to work, and they are trying to find the mechanism to do that."

Hospitals can help ease the transition

As more physicians seek a better work-life balance, they will inevitably leave practice for extended periods. Medical staffs should start preparing now to help physicians reenter practice safely and quickly. Consider the following steps:

➤ **Incorporate flexibility into your organization's culture.** "In most facilities, there is this perception that if you are not working 60 hours, you are not a real doctor," says Jewett. This perception can affect physicians' ability to receive promotions, tenure, and partnership status, he explains. "For that culture to change, there needs to be a commitment from the top levels to not penalize people for being part-time," he says.

Inflexible work environments are particularly difficult for women, who, biologically speaking, are at their prime during the early years of their careers and tend to take time off to raise families. "However, in medicine, it is the early years when you are expected to pay your dues," says Jewett.

This may be due to a healthcare system built around the needs of men, who tend to put in many hours in the beginning of their careers and wind down in the

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later years—just when women are ramping up. ***(Note:*** These are statistical generalities. **MSB** recognizes that men leave medicine to raise children as well, and women don't always put in fewer hours at the beginning of their careers.)

But with more women becoming physicians (50% of pediatricians are women, and that number is expected to grow, according to the American Academy of Pediatrics), it is time to change that mind-set.

"It's just biology, and there is no way around that," says **Claudette Dalton, MD,** medical director of surgical and academic programs at Rockingham Memorial Hospital in Harrisonburg, VA, and chair of the AMA's Council for Medical Education and Reentry, Remediation, and Reeducation Task Force.

"The medical staff should talk to the 28-year-old who just got married and wants to have children and is going to be a star in diabetes care to create flexible pathways for her," Dalton says. "Those kinds of conversations should be part of any contractual interview."

However, residents reported at a recent AMA meeting that marital status and desire for children have been used against applicants, Dalton says. This conversation

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Side by side: Physician reentry programs

This chart examines a sampling of U.S. physician reentry programs.

	OHSU	CPEP	Drexel	KSTAR
Web site	*www.ohsu.edu/som/cme*	*www.cpepdoc.org*	*http://webcampus.drexelmed.edu/refresher/default.asp*	*http://tamhsc.edu/outreach/rchi.html*
Location	Portland, OR	Denver	Philadelphia	Houston
Cost	$5,000–$10,000 per month	– Assessment/reentry plan development: $6,500 – Reentry plan support: $625/month (varies based on specialty and activities)	– Structured preceptorship: $7,500 – Medical update curriculum assessment online: $7,500 – WebOSCE online clinical skills curriculum and assessment: $8,500 – All three tracks: $20,000	– $3,000–$8,500 for the initial assessment, which may include WebOSCE, standardized patients, chart reviews, and communication and pharmacotherapeutics exams. Other testing may be required.
Created	2006	1990	1968	2007
Travel required	Participants receive assessment and training in Portland	Physicians travel to Denver for one-day assessment. Reentry plan activities generally take place in the physician's home community. Travel to continuing medical education courses may be required.	Structured preceptorship is in Philadelphia. Medical update and WebOSCE available online.	Travel to Bryan, TX, for assessment; possible mini-residency in Fort Worth or travel to a preceptorship may be required
Online programs offered	No	In development	– Medical curriculum and assessment – (WebOSCE) in development, available in the fall	Some Web-based courses available; others in development

Source: HCPro, Inc.

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should not be punitive. Discriminating against a candidate due to gender, marriage, or any other characteristic is illegal under the Civil Rights Act.

Dalton adds that these flexible pathways must be so individualized that establishing a national model may be close to impossible. That's why it's imperative that medical staffs take on this responsibility to ensure future staffing levels.

Flexibility is not only good for physicians and may prevent them from leaving practice altogether, but it could also benefit healthcare facilities, says Jewett.

For example, as previously mentioned, women and men tend to have opposite career clocks.Men tend to put in the majority of their hours in the early years and wind down as they reach their 50s and 60s, whereas women tend to put in fewer hours in the beginning of their careers but become highly productive during their later years.

"If you look at a physician's career over time, it actually comes out about even for men and women," says Jewett. Being flexible with female physicians, in particular, during their early years is beneficial for the organization because they will most likely put in more hours later.

In addition, healthcare organizations might benefit from offering physicians shared positions, says Jewett. If two physicians share one position, both physicians are probably putting in more than half of the required hours, he says.

"Part-time people are often more than happy to put in more hours than they are being compensated for because they have an incredible sense of professional commitment," Jewett says. That means the hospital

Why is reentry so expensive?

Physicians trying to reenter the work force after an extended period often have to shoulder the cost of evaluation and education, and that can cost tens of thousands of dollars.

The evaluation piece alone can cost physicians $2,500–$10,000, depending on how long the physician has been out of practice and the type of evaluations needed. But why does it cost so much?

"It's expensive, but let's face it, it's a lot of one-on-one attention," says **Josie Williams, MD,** director of the KSTAR (Knowledge, Skills, Training, Assessment, Research) program at Texas A&M University in Houston.

Physicians entering the KSTAR program start with a day and a half of assessment. "That's 12 hours of physician time right there," says Williams.

The assessment is recorded, and three evaluators watch a 12- to 15-hour video of the clinical interviews and assessments to determine what the physician needs to get back on track. That's 24–27 hours of physician time. Other expenses include the National Board of Medical Examiners exams and the time administrative staff members must take to check physicians' board status, plan the correct assessment, and communicate with them prior to the assessment to prepare them for success, says Williams.

The physician reentry program at John Peter Smith Hospital in Fort Worth, TX (the training and reeducation arm of KSTAR) costs about $9,000 for three months, which is the typical training period, says **Joane Baumer, MD,** department chair of family medicine and physician reentry program director.

More than half of that funds the one-on-one preceptorships trainees do with physician mentors. Portions of that cost also fund the online modules and portfolio development tools, facilities administration, and didactic learning.

"If the government is interested in getting physicians into underserved areas, there would have to be some funding mechanism. I think more physicians would reenter practice if they didn't have to incur the expense," says **Beth Bower, MD, MPH,** director of Oregon Health & Science University's Physician Reentry Program.

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is probably getting 1.5 full-time equivalents for each shared position.

➤ **Create a reentry plan.** If a physician plans to take time off, regardless of the reason, he or she should work with the medical staff to develop a plan that will help him or her return when the time is right, says Jewett. This plan should, at a minimum, include efforts to:

- Maintain professional credentials, including board and state licensure/certification
- Participate in continuing medical education (CME), even if the physician is not in active practice
- Maintain membership in professional societies
- Keep professional connections alive so the physician can network when it is time to start looking for a job again
- Develop a relationship with a medical school or nearby clinic where the physician can practice one or two days per week to keep clinical skills sharp

Should you take a break from full-time practice, try working at a free clinic at night, Dalton suggests. If you have children and a spouse who works during the day, this could be the ideal way to keep your skills fresh while meeting family obligations. Other options include filling in shifts when needed, volunteer work, and shared positions.

"There are creative ways to be partially active. When it becomes a problem is when you don't have a job that is flexible enough," Dalton says.

Read about planning for a leave of absence in the American Academy of Family Physician's journal *Family Practice Management (http://tinyurl.com/AAP-LeaveofAbsence).*

➤ **Keep physicians informed of policy changes.** Medical staffs often don't have a policy in place to guide the reentry process, says Varjavand. "People don't know what their own rules are," she says. Consider establishing a set of reasonable goals that physicians should meet when they attempt to reenter practice.

For example, Uniontown (PA) Hospital allows physicians to take a leave of absence for up to six months without requiring any retraining. After six months, the credentialing committee may require proctoring, CME, and/or retraining, and these decisions are made on a case-by-case basis, says **Danette Minehart,** manager of medical staff services and telecommunications.

Uniontown allows returning physicians to choose their proctors but draws the line at spouses and other family members. In addition, the proctor must have the same privileges that the returning physician is requesting.

Although proctoring has worked well for several physicians returning to the facility, Minehart says requiring proctoring for returning physicians can be a drain on the proctors. "They have to do their own admissions plus they have to be with [the returning physician] to do [his or her] admissions," she says. "It does, however, show you if a physician is competent."

Once your hospital determines the requirements for physicians to safely return to practice, the credentials

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State medical licensure requirements

Wondering how much time you can take off before your state medical board requires you to enroll in a reentry program?

According to AMA's *State Medical Licensure Requirements and Statistics, 2009:*

- ➤ 30 state medical boards (MD and DO) have policies regarding physician reentry into practice.
- ➤ The majority of the state medical boards that have a policy regarding physician reentry require physicians to complete a reentry program after two years of clinical inactivity. Those states include Colorado, Florida, California, Kansas, Montana, North Carolina, Ohio, Tennessee (for MDs and DOs), Utah, and Washington.
- ➤ Allowable absences range from two months in Maryland to four years in Indiana and Virginia. Iowa and Mississippi set the bar at three years.

Visit *www.aap.org/reentry/AMA_reentry_licensure_09.pdf* to see the full list.

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committee should inform physicians who are planning on leaving practice for an extended period of those criteria. Many times, physicians don't find out about these requirements until they attempt to return to practice, which extends their time out of practice as they scramble to meet them, Jewett explains.

Because many physicians are out of practice for several years, the credentials committee should send notices to inactive physicians whenever the reentry criteria change. This will allow physicians to update their reentry plan to accommodate the new requirements.

➤ **Teach physicians to negotiate for work-life balance.** Although it seems counterintuitive from the hospital's perspective to give physicians the tools they need to negotiate fewer responsibilities or more time off, if physicians learn good negotiating skills, both parties may be happier in the long run.

With strong negotiating skills, physicians might be able to attain scheduling flexibility to balance their work lives with their personal lives, and hospitals could retain quality physicians who would otherwise leave practice.

➤ **Create credentialing and privileging systems to allow for the transition.** To help ease the transition for the medical staff and the returning physician, medical staffs could develop a specific privileging category for physicians returning to practice or grant such physicians temporary privileges, says Korinek. "Some hospitals have better ability to incorporate that into their privileging and credentialing processes, and some really struggle with it, and it becomes a barrier," she says.

Medical staffs could offer dependent privileges initially and require supervision or comanagement for a certain number of procedures, says **Richard A. Sheff,**

What to expect during evaluation and training

Physicians attempting to reenter practice might be intimidated if they don't have a clear understanding of what will be expected of them. Most likely, your state medical board or the hospital to which you are applying will refer you to an assessment program. Although every assessment program is different, and your assessment will depend on your specialty and intended practice plan, the following are items you might want to prepare for:

- Online practice exams
- A battery of exams covering everything from general knowledge and pharmacotherapeutics to communication skills and ethics
- Open-book chart review (possibly of your own charts or standardized charts provided by the assessment program)
- Examination of standardized patients (i.e., trained actors)
- Simulated procedures

Once the assessment program has determined what you must do to get back on track, you may be referred to an education/retraining program because some assessment programs are not equipped to provide education and training. This training may include proctoring, continuing medical education, or even a mini-residency.

The physician reentry program at John Peter Smith Hospital in Fort Worth, TX, expects physicians to have 300 patient encounters, develop an online portfolio, participate in online modules, engage in small group exercises, attend didactic training, and work with a physician mentor one-on-one, says **Joane Baumer, MD,** department chair of family medicine and physician reentry program director.

Physicians reentering practice should also expect to see an entirely different healthcare landscape from when they left.

Between the Physician Quality Reporting Initiative and National Committee for Quality Assurance, payers will reward physicians who meet quality standards and penalize those who don't, and that can be a big shocker for folks who have been out of practice for a while, says Baumer. "No matter when you left, medicine is not the same as it used to be—it changes so quickly," she says.

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MD, CMSL, chair and executive director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Once these procedures are successfully completed, the medical staff could grant the physician independent privileges.

If the medical staff doesn't want to grant the physician full independent privileges, it may choose to keep privileges for certain high-risk, complex procedures dependent for a longer period.

"If the credentialing committee doesn't allow a person privileges in the hospital, that makes it difficult to get licensed and maintain board certification," says Jewett. "It also makes it difficult to maintain their professional society membership. All these things are tied together."

The problem is that medical staff credentialing committees often set the bar too high for fear of patient safety issues, says Varjavand. For example, credentialing committees may require physicians to have hands-on experience before they will grant privileges, but it is difficult for physicians to get that experience when they have been out of practice.

"Everyone should work hand in hand—the regulatory body, the credentialing body, and the educational provider—to set the requirements," says Varjavand.

Despite all of the challenges, physicians can and do successfully reenter practice, even after prolonged periods. It takes some effort, Korinek says, but 100% of physicians who completed the CPEP reentry program successfully attained active licensure. ■

Surveys shed light on physician reentry

Data on physician reentry is lacking, but some organizations have recently conducted surveys that yield useful data to help the healthcare industry respond to physicians who wish to reenter practice after an extended leave.

For example:

- The Center for Personalized Education for Physicians conducted a survey between 2007 and 2009 to update the data it collected between 2003 and 2006. The survey revealed that:
  - The average age of physicians reentering the work force is 52.6, and ages range between 36 and 72
  - Physicians leave practice for two to 21 years, with the average being seven years
- A collaborative survey conducted between February 2006 and May 2006 by the American Academy of Pediatrics and the Association of American Medical Colleges that focused on pediatricians aged 50 and older revealed that:
  - The most common reason pediatricians reenter practice is because they missed patient care
  - The majority of physicians who had reentered the work force did not receive retraining before engaging in clinical practice
  - Women were more likely than men to report that they had taken a leave of absence of six months or more
- In 2008, **Ethan Jewett, MA,** codirector of the multi-organizational Physician Reentry into the Workforce Project, conducted a survey of nearly 5,000 physicians under age 65. The survey, funded by the American Academy of Pediatrics and the AMA Women Physician Congress, revealed that:
  - Of the 1,600 respondents, men and women cite personal health concerns as a major driver for leaving medicine
  - Women disproportionately leave the work force to care for children or other family members
  - Men more than women cited issues related to the administrative and business aspects of medicine as a reason for leaving the job
  - For inactive physicians and physicians who had returned to the work force, the primary incentive for returning was the availability of part-time practice or flexible scheduling
  - Few physicians who reentered the work force after an extended period of inactivity indicated that they had undergone retraining or educational programming before returning to practice

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Creating accountability and measuring improvement

The changing face of CME

The good old days when physicians could take a tax-deductible vacation disguised as continuing medical education (CME) are long gone. Although there's nothing wrong with traveling to a beautiful resort and fitting in a game of golf while receiving CME credits, the Accreditation Council for Continuing Medical Education (ACCME) wants CME providers to demonstrate that physicians are learning something, and perhaps even improving their practices as a result.

However, ascertaining the effectiveness of CME activities is tricky, says **Saul Weiner, MD,** deputy director at Jesse Brown VA Medical Center and associate professor of medicine and pediatrics at the University of Illinois at Chicago College of Medicine (see "Study measures effectiveness of CME" below for a description of a recent survey designed to assess knowledge gained through CME).

For example, a physician can attend a well-planned, informative session but not learn anything because he or she chose to catch up on e-mails via Blackberry during that time. "Or someone could be paying attention, but the session isn't providing adequate information or is confusing or irrelevant," Weiner says.

Even trickier is tracking what physicians learn and whether they use that knowledge to improve their practices. For example, the general internists at a hospital could, after attending a CME program on the topic, devise a plan to improve how they refer diabetic patients for eye exams. Soon after changing their processes, they see an increase in referrals.

However, the internists are unaware that at the same time, a community health advocacy group launched a marketing campaign encouraging diabetic patients to get eye exams. In this case, knowing which effort contributed to more patients getting eye exams would be difficult, if not impossible.

"The purpose of CME is to improve patient outcomes. In an ideal world, we would have some way of looking at the relationship between educational interventions and how the patients of practitioners who participated in the intervention do," says Weiner.

Study measures effectiveness of CME

Some types of continuing medical education (CME) seem to be more effective than others, and researchers are trying to understand why. **Saul Weiner, MD,** deputy director at Jesse Brown VA Medical Center and associate professor of medicine and pediatrics at the University of Illinois at Chicago and his colleagues set out to explore this question.

They asked three CME providers presenting at a national Society of General Internal Medicine (SGIM) meeting to develop questions to assess what participants knew and felt about a particular subject before, immediately after, and nine months after the CME intervention. Participants were asked these same questions immediately after the CME session and nine months later.

Participants in all three sessions demonstrated that they had gained knowledge immediately following the session. Those who participated in a 90-minute session on research methods reported a modest gain in knowledge, whereas those who participated in an eight-hour research precourse experienced a large gain. A 90-minute clinical workshop produced a moderate gain in knowledge.

But participants in two out of three sessions reported that they did not retain that knowledge after nine months.

"We don't know why there is variation, but with this small study, we can show that there is variation," says Weiner.

Source: Measuring Continuing Medical Education Outcomes: A Pilot Study of Effect Size of Three CME Interventions at an SGIM Annual Meeting. Journal of General Internal Medicine, *March 2009.*

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Linking CME to performance improvement

Although the standards the ACCME put in place in 2006 (facilities will have until 2012 to fully comply) aren't asking CME providers to track exactly what physicians learn, they require CME to be:

- Focused on practice-based learning
- Derived from the physicians' professional practice gaps
- Designed to change physician strategies, performance, or patient outcomes
- Evaluated for its effectiveness in changing strategies, performance, or patient outcomes

"CME is becoming more aligned with performance improvement. Basically, what the ACCME is saying is that CME doesn't make sense unless it addresses a bona fide need and leads to some real change," says **Charles Huntington, PA, MPH,** associate dean of continuing and community education at the University of Connecticut School of Medicine in Farmington.

Although meeting these requirements sounds daunting, small changes can make a big difference. For example, the University of Connecticut School of Medicine is pushing its various departments to revise their educational interventions to solicit audience participation. "Although there may be a component that is didactic, they really need to allow time for audience discussion," says Huntington.

One department is doing a particularly good job of engaging participants, he says. Each CME topic is covered during the course of two or three sessions, and at the end of the first session, the presenters ask the audience members what they want to learn more about. Presenters then use this information to develop the next two sessions.

The university is also focusing on CME that engages physicians in performance improvement projects within their areas of practice. Practitioners who engage in this type of CME must define an area they want to improve, measure their current performance, plan and implement a process change, and measure the effectiveness of the change.

"This is a real culture change. We are asking our providers to think about CME in a very different way," Huntington says. The ACCME does not dictate how CME providers should measure the effectiveness of their educational interventions; individual CME providers are responsible for finding a system that works for their physician populations. Methods might include administering brief multiple-choice tests, asking participants to write descriptions of how they will incorporate what they learned into clinical practice, simulations using standardized patients, and even real-time performance measures.

Getting buy-in from the top

However your organization chooses to create a more engaging CME process and measure its effectiveness, you probably won't get far without support from the top. Hospital executives should understand that funding and supporting a strong CME program will not only help the hospital meet its accreditation requirements, but also improve quality outcomes and patient safety, says **Murray Kopelow, MD,** ACCME's CEO.

To get the ball rolling, Kopelow suggests bringing medical staff leaders, members of the performance improvement committee, and hospital executives together. "The executive staff needs to hear from the medical staff about how CME can help meet the corporate enterprise and mission," he says.

By getting these teams together, the hospital can identify professional practice gaps within its own walls and within the community. For example, if the mortality rate of breast cancer is higher for one demographic than another within a given community, the hospital should strive to learn whether that gap is due to a lack of knowledge, inappropriate processes, or insufficient resources, says Kopelow. If it is due to a lack of knowledge and inappropriate processes, the team can develop a CME program to bridge that gap.

"For decades, CME has been looked at as an activity that is separate from practice improvement and the performance measures of the institution," Kopelow says. "But if a professional practice gap is contributing to a quality gap, it would behoove the institution to invest in appropriate CME." ■

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Agree to disagree

Managing generation gaps on the medical staff

You've been in the meeting at which the physicians who've been on the medical staff for 25 years and dedicated their lives to medicine bemoan the plight of the younger physicians who insist on working 8 a.m.–5 p.m. and talk about something called "tweeting."

The older doctors try to instill in new generations of physicians traditional processes and methodologies, whereas the younger physicians wonder why they even had to attend this meeting in person when videoconferencing is available.

Medical staffs today consist of a blend of four generations: the World War II Silent Generation (1925–1942), baby boomers (1943–1961), Generation X (1962–1981), and Generation Y (1982–1998). Each generation brings with it a different work ethic, mode of communication, and definitions of professionalism and loyalty. These generational differences can stymie productivity if medical staff members can't agree to disagree.

"If you attempt to change someone else's culture, you are going to be in for a long fight," says **Phillip Kibort, MD, MBA,** vice president of medical affairs and chief medical officer at Children's Hospitals and Clinics of Minnesota in Minneapolis and St. Paul. "The best leaders are the ones who work with these differences as opposed to trying to change them."

Redefining professionalism

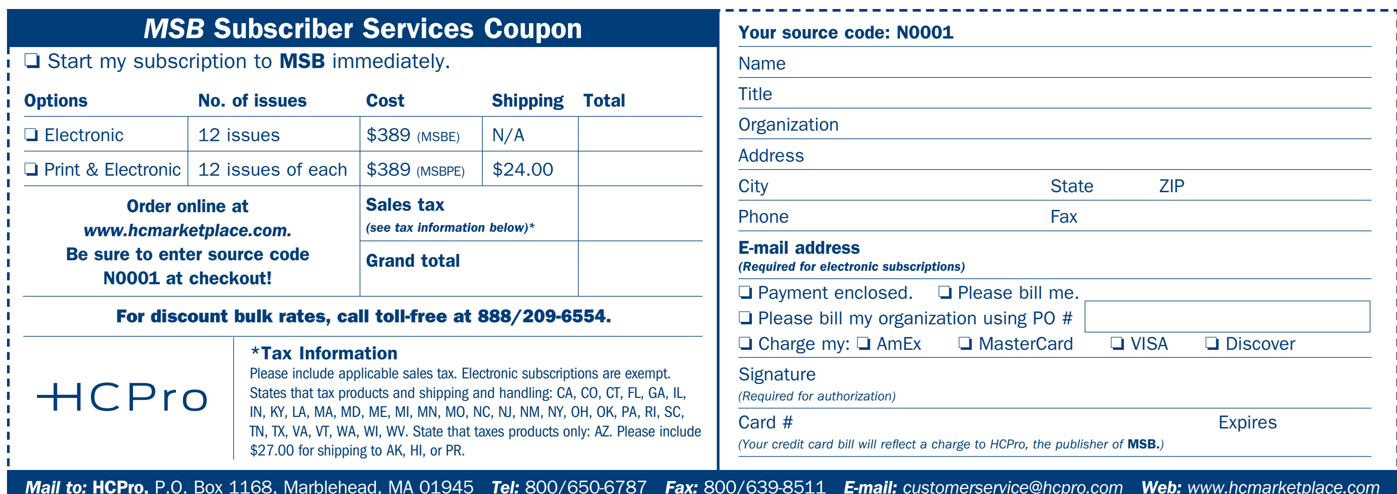
The Silent Generation and baby boomers generally consider medicine a calling and have dedicated their lives—and their families' lives—to their practice, says **Tracy Sanson, MD, FACEP,** associate professor at the University of South Florida in Tampa.

Gen Xers and Gen Yers most likely regard medicine as a career or job. They want time off to do volunteer work, a flexible schedule, and to play an active role in their families.

"We now have two very discrepant ideas of what a professional is, and they are both right," says Sanson. "There is no longer this idea that you have to spend 80–100 hours per week in the hospital."

And this is probably a good thing. Gen X and Gen Y have forced the medical community to introduce creative concepts such as paternity leave, flex time, and part-time schedules, which Sanson says is desperately needed to attract future generations of physicians. This flexibility is also good for older generations who are faced with the challenge of caring for ailing parents, she adds.

In addition, members of the Silent Generation and baby boomers entered into practice with the idea that they would move up the ladder and become a hospital leader in 20 years. "The Xers and Yers come in and want



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to know why they are not department director already," says Sanson. "We've turned the ladder sideways."

Although it may be difficult for physicians who put in 20 years before taking on a leadership position to watch young physicians flip the ladder, this, too, could push the medical community in a positive direction.

For example, department chairs have traditionally shouldered the brunt of the responsibilities associated with running a department. Now, departments are starting to delegate authority to multiple individuals, such as an education or PR director.

"It has spread out people's ownership of the department instead of it resting on the department chair," says Sanson.

Gen Xers and Yers are also changing the way medical staffs communicate; not only are they never without a cell phone, laptop, or PDA, but they also expect immediate responses. This pace may be new to some older physicians and may make it difficult for them to recruit younger physicians, says Sanson. Twenty years ago, medical staff leaders mulled over recruiting decisions for weeks or even months, leaving physician candidates in limbo, she says.

"Now, if you are not texting them as they are getting in their car after an interview, they think you are not interested in them and they move on," explains Sanson.

Not only do Gen Xers and Yers demand immediate responses, they aren't afraid to shop around for the best deal, and this is changing the definition of loyalty. In the era of eBay and Sam's Club, newer generations are happy as long as a brand delivers on their increasingly high expectations, but they aren't opposed to moving on if something better arises—and this applies to jobs, too.

Bridging the gap

To leverage the strengths that all four generations bring to the workplace, Sanson suggests developing a mentoring program that pairs members of the Silent Generation and baby boomers with Gen Xers and Yers. Older generations have plenty to teach the younger ones, particularly when it comes to loyalty and teamwork.

"The Xers and Yers forget that the Silent Generation and baby boomers have institutional knowledge and a wealth of experience, so we need to tap into that," says Sanson. At the same time, Gen Xers and Yers bring the "Why does it need to be done that way?" mentality to the table.

Mentoring relationships can help physicians develop each other's potential, "but not with the idea of denigrating the other person for what they don't know and what you do," says Sanson.

Kibort explains that because the younger generations aren't as interested in pursuing leadership positions as their predecessors, recruitment is often difficult. To help, Children's Hospitals and Clinics of Minnesota has developed a program that invites young physicians with leadership potential to undergo two years of leadership training at a local university. "There is still a high percentage who aren't interested, but we get a good return on investment for the ones we do work with," Kibort says. "We hope those people will participate more in the hospital."

If a mentoring program or leadership development program isn't in your organization's immediate future, start small. Sanson and Kibort suggest all parties simply try to understand the other's perspective and try to adapt.

"If you have an older physician who doesn't e-mail or text, it's like they are not speaking at all to the Xers and Yers," says Sanson. In that case, the older physician can learn how to use communication technology while younger physicians make an effort to communicate with that individual in person or over the phone.

"If you go in with a mind-set that someone else has to accept your values and way of life, you will not find creative solutions," says Kibort. "These values are not right or wrong, just different." ■

Save the date!

Send your team to the first Greeley Medical Staff Institute Symposium November 8–9 at the Ritz Carlton in Naples, FL. Visit *www.greeley.com/seminars* for more information.

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Physician-hospital competition and collaboration

Sailing the seven Cs: Resolving conflict

by ***William K. Cors, MD, MMM, FACPE, CMSL,*** *vice president of medical staff services at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA*

As we noted at the beginning of this series, the seven Cs of physician-hospital competition and collaboration are:

- Step 1: Embracing change
- Step 2: Achieving collaboration
- Step 3: Improving communication
  - Step 3a: Develop communication channels
  - Step 3b: Put tools in your toolbox
- Step 4: Managing competition
- **Step 5: Resolving conflict**
- Step 6: Influencing culture
- Step 7: Cultivating influence

The way an organization manages conflict is often determined by its culture. Some hospital cultures view every conflict as an opportunity to crush the competition, whereas others respond with sensitivity and thoughtfulness. To begin conflict resolution, first understand your organization's conflict management style and then objectively analyze whether it is achieving desired results.

Next, develop a comprehensive conflict management and resolution system at a time when your organization faces no immediate or pressing conflicts. It is much more difficult to implement change in the throes of conflict.

In their book, *Designing Conflict Management Systems*, Costantino and Merchant point out that there is a spectrum of alternative dispute resolution (ADR) options that range from the least to the most invasive. The least invasive options allow all parties a sense of control over the conflict resolution process and the outcome (e.g., negotiation). The most invasive ADRs allow the disputants little control over the conflict resolution process and outcome (e.g., binding arbitration).

When designing a progressive conflict management and resolution system, consider the following ADRs, which I have presented in sequence from least to most invasive:

- **Prevention.** Hospitals can prevent conflict by partnering, joint venturing, building consensus, setting expectations and rules, and joint problem-solving with physicians. Developing a physician-hospital compact that defines the "give" and the "get" between physicians and hospital is an excellent place to start.
- **Principled negotiation.** Resolve conflict through collaboration. Separate people from the problem; focus on interests, not positions; invent options for mutual gain; and insist on using objective criteria.
- **Facilitation.** Parties may wish to bring in a third party to facilitate and mediate discussion. Principled negotiation is often an effective strategy when a third party is leading the discussion.
- **Fact finding.** In addition to using a third-party mediator to facilitate discussion, hospitals and physicians may want to enlist the help of a neutral third party to gather data on which to base important decisions.
- **Advisory.** Difficult-to-resolve conflicts may require nonbinding arbitration.
- **Imposed settlement.** It's not pleasant, but sometimes binding arbitration is the only way to resolve a conflict.
- **Legal remedies.** Contact counsel if, and only if, all else fails. ■

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hospitalist leadership Advisor

A SUPPLEMENT TO MEDICAL STAFF BRIEFING

Special report

Integrating PAs and NPs into hospitalist practice

As the hospitalist movement grows and the primary care shortage deepens, nurse practitioners (NP) and physician assistants (PA) are increasingly migrating from the outpatient setting into hospital-based medicine.

"Nurse practitioners are absolutely filling in the gap in primary care. That is one of the reasons the role was created," says **Mary Jo Goolsby, EdD, MSN, ANP-C, FAANP,** director of research and education at the American Academy of Nurse Practitioners in Austin, TX.

We talked to several experts in the field to help answer your questions about integration:

➤ **Should the hospitalist program assign NPs and PAs to a physician, a floor, or a service?** That really depends on your practice, says **Mitchell Wilson, MD, FHM,** corporate medical director at Eagle Hospital Physicians in Atlanta, who has been working with PAs and NPs in hospital practice for more than 10 years.

For example, if your hospitalist program has an observation or rapid treatment unit, you may find that assigning NPs and PAs to particular services is beneficial. Conversely, floor or unit assignments may better suit a program with only a few physicians.

However, Wilson prefers team assignments—ideally one NP or PA paired with one or two physicians. Members of the team learn each other's practice habits and to communicate efficiently. NPs and PAs should not work with a larger group of physicians, Wilson says. "Once you get beyond two [physicians], it starts getting inefficient," he says. It becomes difficult for the NP or PA to keep up with each physician's preferences, and the physicians don't realize the full benefit of having an NP or PA on board.

Alan Platt, PA-C, MMSc, program and advanced didactic cocoordinator in the Physician Assistant Program at Emory University School of Medicine in Atlanta, says the ideal ratio is two NPs or PAs for every one physician. "PAs can function at the level of the hospitalist and substitute for them as long as they are supervised correctly," Platt explains.

With that in mind, PAs earn about half of what hospitalists earn, yet bill for the same services. "Instead of

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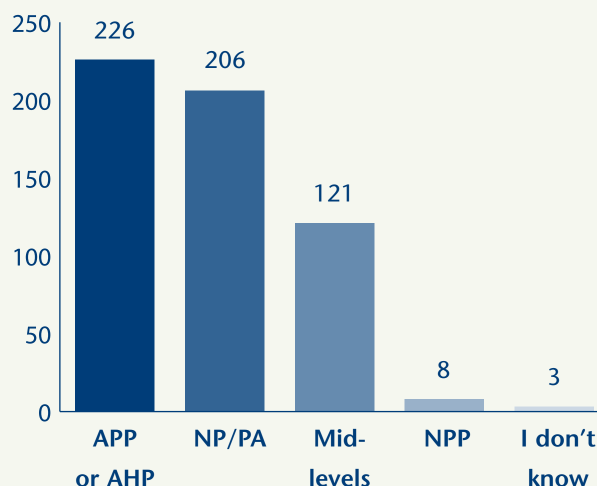

Source: HospitalistLeadership.com reader poll, conducted from May to June. Readers could select more than one choice.

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IN THIS ISSUE

p. 4 **PA and NP roles and responsibilities**
Use this chart to compare PA and NP duties and privileges.

Want more?
Visit us on our blog at *www.hospitalistleadership.com* to learn more about NPs and PAs in hospital medicine. Hear from the experts and join in the discussion!

PAs and NPs

< continued from p. 1

hiring three hospitalists, you can hire one hospitalist and two PAs," Platt says.

➤ **What is the biggest mistake hospitalist programs make when hiring NPs and PAs?** Not having a clear definition of the PA's or NP's role can be very frustrating for new hires, says **Laura Rosenthal, MSN, ACNP,** director of NPs in the hospitalist medicine service at the University of Colorado Health Sciences Center in Aurora.

"When I started in this role, they weren't sure what to do with me," Rosenthal says.

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Physicians may not understand what NPs and PAs are trained to do. "We are finding that [NPs and PAs] have different training experiences, so hospitalist programs don't know what they are getting," says Rosenthal.

First, define which functions the NP or PA will perform. For example, some programs may wish to hire an NP or PA to admit patients, whereas another may simply want to increase patient encounters by lightening the load for one or two physicians.

Next, focus on the interview process. "It is important to choose the best candidate for your practice. Focus not on the initials behind the name, but rather on the candidate's experience, ability to work in a fast-paced environment, and the ability to work as part of a team," says **Jina Saltzman, PA-C,** at the University of Chicago Medical Center's Section of Hospital Medicine and founder of the Association of Physician Assistants in Hospital Medicine.

Provide orientation for new NPs or PAs and for the existing physicians. Saltzman says hospitalist groups often fail to provide adequate orientation to new NPs and PAs. "A new graduate will need more orientation, but keep in mind that an experienced practitioner will also need some orientation to the practice and the hospital's culture," she says.

Another barrier to successfully incorporating NPs and PAs into hospitalist practice is that physicians often don't know how to work with these practitioners.

"Docs who have been on their own are used to doing it all themselves," says Wilson. "If they are told they have to delegate to someone else, they might end up micromanaging and duplicating work." NPs and PAs must build trust with such physicians.

➤ **What is the best way to train NPs and PAs who are joining my hospitalist group?** In general, it takes NPs and PAs six to 12 months, starting with a few days to a week of shadowing, to become fully up to speed, says Wilson. A physician with teaching experience should work with new hires one-on-one. "The

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fewer physicians they can work with at first, the better," says Wilson.

"Physicians have very different practice patterns, so having a new hire work with many new physicians at once can be extremely overwhelming," Saltzman says.

A physician mentor should start NPs and PAs performing tasks that match their education, skill set, and prior experience. For example, an NP experienced in the ICU will be better positioned to care for patients with comorbid conditions, whereas a PA right out of training should see younger, less acute patients, says Wilson.

As the NP or PA gets more comfortable and picks up new skills, the physician mentor can select cases that will challenge him or her. By gradually expanding the complexity of cases and the number of physicians a new NP or PA works with, the better your chances of retaining this individual, says Wilson. Keep in mind that the educational experience doesn't end after six to 12 months. Physicians should give NPs and PAs regular feedback by reviewing history and physical exams, performing annual evaluations, and engaging in daily discussions.

➤ **What's the best way to schedule NPs and PAs?** "If you have the opportunity for your PA and NP schedules to mirror your doctors' schedules, I think it creates more harmony," says Wilson. Regardless of your scheduling methodology, continuity of care should be top of mind when scheduling NPs and PAs, he says.

Hospitalist programs often make the mistake of having one NP or PA work Monday, Wednesday, and Friday, and another PA work Tuesday, Thursday, and Saturday. "Create a schedule where a person works several days in succession," Wilson says.

Even if your hospitalist program schedules NPs and PAs for several successive days, don't make the mistake of assigning them to different patients from day to day. "They should be following the same patients every day," Wilson explains. "At least half of the patients on your service should be seeing the same providers."

If your hospitalist program schedules hospitalists on a seven-days-on/seven-days-off rotation, and switch-over day is Sunday, Wilson suggests having your NPs and PAs switch over on Tuesday or Wednesday, so not everyone is getting acquainted with new patients on the same day.

➤ **Do NPs and PAs help improve hospitalist recruitment and retention?** They may, depending on whether the physicians in your program are open-minded. Anecdotal evidence suggests that a blended team of physicians, NPs, and PAs can increase professional satisfaction for everyone, Platt says. "The PAs are happy if they are treated well, and the hospitalists can have a life," he says.

This satisfaction can help increase the success of a program's recruitment and retention efforts. However, Wilson says many physicians feel that only physicians should be able to perform the clinical and diagnostic work that NPs and PAs do. "Physicians go through four years of medical school and three years of residency training, and someone who finishes their degree in two to three years is doing the same kind of work—that can be a bitter pill for some physicians to swallow," he says. As a result, bringing NPs and PAs into your practice can hinder recruitment and retention if your group's culture doesn't change.

➤ **What is the return on investment (ROI)?** According to the Society of Hospital Medicine's *2007–2008 Biannual Survey*, total compensation for NPs and PAs was about half of that for adult hospitalists (median: $95,000 vs. $183,900) and two-thirds of that for pediatric hospitalists (median: $95,000 vs. $144,600).

When hiring NPs and PAs, don't think about ROI solely in monetary terms, says Rosenthal. "Having enough staff on board so that patients can be seen in a timely manner is definitely good for patient care," she says.

An American Academy of Nurse Practitioners' position paper, *Nurse Practitioner Effectiveness,* cites several studies suggesting that NPs contribute to reduced length of stay, lower readmission rates, and lower mortality rates, which means greater hospital profit.

"It is not because our salaries are less; it is because the cost savings we bring to the hospitals are so great," says Goolsby.

Wilson says the work force of the future is a blended one that includes MDs, DOs, NPs, PAs, and other practitioners, all of whom deliver professional services. ■

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PA and NP roles and responsibilities

Physician assistant (PA) and nurse practitioner (NP) duties and privileges can be confusing for many, especially since they often vary by state. To help clarify their roles, we have provided a comparison chart below.

	PAs	NPs
Minimum education	Average PA program is 26 months; several programs offer postgraduate programs *** Average PA program applicant has a bachelor's degree and four years of healthcare experience ***	Graduate degree in nursing is now an entry-level requirement. Many programs offer postgraduate certificates and doctoral degrees. *
Salary	Median income for PAs working at least 32 hours per week and not self-employed: $85,710 ***	Total median compensation: $88,000–$95,000 (Society of Hospital Medicine combined PA and NP salaries in this estimate) ****
Responsibilities	(For all of the following): ** ➤ Obtain history and physical exam (H&P) for admission to the hospitalist service ➤ Prepare admission orders ➤ Perform daily assessment and physical examination prior to rounding with attending physician ➤ Order laboratory tests and diagnostic studies ➤ Arrange appropriate inpatient consultative services ➤ Write prescription orders and therapies ➤ Provide consultative services to surgical teams ➤ Recognize and assess changes in patients' condition and alert supervising physician ➤ Perform certain diagnostic/therapeutic procedures, including lumbar puncture, paracenteses, thoracenteses, central line placement, arterial blood gas, and suture placement ➤ Assist with discharge planning ➤ Communicate with patients and families ➤ Dictate H&Ps, consultations, and discharge summaries ➤ Participate in teaching medical and PA students	➤ Order, perform, and interpret diagnostic tests, such as lab work and x-rays * ➤ Diagnose and treat acute and chronic conditions, such as diabetes, high blood pressure, infections, and injuries * ➤ Prescribe medications and other treatments * ➤ Manage inpatients' overall care, including consultation, pre- and postoperative management, and inpatient management of acute and chronic conditions ** ➤ Perform diagnostic and therapeutic procedures * ➤ Counsel patients * ➤ Educate patients about health and well-being * ➤ Discharge planning and case management *
Supervision	PAs in every state must practice under the supervision of a licensed physician **	In some states, NPs can practice independently; in others, they must practice under a collaborative agreement with a licensed physician
Certification/ licensure	National Commission on Certification of Physician Assistants (NCCPA); state medical boards	American Academy of Nurse Practitioners Certification Program; state board of nursing regulation (visit the National Council of State Boards of Nursing at *www.ncsbn.org*); other state certification agencies
Recertification	100 hours of continuing medical education required every two years; recertification from NCCPA every six years *****	Determined by certification agencies; continuing education and practice required
Considered members of the medical staff	Sometimes	Sometimes

*Sources: * American Academy of Nurse Practitioners* (www.aanp.org), *** Association of Physician Assistants in Hospital Medicine* (www.hospitalistpa.org), **** American Academy of Physician Assistants* (www.aapa.org), ***** Society of Hospital Medicine* (www.hospitalmedicine.org), ****** National Commission on Certification of Physician Assistants* (www.nccpa.net).

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