# A Challenge for a New Specialty

# A White Paper on
# Hospitalist Career Satisfaction

**Prepared by:**

**The SHM Career Satisfaction Task Force**

**December, 2006**

# Contributors

This White Paper is a collaborative effort of the Career Satisfaction Task Force. The Co-Chairs of the Task Force, Sylvia McKean MD and Winthrop Whitcomb MD, provided overall leadership and are largely responsible for the conceptual framework of the White Paper. In addition, members of the Task Force contributed to individual chapters as follows:

Chapter 3 (Job Fit) and Chapter 6 (Autonomy/Control)

- **Tosha Wetterneck, MD**
  University of Wisconsin Hospital/Clinics, Madison, WI
- **Justin Psaila, MD**
  St. Luke's Hospital, Bethlehem, PA

Chapter 4 (Reward/Recognition)

- **Sylvia McKean, MD**
  Brigham & Women's Hospital, Boston, MA (Co-Chair)
- **Adrienne Bennett, MD, PhD**
  Ohio State University Medical Center**,** Columbus, OH

Chapter 5 (Workload/Schedule)

- **Winthrop Whitcomb, MD**
  Mercy Medical Center, Springfield, MA (Co-Chair)
- **Douglas Carlson, MD**
  St Louis Children's Hospital, St. Louis, MO
- **Jeffrey Genato, MD**
  Hospital Medicine Consultants, Frisco, TX

Chapter 7 (Community/Environment)

- **Mark Brauning, MD**
  Stamford Hospital, Stamford, CT
- **Noah Harris, MD** Scott & White Hospital & Clinic, Belton, TX

The other members of the Task Force provided input to and review of the White Paper:

- **Claudia Claiborne, MD**
  PrimeDoc Management Services, Asheboro, NC
- **Michael Ruhlen, MD**
  Toledo Childrens Hospitalists**,** Toledo, OH
- **Gary Salem, DO**
  IPC- Detroit, Troy, MI

The Task Force engaged a professional writer who contributed to editing and re-drafts of the chapters:

- **Phyllis Hanlon,** Charlton, MA

The final version of the White Paper was drafted by the Task Force coordinator:

- **Joseph A. Miller,** Senior Vice President, Society of Hospital Medicine

The White Paper was reviewed by the following "external" reviewers:

- **Peter J. Pronovost, MD, PhD**
  Associate Professor Departments of Anesthesiology and Critical Care, Surgery, and Health Policy and Management
  Medical Director, Center for Innovations in Quality Patient Care
  The Johns Hopkins University School of Medicine
- **Charles Hatem, MD**
  Harold Amos Academy Professor
  Director of Professional Development
  The Academy at Harvard Medical School
- **John Adam Fromson, MD**
  Assistant Professor of Psychology
  Harvard Longwood Residency Training Program
  Harvard Medical School
  Director, Physician Health Services
  Massachusetts Medical Society

# Table of Contents

# Chapter 1
# Introduction

In 1996, when Robert M. Wachter, MD, coined the term "hospitalist," the medical world, as well as the general public, never imagined this niche area would have the impact it has. Fewer than 1,000 hospitalists existed at that time. Today, that figure exceeds 15,000 and almost 40 percent of the 5,000 hospitals nationwide employ hospitalists.

Hospital administrators and their medical staff have come to depend on hospitalists to address a wide range of concerns, including cost savings, quality and safety, throughput, medical staff leadership, 24x7 coverage, and education. Hospitalists have become critical players in the hospital environment. Many have enjoyed rewards for their work, including recognition for their excellence and appreciation from patients, family, and colleagues.

But growth and success is a two-sided coin. Just as other specialty areas, such as emergency medicine and critical care, experienced growing pains, hospital medicine faces the challenge of heavy workloads, demanding schedules and numerous administrative responsibilities. Hospitalists are continually being asked to demonstrate that they are worth the investment made by their hospital. And individual hospitalists are concerned with professional advancement, personal financial pressures, and the competing demands of family and social life. The diagram below depicts the many stresses that hospitalists face.

| **The nature of the work** | **The nature of the work environment** | **External influences** |
|---|---|---|
| • High acuity/complexity of illness/lack of predictability<br>• Life and death implications of clinical decisions<br>• Provider interdependency and communication<br>• Limited patient information<br>• Administrative and documentation requirements<br>• Medical legal risk<br>• Potential hostility from patient's family<br><br>**Personal issues**<br><br>• Professional advancement<br>• Financial pressures | • Volume of work<br>• Time pressure<br>• Night and weekend coverage responsibilities<br>• High census conditions<br>• Intermittent demand (beeper always going off)<br>• Workplace conflicts and interruptions<br>• Workplace discrimination<br>• Lack of understanding of the role of the hospitalist by hospital administrators<br>• Hospitalists working on a temporary basis while waiting to pursue other career plans | • Impact of ACGME work rules on patient care/teaching<br>• Legal and regulatory concerns<br>• Financial pressures from payers<br><br>**Career/organizational issues**<br><br>• Reimbursement based on office model<br>• No established track for promotion<br>• Little control over key issues (workload, schedule, case types)<br>• Conflict between service mission and other equally |

| | | |
|---|---|---|
| • Pressures from spouse/family<br>• Unrealistic job expectations<br>• Inability to say "no" | • Medical staff conflicts<br>• Ergonomics (poorly designed work space and/or equipment)<br>• Limited workspace | important responsibilities<br>• Limited professional recognition and funding for scholarly activities<br>• Leadership structure within the hospital (not "at the table") |

Hospitalists practice in a variety of settings – community hospital, academic medical center, private group practice, adult medicine or pediatrics, large practice or small, closed vs. open practice model ICU's, physician extender use, etc. Each hospital medicine group has its own unique pressures and stresses.

These stresses lead to a range of undesirable outcomes, including:

- Unplanned turnover
- Absenteeism
- Judgment and action errors
- Conflicts and alienation from professional colleagues

There is also the potential of more tangible adverse outcomes such as accidents, litigation, and increased worker's compensation cases. Research has documented that work stress also can lead to physical illness, such as cardiovascular disease and other conditions, as well as psychological distress (Bovier, Glymour, O'Sullivan, Vanagas). In addition, stress may lead to a poor balance of work/family and the reliance on maladaptive coping strategies (e.g., drug and alcohol abuse and dependence).

Career satisfaction has become a critical issue for the hospital medicine specialty. In SHM's 2005 bi-annual survey, hospital medicine leaders were asked to rank the top challenges their groups face. Many of the major concerns relate to career satisfaction. Survey respondents identified the following issues as highest priorities:

1. Work hours/work life balance 42%
2. Recruitment 35%
3. Daily work load 29%
4. Expectations/demand from hospital 23%
5. Reimbursement and collections 17%
6. Professional respect and job satisfaction 17%
7. Career sustainability 15%
8. Retention 15%
9. Quality of care/quality indicators 13%

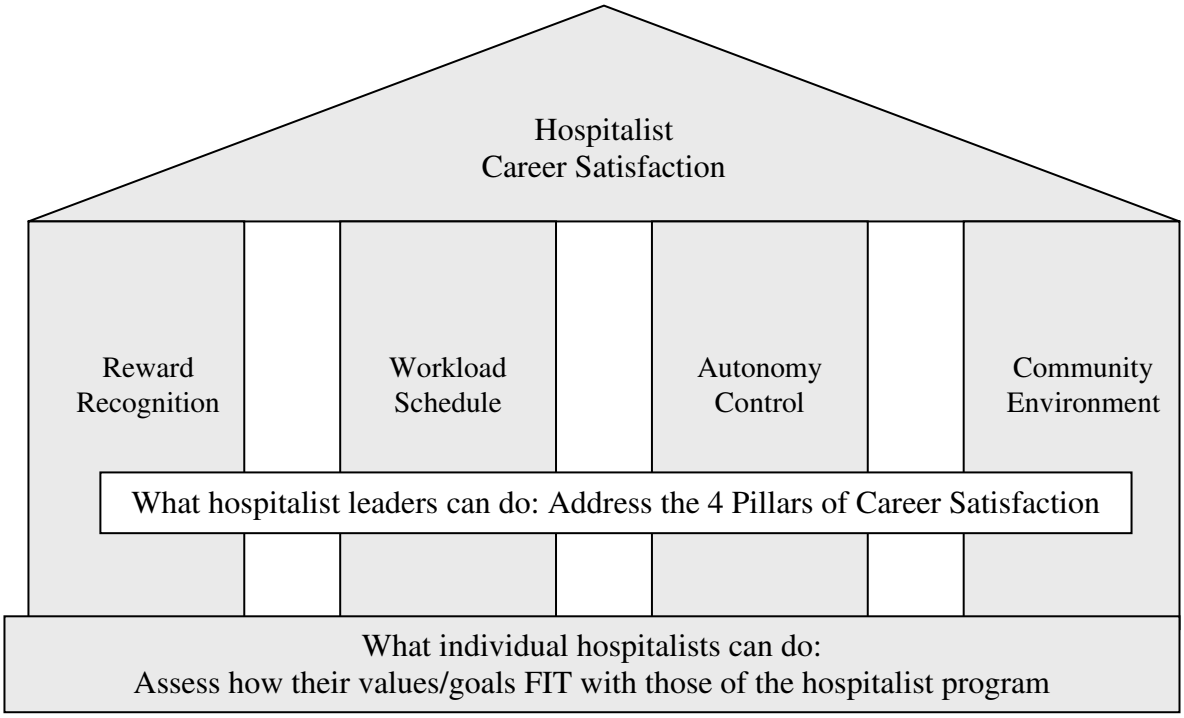
In response to this increasing concern, SHM established the Career Satisfaction Task Force in March 2005. This white paper summarizes the work and recommendations of this Task Force.

# Chapter 2
# Framework

The Career Satisfaction Task Force examined the research surrounding career satisfaction, both in healthcare and in other organizational environments. Multiple models of quality of working life have influenced the Task Force's conclusions:

- Karasek's model on job stress reflects how job control, workload/time pressure and job support all contribute to job stress.
- Greenburger identifies four dimensions of job control: task control, decision/ organizational control, physical environment control, and resource control.
- Linzer's work on physician satisfaction identifies multiple domains which influence overall job satisfaction (autonomy; relationships with patients and other physicians; income and rewards; resources; and community/environment)
- Maslach work on burnout and job engagement defines six "domains" that are critical for obtaining job-person fit. A poor fit may lead to job dissatisfaction, stress, and potential burnout.

The resulting framework for hospitalist career satisfaction developed by the Task Force is depicted in this diagram:



For *individual hospitalists*, the Task Force's major recommendation pertains to ***Job Fit***. As described in Chapter 3 of this white paper, there are four areas of job control that contribute to career satisfaction:

- Task Control: control over when, how, and how quickly a task is done
- Decision/Organizational Control: control over task assignment and policies
- Physical Environment Control: control over the location, layout, and climate of where work is done
- Resource Control: control over the availability of support staff, supplies, and materials

A questionnaire has been developed that helps hospitalists understand their personal priorities and values with regard to job control and evaluate these control elements in their current and potential work situation.

For areas *hospitalist leaders* can influence, the Task Force developed tools on four topics, depicted as the four "pillars" in the diagram:

- Pillar 1 – Reward Recognition: the need for appropriate reward – monetary and non-monetary – for a job well done
- Pillar 2 – Workload Schedule: the need for a manageable workload and a sustainable schedule
- Pillar 3 – Autonomy/Control: the need to be able to impact the key factors that affect job performance
- Pillar 4 – Community/Environment: the need for a community and environment that supports a satisfying, engaged career

These pillars are discussed in Chapters 4-7 of this white paper. In each Chapter, there is: 1) a ***definition*** of the key concepts relating to the pillar; 2) a ***scorecard*** that can be used by hospitalist leaders to benchmark the current career satisfaction status of their program; and 3) a series of ***action steps*** that hospitalist leaders can take to improve the career satisfaction of the hospitalists in their group. Each of the Chapters also has one or more appendices that contain ***tools and other resources*** that hospitalist leaders can use in their program.

The action steps outlined in each Chapter are broken into five categories:

- Get the facts: suggestions on information that can be researched, analyses that can be conducted, and/or surveys that might be administered
- Organizational/Structural Strategies: suggestions on formal steps that can be taken with regard to the structure of the hospitalist group, how it is staffed, and/or how hospitalists are compensated

- Systems Strategies: suggestions on changes that can be made to the operation (processes) of the hospitalist group
- Professional Development Strategies: suggestions on actions that can be taken directed at individual hospitalists
- Marketing/Relationship Strategies: suggestions on how hospitalists can re-define how they relate to other key stakeholders in their work environment

A spreadsheet that summarizes all of the action steps, in these five categories for the four pillars, is outlined in Table 1.

As the reader reviews the following chapters, there are some fundamental concepts that serve to both integrate and enhance the ideas which are presented. Specifically:

The Basics

- Recognize each hospitalist as an individual. Each hospitalist has his/her own preferences, interests, and goals.
- Assure there are adequate environmental resources in place. Before the more sophisticated satisfaction issues can be addressed, sufficient administrative support, space, and equipment must be in place.
- Assure there is adequate professional development support in the form of peer groups or individual supervision and mentoring.
- Make informed decisions. Addressing hospitalist career satisfaction requires making sure there is an understanding of the current state of affairs and the available options.

Leadership Principles

- Build a cohesive team. Individual hospitalists will be more satisfied when they feel like they are part of a group with similar values, philosophies, and attitudes.
- Build positive relationships. The hospitalist practice does not operate in a vacuum. Addressing career satisfaction requires positive relationships with hospital leadership, members of the medical staff, and non-physician healthcare professionals.
- Create an ownership mentality. If hospitalists are to be treated with respect, they must view their group in a manner similar to private physicians in the community. This includes having a shared sense of accountability for the practice's performance, including financial matters.
- Operate the practice in a business-like manner. There should be some formality to the hospitalist practice (e.g., a business plan, negotiated service agreements, and annual budgets).

# Table 1: Action Steps to Address Hospitalist Career Satisfaction

| | **PILLAR 1**<br>**Reward/Recognition**<br>*The need for appropriate reward, monetary & non-monetary, for a job well done* | **PILLAR 2**<br>**Workload/Schedule**<br>*The need for a manageable workload & a sustainable schedule* | **PILLAR 3**<br>***Control/Autonomy***<br>*The need to be able to impact the key factors that affect job performance* | **PILLAR 4**<br>**Community/Environment**<br>*The need for a community & environment that supports a satisfying, engaged career* |
|---|---|---|---|---|
| **Get the Facts**<br>*Suggestions on information that can be researched, analyses that can be conducted, and/or surveys that might be administered* | • Conduct a formal review/ analysis of compensation and benefits<br>• Survey medical staff on satisfaction with hospitalists<br>• Survey nursing staff on satisfaction with hospitalists<br>• Survey hospitalists on career satisfaction | • Document hospitalist workload/productivity<br>• Document hospitalist responsibilities<br>• Benchmark workload/ productivity against SHM Survey data<br>• Survey hospitalist perceptions re: workload<br>• Research hospitalist scheduling/staffing models | • Use the Job Fit questionnaire to profile the control elements of the hospitalist practice<br>• Become familiar with the hospital's leadership and committee structure<br>• Understand key payer issues that might impact inpatient care<br>• Review the hospitalist job description | • Review and communicate hospital policies re: harassment and discrimination<br>• Research availability of professional counseling resources<br>• Determine which, if any, hospitalists look at their job as a "temporary" position |
| **Organizational/Structural Strategies**<br>*Suggestions on formal steps that can be taken with regard to the structure of the hospitalist group, how it is staffed/organized, and/or how hospitalists are compensated* | • Create an "ownership mentality" in the hospitalist group<br>• Implement an incentive compensation program<br>• Establish a formal negotiation process with hospital leadership<br>• Establish a formal negotiation process with medical staff<br>• Change organizational model (to private group)<br>• Create an organizational structure that recognizes hospitalists multiple roles | • Implement an incentive compensation program<br>• Add administrative support staff<br>• Add non physician staff<br>• Add additional physician staff<br>• Use part-time hospitalists<br>• Use nocturnists<br>• Include dedicated time for non clinical work in the job definition | • Involve hospitalists in participative decision-making on key work-life issues<br>• Create an "ownership mentality" in the hospitalist group<br>• Establish a formal negotiation process with hospital leadership<br>• Establish a formal negotiation process with medical staff<br>• Establish mission and value statements for the hospitalist group | • Pursue leadership in hospital committees<br>• Conduct regular hospitalist group meetings<br>• Define hospitalist group goals<br>• Create a culture of teamwork and empower members to voice concerns |
| | **PILLAR 1** | **PILLAR 2** | **PILLAR 3** | **PILLAR 4** |

| | **Reward/Recognition**<br>*The need for appropriate reward, monetary & non-monetary, for a job well done* | **Workload/Schedule**<br>*The need for a manageable workload & a sustainable schedule* | ***Control/Autonomy***<br>*The need to be able to impact the key factors that affect job performance* | **Community/Environment**<br>*The need for a community & environment that supports a satisfying, engaged career* |
|---|---|---|---|---|
| **Systems Strategies**<br>*Suggestions on changes that can be made to the operation (processes) of the hospitalist group* | • Create an awards committee to recognize exceptional performance<br>• Incorporate job satisfaction into quarterly hospitalist reviews | • Implement a new schedule/staffing model (shorter but more shifts? backup call?)<br>• Generate reports on hospitalist productivity and workload<br>• Establish back up plan for family/med emergencies<br>• Use a dedicated *on call* pager (perhaps also covering admits, RRT)<br>• Maximize pager technology<br>• "Pool" non-urgent nursing concerns<br>• Use PRN admit orders | • Document in writing understandings with hospitalists re: workload/schedule<br>• Establish formal agreement with medical staff on types of patients seen by hospitalists<br>• Seek improvements in hospital processes that impact hospitalist performance (e.g., throughput)<br>• Establish standards for hospitalist processes (e.g., PCP communication, sign-outs, admission, discharge) | • Structure sufficient time for patient/family communications<br>• Assure dedicated time for non patient care responsibilities<br>• Create a mentorship program with regularly scheduled meetings |
| **Professional Development Strategies**<br>*Suggestions on actions that can be taken directed at individual hospitalists* | • Establish peer or individual supervision<br>• Identify and take a pro-active role in establishing mentoring relationships<br>• Organize/participate in hospitalist chapter meetings<br>• Clearly set expectations for individual hospitalists<br>• Clarify individual performance goals and acknowledge when they are achieved | • Recognize individual goals/preferences in scheduling/staffing<br>• Clearly describe the group's work philosophy to new hires<br>• Measure and discuss productivity and workload with hospitalists | • Use Job Fit questionnaire to assess potential hospitalists (and share info with the candidates)<br>• Allow each hospitalist to choose which committees and/or projects they want to participate on<br>• Establish core values that promulgate peer support and rewards for identifying problems and asking for help<br>• Get Leadership training for hospitalist director | • Include hospitalists in key meetings<br>• Develop communication skills via conferences/CME<br>• Communicate job requirements/expectations to new hires<br>• Establish a journal club<br>• Reimburse membership in SHM and other professional groups<br>• Establish personal goals/expectations<br>• Assure sufficient vacations to revitalize |
| | **PILLAR 1** | **PILLAR 2** | **PILLAR 3** | **PILLAR 4** |

| | **Reward/Recognition**<br>*The need for appropriate reward, monetary & non-monetary, for a job well done* | **Workload/Schedule**<br>*The need for a manageable workload & a sustainable schedule* | ***Control/Autonomy***<br>*The need to be able to impact the key factors that affect job performance* | **Community/Environment**<br>*The need for a community & environment that supports a satisfying, engaged career* |
|---|---|---|---|---|
| **Marketing/Relationship Strategies**<br>*Suggestions on how hospitalists can re-define how they relate to other key stakeholders in their work environment* | • Formally present performance results to hospital leadership/ medical staff (Hospitalist Quarterly Reports)<br>• Assume responsibility for physician education programs at hospital<br>• Take the hospital CEO on hospitalist rounds<br>• Pursue leadership roles on committees, teaching, research, etc.<br>• Establish formal team meetings with nurses, discharge planning, etc.<br>• Pursue PR opportunities in hospital and community publications<br>• Seek speaking engagements at community, specialty, and national professional meetings<br>• Seek advocates/allies among hospital leadership/medical staff | • Communicate schedule/ staffing model to hospital leadership<br>• Communicate schedule/ staffing model to medical staff<br>• Work with nurses and other team members on productivity | • Seek representation on hospital committees/ boards that impact hospitalists<br>• Establish formal team meetings with nurses, discharge planning, etc.<br>• Seek advocates/allies among hospital leadership/ medical staff | • Conduct meetings with hospital administration to discuss performance<br>• Conduct meetings with referring physicians (PCPs) to discuss performance<br>• Conduct meetings with non-referring physicians to market the program<br>• Conduct meetings with specialist physicians to educate<br>• Conduct meetings with nursing administration<br>• Announce new hospitalists<br>• Create a hospitalist program website for patients, families, and physicians<br>• Print and distribute a hospitalist program brochure |

References

Bovier PA and Perneger TV. Predictors of work satisfaction among physicians. *Eur J Public Health.* 2003 Dec; 13(4): 299-305.

Glymour MM, Saha S, Bigby J; Society of General Internal Medicine Career Satisfaction Study Group. Physician race and ethnicity, professional satisfaction, and work-related stress: results from the Physician Worklife Study. *J Natl Med Assoc.* 2004 Oct; 96(10): 1283-9, 1294.

Greenburger DB, Strasser S, Cummings LL, Dunham RB. The impact of personal control on performance and satisfaction. *Organizational Behavior and Human Decision Processes*. 1989;43:29-51.

Karasek RA. Job demands, job decision latitude, and mental strain: implications for job redesign. *Admin Sci Q*. 1979;24:285-307.

Linzer M et al. Managed care, time pressure, and physician job satisfaction: results from the physician work life study. *J Gen Intern Med.* 2000 Jul;15(7):517-8.

Maslach C, Schaufeli WB, Leiter MP. Job Burnout. Annu Rev Psychol. 2001;52:397-422.

O'Sullivan B, Keane AM, Murphy AW. Job stressors and coping strategies as predictors of mental health and job satisfaction among Irish general practitioners. *Ir Med J.* 2005 Jul-Aug; 98(7): 199-200, 202.

Smith, L. Medical professionalism and the generation gap. *Am J Med*. 2005;118(4):439-442.

Vanagas G, Bihari-Axelsson S. Interaction among general practitioners age and patient load in the prediction of job strain, decision latitude and perception of job demands: a cross-sectional study. *BMC Public Health.* 2004 Dec 7; 4:59.

Yandrick, Rudy and Freeman, Michalel (General Editor), 1996. *Behavioral Risk Management: How to Avoid Preventable Losses from Mental Health Problems in the Workplace.* San Francisco, CA: Jossey-Bass Publishers**.**

# Chapter 3
# Job Fit

The most powerful strategy available to an individual with regard to career satisfaction is to choose a job that fits with his/her preferences and attitudes. The recommendations on Job Fit developed by SHM's Career Satisfaction Task Force are derived from the work done on Autonomy/Control (Chapter 6). Measuring job control can be difficult as it is affected by skill level and variety as well as job scope and complexity. The actual effect of job control on the individual depends **not only on how much control the individual perceives that they have over something, but also on how much importance the individual places on having control over something**. A research study observed that, in general, physicians who care less about having autonomy are happier than those who do care (Williams).

In developing a Job Fit Questionnaire (see Appendix 3A) for hospitalists, the Career Satisfaction Task Force focused on four dimensions of job control in the job control literature (Greenburger). The four areas of control and their components, as applied to hospital medicine, are as follows:

- Task Control: control over when, how, and how quickly a task is done
- Decision/Organizational Control: control over task assignment and policies
- Physical Environment Control: control over the location, layout, and climate of where work is done
- Resource Control: control over the availability of support staff, supplies, and materials

Depending on their work situation, hospitalists may have varying ability to change the conditions under which they work. Nevertheless, hospitalists need a reasonable amount of autonomy/ control over their work life to moderate stress levels. When evaluating ways in which increased job control/autonomy might decrease the incidence of job stress, the hospitalist must keep in mind the realities of the job.

Each physician needs to identify which areas of job control are most important and seek a job that allows more control over those parts of their work life. This may depend on practice type and setting. The Job Fit Questionnaire can be a useful tool in this evaluation. Consider the following plan of action:

1. Use the questionnaire to understand yourself as a person and evaluate the current and desired job control elements in your present work situation.

2. Prioritize control items to determine which items you must have control over and which items that you are willing to have less control over. Rate how much each item matters to you.

3. Redo the checklist for the hospital medicine group (i.e., your current or proposed work environment) to match where the areas of control align.

4. If there is an area of control that is of great importance to you, assess yourself to know if you have sufficient knowledge and skills to exert effective control over this area. Does your program have the knowledge and skills? If not, seek this or reevaluate.

# APPENDIX 3A
# Job Fit Questionnaire

INSTRUCTIONS: Assess your perceived control and its importance on each of the following items. Please circle your response. Note two scales for each item: the top scale indicates amount of control you currently have and bottom scale represents the amount of desire for control. Identify the gaps between *having* control and *wanting* control.

| **Amount of control you currently have** | **Amount of desire for control** |
|---|---|
| **1 = no control over item**<br>**2 = minimal control over item**<br>**3 = some control over item**<br>**4 = significant control over item**<br>**5 = total control over item** | **1 = not important at all to have control over item**<br>**2 = slightly important to have control over item**<br>**3 = desire some control over item**<br>**4 = desire significant control over item**<br>**5 = absolutely must have control over item** |

*Task*

1. Set the pace of work
   Amount of control you currently have 1 2 3 4 5
   Amount of desire for control 1 2 3 4 5

2. Work schedule (hours, location)
   Amount of control you currently have 1 2 3 4 5
   Amount of desire for control 1 2 3 4 5

*Decision*

3. Select consultants
   Amount of control you currently have 1 2 3 4 5
   Amount of desire for control 1 2 3 4 5

4. When to:
   a. Admit patient
      Amount of control you currently have 1 2 3 4 5
      Amount of desire for control 1 2 3 4 5
   b. Discharge patient
      Amount of control you currently have 1 2 3 4 5
      Amount of desire for control 1 2 3 4 5

5. Type of patients you will admit
   Amount of control you currently have 1 2 3 4 5
   Amount of desire for control 1 2 3 4 5

| | | |
|---|---|---|
| 6. Determine LOS | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 7. Provide medications of choice | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 8. Order and obtain diagnostic tests | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 9. Volume of paperwork | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 10. Workload volume | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 11. Influence/change hospital policy | | |
| | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 12. Time away from work | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 13. Cost of care provided | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 14. Quality of care provided | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |

*Environment*

| | | |
|---|---|---|
| 15. Which nursing unit you work on | | |
| | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 16. Which hospital you work at | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 17. Work interruptions | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |
| 18. Designated working space | Amount of control you currently have | 1 2 3 4 5 |
| | Amount of desire for control | 1 2 3 4 5 |

*Resources*

| | | | | | | |
|---|---|---|---|---|---|---|
| 19. Computer terminal availability | Amount of control you currently have | 1 | 2 | 3 | 4 | 5 |
| | Amount of desire for control | 1 | 2 | 3 | 4 | 5 |

20. Availability and/or efficiency of computer systems (e.g., Computerized Physician Order Entry and/or Electronic Medical Records)

| | | | | | | |
|---|---|---|---|---|---|---|
| | Amount of control you currently have | 1 | 2 | 3 | 4 | 5 |
| | Amount of desire for control | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 21. Office space/assigned rooms | Amount of control you currently have | 1 | 2 | 3 | 4 | 5 |
| | Amount of desire for control | 1 | 2 | 3 | 4 | 5 |

# Chapter 4
# Pillar 1: Reward and Recognition

## Definition

One type of mismatch between the person and the job *"involves a lack of appropriate rewards for the work people do. Sometimes these may be insufficient financial rewards, as when people are not receiving the salary or benefits commensurate with their achievements. Even more important at times is the lack of social rewards, as when one's hard work is ignored and not appreciated by others. This lack of recognition devalues both the work and the workers. In addition, the lack of intrinsic rewards (such as pride in doing something of importance and doing it well) can also be a critical part of this mismatch. Lack of reward is closely associated with feelings of inefficacy." (Maslach)*

Applying these concepts to hospital medicine:

- *Financial rewards/recognition* involve compensation (including salary, bonuses, and benefits)
- *Social rewards/recognition* involve appreciation by other hospitalists (both inside and outside the group), members of the medical staff, non-physician providers (including nurses, case managers, pharmacists, etc.), hospital leadership, patients, and family members
- *Intrinsic rewards/recognition* involve getting satisfaction from healing and educating patients, practicing quality care, effectively teaching house staff and medical students, being efficient and productive, and continuing to learn and grow professionally

## Scorecard: Benchmarking my Program

*Compensation*

- Have compensation levels been benchmarked against published standards?
- Does the compensation program recognize hours worked on nights and weekends?
- Does the compensation program recognize additional hours worked (beyond 1 FTE)?
- Does the compensation program appropriately recognize performance?
- Does the compensation program appropriately recognize non-clinical responsibilities?

*Benefits*

- Do hospitalists get adequate time off for personal life?
- Do hospitalists get funds for professional development?

*Administrative Support*

- Does the hospitalist program have adequate space and equipment?
- Does the hospitalist program have adequate administrative support?
- Does the hospitalist program have access to resources to do utilization/financial/ satisfaction analyses?

*Individual Recognition*

- Does each hospitalist get formal feedback on his/her performance?
- Are there service, teaching, and leadership awards for hospitalists?

*Recognition by hospital/institutional leadership*

- Does the hospitalist program formally present its performance to hospital leadership on a periodic basis?
- Does the hospitalist program negotiate the amount of its financial support payment with the hospital/medical group?
- If part of a division, is the hospitalist service fully integrated within the division?
- Are members of the hospitalist service on the radar screen of physician leaders when new opportunities for leadership arise?
- Are members of the hospitalist service on the radar screen of clinicians engaged in clinical research and/or quality improvement?

*Peer/Professional Recognition*

- Do primary care physicians treat the hospitalists as professional peers?
- Do physician specialists recognize hospital medicine as a "legitimate" specialty?
- Are there positive evaluations by the nursing staff? Other ancillary providers?

*Personal Satisfaction*

- Do hospitalists get personal satisfaction from their individual interactions/successful therapeutic relationships with patients (and families)?
- Do hospitalists get personal satisfaction from participation/leadership of the care team (nurses, case managers, therapists, etc.)?
- Are hospitalists intellectually challenged?
- Do hospitalists feel that their work is diverse and varied?
- For hospitalists that have left the program, have they identified rewards and recognition as a reason for their departure?

## Action Steps: What can we do?

*Get the Facts*

- Conduct a formal review/ analysis of compensation and benefits

- Survey medical staff on satisfaction with hospitalists
- Survey nursing staff on satisfaction with hospitalists
- Survey hospitalists on career satisfaction

*Organizational/Structural Strategies*

- Create "ownership mentality" in hospitalist group
- Implement an incentive compensation program (see Appendix 4A for description of alternative compensation models)
- Establish a formal negotiation process with hospital leadership
- Establish a formal negotiation process with medical staff
- Change organizational model (to private group)
- Create an organizational structure that recognizes hospitalists' multiple roles

*Systems Strategies*

- Create an awards committee to recognize exceptional performance
- Incorporate job satisfaction into quarterly hospitalist reviews

*Professional Development Strategies*

- Establish peer or individual supervision
- Identify and take a pro-active role in establishing mentoring relationships
- Organize/participate in hospitalist chapter meetings
- Clearly set expectations for individual hospitalists (See Appendix 4B)
- Clarify individual performance goals and acknowledge when they are achieved

*Marketing/Relationship Strategies*

- Formally present performance results to hospital leadership/ medical staff
- Assume responsibility for physician education programs at hospital
- Take the hospital CEO on hospitalist rounds
- Pursue leadership roles on committees, teaching, research, etc.
- Establish formal team meetings with nurses, discharge planning, etc.
- Pursue PR opportunities in hospital and community publications
- Seek speaking engagements at community, specialty, and national professional meetings
- Seek advocates among hospital leadership/ medical staff

# APPENDIX 4A
# Comparison of Compensation Models

| Compensation Model | Definition | Advantages | Disadvantages |
|---|---|---|---|
| Straight Salary | Hospitalist is an employee, typically of a hospital, paid a flat salary regardless of workload. | Professionalism as the driver of the work ethic | No financial incentive to be more productive/see more patients. |
| Straight Productivity | Based solely on physician billing for professional services. | Enhanced productivity (seeing more patients) as the driver of the work ethic.<br><br>Can create an "ownership mentality" among participating physicians. | No compensation for non-patient care related work.<br><br>Insurance reimbursement for inpatient care may be insufficient compensation for the intensity or time.<br><br>Impact on communication, quality, safety of patient care, efficiency unknown. |
| Base Salary with Incentive | Base salary supplemented by an incentive bonus, usually based solely on productivity (seeing more patients, billing more RVUs), but may include quality of care targets | Goal to align physician and employer interests, leading to increased productivity or improved patient outcomes.<br><br>Consistent with the incentives that exist in most physician practices.<br><br>Can create an "ownership mentality" among participating physicians. | Depends on fairness of incentive to achieve reasonable compensation.<br><br>Legal issues (gainsharing) if incentives based on reductions in length of stay. |

# APPENDIX 4B
# An Example of Setting Expectations
# An Academic Hospitalist Job Description

1. Serve as a teaching attending on the general medical service for ___ months of the year.
    - Supervise housestaff in their care of approximately _____patients on the team, referred to the hospitalist service and who otherwise do not have an attending of record.
    - This requires on-site availability from ____ am to ____ pm and 24/7 beeper availability.
    - Teaching responsibilities include teaching residents, medical students, and teaching about the care of all patients on the team and individual meetings with students.
    - Service responsibilities include writing daily notes, billing within 48 hours of encounter, and daily communication with primary care physicians and discharge planners.

2. Serve as an attending on the general medical service with physician assistants and other members of the multidisciplinary team.
    - Teaching responsibilities include teaching physician assistants, medical students, and nurses about the care of all patients on the team.
    - This requires on-site availability from ____ am to ____ pm and 24/7 beeper availability.
    - Service responsibilities include writing daily notes, billing within 48 hours of encounter, and daily communication with primary care physicians and discharge planners.

3. Serve as Medical Consultation Service teaching attending for ____ months each year.
    - Teaching responsibilities include teaching residents how to be consultants with daily rounds reviewing treatment recommendations.
    - Service responsibilities include writing daily consult notes, billing within 48 hours of encounter, and availability to see emergent consults from ___am to ___pm.

4. Serve as a “float” physician backup during high census conditions and coverage during illness.
    - This time can be a period of decompression from more intense rotations along with the medical consultation service.

- Service responsibilities vary, but would include a minimal census and no teaching responsibilities beyond direct patient care.

5. Weekends, Holidays
    - Holidays are shared equally among members of the hospitalist service irrespective of FTE: Major holidays (Thanksgiving, Christmas, New Years) are considered = two holidays
    - Service responsibilities include 4 weekends per year as part of salary, with additional weekend coverage resulting in additional compensation.

6. Salary support for non-patient educational, personal development, and scholarly pursuits.
    - Two months per year.
    - Quarterly feedback
    - Opportunities for professional development (leadership courses, medical school initiatives, assigned mentor with similar interests – education or research or quality improvement)

7. Salary support for less intense rotations
    - Medical consultation
    - Float
    - Two week compensation time away from hospital in addition to 4 weeks vacation

8. Incentive policy
    - Bonus compensation when service has less than budgeted FTE to cover rotations (illness, leave, resignation)
    - No withholds
    - Additional funding depending upon agreed upon goals in advance of implementation

# Chapter 5
# Pillar 2: Workload/Schedule

## Definition

*"A mismatch [between the person and the job] in workload is generally found as excessive overload, through the simple formula that too many demands exhaust an individual's energy to the extent that recovery becomes impossible. A workload mismatch may also result from the wrong kind of work, as when people lack the skills or inclination for a certain type of work, even when it is required in reasonable quantities. Emotional work is especially draining when the job requires people to display emotions inconsistent with their feelings. Generally, workload is most directly related to the exhaustion aspect of burnout." (Maslach)*

For hospitalists, workload includes several dimensions:

- *Type of work*: patient care, teaching, administrative activities, etc.
- *Volume of work*: e.g., for patient care, this involves the number of patients
- *Intensity of work*: for patient care this may be defined by the acuity of patients and/or the work of doing admissions/discharges as compared to rounding
- *Time pressure*: the need to get the work done within a specified timeframe
- *Variability of work*: some days have less volume, intensity, and time pressure than others (peaks and valleys); work on nights/weekends is different than weekday, daytime work
- *Interruptions*: patient care work can be intermittent (e.g., you never know when your beeper might go off)

Scheduling and workload are complementary concepts for hospitalists. A schedule must be developed that addresses all of the above factors PLUS takes into consideration the issues, concerns, and preferences of the individual hospitalist.

## Scorecard: Benchmarking my Program

*Hospitalist Responsibilities* (see Appendix 5A)

- What are the hospitalists' patient care/clinical responsibilities during routine day-time hours?
- What are the hospitalists' patient care/clinical responsibilities on nights and weekends?

- What are the hospitalists' non-clinical responsibilities?

*Patient Care Workload* (see Appendix 5B)

- Numerator: How much work/production did each hospitalist generate?
- Denominator: How many shifts/hours did each hospitalist work?
- What is a reasonable projection for future workload? (include all sources including ED unassigned, PCP referrals, surgical co-management, consultations, etc.)
- What are the trends in workload over time?
- What are the variations in the workload? (by time of day, by day of week, by month of year?)

## Action Steps: What can we do?

*Get the Facts*

- Document hospitalist workload/productivity
- Document hospitalist responsibilities
- Benchmark workload/productivity against SHM Survey data
- Survey hospitalist perceptions re: workload
- Research hospitalist scheduling/staffing models (See Appendix 5C)

*Organizational/Structural Strategies*

- Implement an incentive compensation program
- Add administrative support staff
- Add non physician staff
- Add additional physician staff
- Use part-time hospitalists
- Use nocturnists
- Include dedicated time for non clinical work in the job definition

*Systems Strategies*

- Implement a new schedule/staffing model (See Appendix 5D for issues to consider when developing a schedule/staffing model)
- Generate reports on hospitalist productivity and workload
- Establish back-up plan for family/medical emergencies
- Use a dedicated "on call" pager (perhaps also covering admissions, rapid response teams, etc.)
- Maximize pager technology
- "Pool" non-urgent nursing concerns
- Use PRN admit orders

*Professional Development Strategies*

- Recognize individual goals/preferences in scheduling/staffing
- Clearly describe the group's work philosophy to new hires
- Measure and discuss productivity and workload with hospitalists

*Marketing/Relationship Strategies*

- Communicate schedule/ staffing model to hospital leadership
- Communicate schedule/ staffing model to medical staff
- Work with nurses and other team members on productivity

# APPENDIX 5A
# Hospitalist Responsibilities

*Clinical/Patient Care Responsibilities*

- Attending physician for hospital inpatients (includes ED unassigned patients and PCP referrals)
    - Admit, discharge and round
    - Interact with patients and families
    - Communicate with staff and referring physicians
    - Schedule patient care activities
    - Document in the medical record
    - Respond to new urgent needs of the patient
    - Treat patients in critical care units
    - Treat babies in newborn nurseries (pediatric hospitalists)
    - Do procedures
- Consultations
- Surgical co-management
- Cardiac arrest coverage
- Rapid Response Teams
- Long term acute care (LTAC)
- Outpatient services

*Non-clinical Responsibilities*

- Committee participation
- Quality Improvement
- Practice Guidelines
- Utilization Review
- CPOE/Information Systems
- Teaching: House Staff
- Teaching: Non physicians
- Recruitment/Retention of physicians
- Community Service
- Disaster Response Planning
- Research
- Mentorship (mentor and mentee)
- Participation in peer or individual clinical supervision

# APPENDIX 5B
# Measuring Workload

Hospitalist workload needs to be analyzed as a ratio:

Workload = WORK/TIME

- The numerator is WORK. There are several ways that WORK can be measured. The most common metrics are: 1) Encounters; 2) Admissions; and 3) Relative Value Units (RVUs). Non-billable work MUST also be taken into account in a quantified way. There are a number of ways to do this.

- The denominator is TIME. The most common time periods used are: 1) Day or Shift; and 2) Year.

Most often, hospitalists discuss workload in terms of Encounters per Day/Shift. Conventional wisdom says that productive hospitalists should be able to see 12-18 encounters per day. However, that ratio has its limitations. For example, it does not reflect the fact that admitting or discharging a patient requires much more work than rounding on a patient. RVUs is superior to encounters in that it is a metric that does reflect the variation in the amount of work required for different tasks. SHM survey data indicates that the median number of RVUs per Year generated by a full time hospitalist is 3,213.

The following example demonstrates how using different workload measures can lead to different conclusions:

Doctor A: Has an average daily census of 17
Doctor B: Has an average daily census of 13

- Using the metric of encounters per day, it appears that Doctor A has a greater workload

BUT:
Doctor A: Works 7 on/7off (183 days per year), seeing 3,111 encounters
Doctor B: Works 240 days per year, seeing 3,120 encounters

- Now, using the metric of encounters per year, it appears that Doctor B has a greater workload

HOWEVER:
Doctor A: Has an ALOS of 4.1 days, therefore seeing 759 admits/discharges
Doctor B: Has an ALOS of 4.3 days, therefore seeing 726 admits/discharges

- Using the metric of admissions per year, once again it appears that Doctor A has a greater workload

SHM has been asked to consider taking a position on what the maximum workload for a hospitalist should be. For, example, "hospitalists should not see more than 20 encounters per day". However, SHM has determined that it cannot define a standard that is

reflective of all hospitalist environments and staffing arrangements. Furthermore, circumstances might change over time such that the standards were no longer relevant. Consider the following factors that impact hospitalist workload:

- Patient acuity
- Patient social issues
- Administrative support
- Use of non physician providers
- Length of shift
- Hospitalist clinical responsibilities
- Hospitalist non-clinical responsibilities
- Degree of automation at the hospital

SHM position is that hospitalist programs should develop analytical frameworks, understood by both hospitalists and medical leadership at the hospital, that reflect the actual work performed by hospitalists and establish reasonable boundaries for that work.

One of the most challenging tasks for a hospitalist medical director is determining "how many hospitalists are needed to staff my program?" Conceptually this is an easy task. It requires projecting the work for a time period (e.g., 10,000 encounters) and dividing that projection by the amount of work performed by one FTE hospitalist (e.g., 2,500 encounters). Based on SHM survey data, the following are ranges for the annual work performed by one FTE hospitalist:

- 2,000 – 2,500 encounters
- 3,000 – 3,500 work RVUs
- 350 – 700 admissions

However, there are a variety of considerations that might affect the projected number of hospitalists required for a program:

- Staffing model: use of non physician providers, administrative staff, part timers, moonlighters, etc.
- Variation in workload: need to staff somewhat higher than the "average" workload to address peaks and valleys
- Unexpected growth: experience has shown that hospitalist programs grow faster than expected, so it is often better to over-staff to address that likelihood
- Unexpected turnover: incorporate redundancy into the schedule to cover unexpected absences, promotions, etc.

# APPENDIX 5C
# The Common Hospitalist Work Schedules

| Schedule type | Traditional scheduling (with shared call) |
|---|---|
| Practice demographics | Small hospital medicine groups (3+ FTEs) |
| Description | Shifts divided among hospitalists in traditional fashion based upon available staffing during the week (e.g. a hospitalist in a three-person group would take call once every three days) or on weekends (e.g. a hospitalist in a three-person group would be responsible for group coverage once every three weekends). |
| Benefit(s) | Continuous coverage |
| Challenge(s) | During weekends and holidays, volume potentially increases considerably beyond workload capacity. How many consecutive days does one hospitalist work? |

| Schedule type | Block scheduling |
|---|---|
| Practice demographics | Myriad of variations |
| Description | Hospitalists work in "blocks" of time, usually measured in time worked and time off, e.g., a hospitalist works seven consecutive days and is off the next seven days. |
| Benefit(s) | Hospitalist hands off patients at the end of a "block." Overlapping "blocks" provides continuous coverage. |
| Challenge(s) | Trying to schedule around major holidays, long vacations, and unexpected or prolonged illness could potentially increase beyond workload capacity. |

| Schedule type | Shift-based scheduling |
|---|---|
| Practice demographics | Myriad of variations, can be accomplished with as little as 3 FTEs |
| Description | Hospitalists work defined hours during which all hospitalist activities are performed. Handoffs occur at the end of each shift between hospitalists detailing current treatment plans. |
| Benefit(s) | Continuous coverage is provided by dividing the day into a number of shifts, which are staffed by the hospitalists. Large groups can also assign workload into various types of shifts (daytime admitting shift, night shift, etc.). |
| Challenge(s) | Loss of continuity can potentially decrease patient satisfaction and increase duplication of tests. Another challenge (especially for larger groups) is the complexity of the schedule itself, particularly as the number and type of shifts increase. As the types of shifts become more specialized, there is also the potential for various shifts to be less equal in terms of workload and intensity. |

It should be noted that SHM surveys indicate a trend toward fewer hospitalist groups using a traditional scheduling model (with shared call) and an increase in the number of groups using a shift based schedule.

When constructing and evaluating a scheduling system, hospital medicine groups and individual hospitalists should bear in mind a few caveats:

- There is no single standardized schedule for hospitalists.
- Non-hospitalist physicians can be used in any basic schedule to increase the productivity of the hospital medicine group in numerous ways (admissions coverage, sick/backup coverage, night coverage, etc.).
- The above schedules models can be mixed and matched. A popular example is a shift-based block schedule.

# APPENDIX 5D
# Considerations When Developing a Schedule

- *Circadian rhythms:* Shifts should rotate clockwise (day to evening to night), even when there are days off in between, since it allows workers to approach healthy norms.

- *Length of shifts*: Although dependent on workload and personal preference, hospitalists who work day shifts with high workloads and patient acuity should consider an 8 to 12 hour shift. If workload is less, then longer shifts, e.g., 14 to16 hours, may be acceptable and produce limited fatigue. Generally, shifts 24 hours or longer should be avoided, except in unusual circumstances. There is evidence that medical decision-making is significantly impaired by the end of a 24-hour work shift or when working as little as 12 hours on consecutive days.

- *Limited long stretches of days worked:* After approximately seven consecutive full workdays, time off should be provided. Frequent stretches longer than this should generally be avoided. For academic medical centers, consideration should be given to weekend coverage at least one weekend out of every two weeks in a row worked.

- *Sufficient rest time:* Sufficient time for rest is important for all hospitalists, but especially for hospitalists working predominantly nights and for those doing several shifts on consecutive days. Daytime responsibilities for night workers should be kept to a minimum. Incentives should be considered to compensate those who work mostly nights.

- *In-hospital continuity of care:* Care should be taken to balance the number of days in a row that a given hospitalist cares for a patient to maximize continuity of care against the needs of the hospitalist.

- *Vacations:* It is better to have vacations scheduled when patient load is lighter, than when patient load is high. (COMMENTS: For academic hospitalist services, it is often busiest in the summer when surgeons are on vacation. For high census hospitals, there may be no downtimes.)

- *Specialized Staffing:* Seek out hospitalists willing to work more flexible or unusual hours. This includes part-timers (less than 1 FTE), moonlighters (part-timers that work when requested), nocturnists (only work nights), weekendists (only work weekends), etc. Also consider use of non-physicians (NPs and PAs).

- *Start/Stop Times:* Consider flexibility in start/stop times. Hospitalists should understand that when they start and stop work each day is a function of how busy they are. But boundaries should be provided, e.g., always start in time to see all potential discharges by 11 AM, and if done with work early in the day, stay available by pager until the night call person takes over.

- *Patient Caps:* A cap in the number of patients seen by a single physician (i.e., once a doctor reaches a certain volume, others in group take the next referrals) facilitates planning for the need for additional FTEs that will need to be recruited. A cap for the entire hospitalist group (i.e., the group turns away patients) is usually not a good idea unless there are clear patient safety issues. A group cap can hurt the reputation of the hospital medicine program. Anticipating staffing needs is critical to ensuring sustainability.

# Chapter 6
# Pillar 3: Autonomy/Control

## Definition

*"A mismatch in control is generally related to the inefficacy or reduced personal accomplishment aspect of burnout. Mismatches in control most often indicate that individuals have insufficient control over the resources needed to do their work or have insufficient authority to pursue the work in what they believe is the most effective manner. Individuals who are overwhelmed by their level of responsibility may experience a crisis in control as well as in workload. This mismatch is reflected as one of responsibility exceeding one's authority. It is distressing for people to feel responsible for producing results to which they are deeply committed while lacking the capacity to deliver on that mandate." (Maslach)*

There is a rich literature that supports the belief that control and autonomy play a significant role in job satisfaction. Given the nature of a hospitalist's job, the pressures of work, and the demands of personal/family issues, finding a balance becomes daunting when a lack of control overshadows the picture.

The definition of job control has been extensively studied and can be conceptualized in two ways: as **decision latitude** (Karasek), which comprises both *skill discretion***,** i.e., sufficient training and practice to give a sense of mastery, and *decision authority,* i.e., sufficient seniority or authority to make decisions. Other research studies interpret job control as **the ability to exert influence over one's environment** (Aronsson, Ganster). In both cases, job control represents something of which the worker has "more" or "less."

Findings from a recent study showed that "…the single most important predictor for professional satisfaction, organization commitment, and burnout among physicians working for the Kaiser system was a sense of control over the practice environment." (Freeborn)

Autonomy, a related term, refers to being free from the control of others or outside forces, to act independently and in a self-directed manner. Job autonomy and job control are considered equivalent in the job stress literature.

Any discussions of job control/autonomy must emphasize a key point: control is measured from the viewpoint of the individual involved. In other words, it is <u>perceived</u> control or lack of control that impacts a situation.

….*People are disturbed not by things, but by their perception of things*…. Epictetus

## Scorecard: Benchmarking my Program

NOTE: This evaluation framework comes is also the basis of the Job Fit Questionnaire described in Chapter 3.

*Task Control*

- Do hospitalists have control over setting the pace of work?
- Do hospitalists have control over work schedules?

*Environmental Control*

- Do hospitalists have control over what unit they work on?
- Do hospitalists have control over which hospital they work at?
- Do hospitalists have control over interruptions (e.g., beepers)?
- Do hospitalists have control over their designated working space?

*Decision Control*

- Do hospitalists have control over what consultants are used?
- Do hospitalists have control over when to admit/discharge a patient?
- Do hospitalists have control over what types of patients are seen?
- Do hospitalists have control over determining the patient LOS?
- Do hospitalists have control over what medications to prescribe?
- Do hospitalists have control over what diagnostic tests to order?
- Do hospitalists have control over the volume of paperwork/documentation?
- Do hospitalists have the ability to impact/influence hospital policies?
- Do hospitalists have control over their time away from work?
- Do hospitalists have control over the cost of care provided?
- Do hospitalists have control over the quality of care provided?

*Resource Control- Workplace issues*

- Do hospitalists have sufficient access to computers?
- Do hospitalists have sufficient office space?
- Do hospitalists have sufficient availability of procedure equipment?

*Resource Control- Patient Care Resources*

- Do hospitalists have sufficient access to SNFs/nursing home beds?
- Do hospitalists have sufficient access to hospice/end of life care resources?
- Do hospitalists have sufficient access to home health resources?
- Do hospitalists have sufficient access to PCP follow up availability?
- Do hospitalists have sufficient access to free medications for needy patients?
- Do hospitalists have sufficient access to community resources for patient support?

## Action Steps: What can we do?

*Get the Facts*

- Use the Job Fit questionnaire to profile the control elements of the hospitalist practice
- Become familiar with the hospital's leadership and committee structure
- Understand key payer issues that might impact inpatient care
- Review the hospitalist job description

*Organizational/Structural Strategies*

- Involve hospitalist in participative decision-making on key work-life issues
- Create an "ownership mentality" in the hospitalist group
- Establish a formal negotiation process with hospital leadership
- Establish a formal negotiation process with medical staff
- Establish mission and value statements for the hospitalist group

*Systems Strategies*

- Document in writing understandings with hospitalists re: workload/schedule
- Establish formal agreement with medical staff on types of patients seen by hospitalists
- Seek improvements in hospital processes that impact hospitalist performance (e.g., throughput)
- Establish standards for hospitalist processes (e.g., PCP communication, sign-outs, admission, discharge)

*Professional Development Strategies*

- Use Job Fit questionnaire to assess potential hospitalists (and share information with the candidates)
- Allow each hospitalist to choose which committees and/or projects they want to participate on
- Establish core values that promulgate peer support and rewards for identifying problems and asking for help
- Get Leadership training for the hospitalist medical director

*Marketing/Relationship Strategies*

- Seek representation on hospital committees/ boards that impact hospitalists
- Establish formal team meetings with nurses, discharge planning, etc.
- Seek advocates/allies among hospital leadership/ medical staff

# APPENDIX 6A
# Expectations and Obstacles

## Expectations

What do hospitalists expect from their job as far as autonomy/control is concerned?

- Reasonable patient load/census
- Cooperation with other hospitalists
- Input regarding level/type of care decisions for individual patients
- Appropriate workspace and equipment
- Adequate support staff
- Ability to balance work/home life
- Participatory decision-making privileges
- Fair and equitable treatment by other specialists
- Professional respect (as an individual and a group)
- Strong leadership

Hospital medicine group leaders harbor the same expectations as individual hospitalists, with a few additions.

- Representation on hospital boards and committees
- Access to appropriate financial information which impacts the facility's bottom line
- Ability to renegotiate contract or business plan on a regular basis

## Obstacles

Regardless of work setting, circumstance, gender or age/generation, certain obstacles to attaining expectations can be anticipated. Some common obstacles include the following:

- Hospital administration mandates
- Medical staff demands
- ACGME mandates
- Specialist unavailability
- Inadequate hospitalist staffing
- Unexpected spikes in demand for services
- Variations in issues/concerns of hospitalists/hospital medicine groups
- Weak hospital medicine group leadership
- Insufficient administrative support
- Inadequate physical resources

- Lack of input on hospital policy
- Differing perceptions of the role of the hospitalist in a young, evolving specialty

# Chapter 7
# Pillar 4: Community/Environment

## Definition

*[A …] "mismatch occurs when people lose a sense of positive connection with others in the workplace. People thrive in community and function best when they share praise, comfort, happiness, and humor with people they like and respect. In addition to emotional exchange and instrumental assistance, this kind of social support reaffirms a person's membership in a group with a shared sense of values. Unfortunately, some jobs isolate people from each other, or make social contact impersonal. However, what is most destructive of community is chronic and unresolved conflict with others on the job. Such conflict produces constant negative feelings of frustration and hostility, and reduces the likelihood of social support." (Maslach)*

Hospitalists relate to four communities. They must address the expectations of each of these four groups:

- **Hospital community:** This includes hospital administration, referring physicians, non-referring physicians, the emergency department, house staff, medical students and other healthcare staff (nurses, healthcare extenders, pharmacists, laboratory techs, etc.).
- **Hospitalist community:** This consists of the hospitalists in their own group, as well as relationships with other hospitalists and hospitalist groups.
- **Patient community:** This includes not only patients and their families, but also the broader public community served by the group and hospital.
- **Home community:** This is an external, but vital component of the hospitalist environment consisting of family and friends.

Hospitalists also relate to the environment in which they work, which includes office space, support technology, as well as support staff.

## Scorecard: Benchmarking my Program

See Appendix 7A for examples of each of the following issues.

*Hospital community*

- What are the expectations of hospital administration?

- What are the expectations of primary care providers?
- What are the expectations of specialists?
- What are the expectations of nursing staff?
- What are the expectations regarding non patient care responsibilities?
- What are the expectations regarding academic/teaching responsibilities?
- Are there inequalities or harassments re: gender, sexual orientation, race, etc.?
- How are patients triaged to the hospitalist service?

*Hospitalist community*

- What are the expectations of individual hospitalists?
- What are the expectations of the hospitalist group?
- How cohesive is the hospitalist group?
- Are there inequalities or harassments re: gender, sexual orientation, race, etc.?

*Patient community*

- What are the expectations of patients?
- What are the expectations of patients' families?
- What are the expectations of the general public/community re: the role of the hospitalist?
- What are the expectations of the general public/community re: public emergencies or crises?

*Home community*

- Are there constant interruptions at work?
- Can hospitalists take reasonable time off from work to address family emergencies?
- Do the hospitalists have sufficient social support to achieve a balance between personal and professional life?
- What are the expectations of hospitalists re: home-work balance?

*Environment*

- Is there sufficient personal work area/office space?
- Is their updated support technology (e.g., computer, phone, fax machine)?
- Is there sufficient support staff (e.g., secretary, dedicated case manager)?
- Is there sufficient support of hospitalist decision-making re: triage and other issues by the Department of Medicine?
- Does the hospitalist group feel part of their division of general internal medicine or Department of Medicine?

## Action Steps: What can we do?

*Get the Facts*

- Review and communicate hospital policies re: harassment and discrimination
- Research availability of professional counseling resources
- Determine which, if any, hospitalists look at their job as a "temporary" position

*Organizational/Structural Strategies*

- Pursue leadership in hospital committees
- Conduct regular hospitalist group meetings
- Define hospitalist group goals
- Create a culture of teamwork and empower members to voice concerns

*Systems Strategies*

- Structure sufficient time for patient/family
- Assure dedicated time for non patient care responsibilities
- Create a mentorship program with regularly scheduled meetings

*Professional Development Strategies*

- Include hospitalists in key meetings
- Develop communication skills via conferences/CME
- Communicate expectations/job requirements to new hires
- Establish a journal club
- Reimburse membership in SHM and other professional groups
- Establish personal goals/expectations
- Assure sufficient vacations to revitalize

*Marketing/Relationship Strategies*

- Conduct meetings with hospital administration to discuss performance
- Conduct meetings with referring physicians (PCPs) to discuss performance
- Conduct meetings with non-referring physicians to market the program
- Conduct meetings with specialist physicians to educate
- Conduct meetings with nursing administration
- Announce new hospitalists
- Create a hospitalist program website for patients, families, and physicians
- Print and distribute a hospitalist program brochure

# APPENDIX 7A
# Examples of Community/Environment Issues

| Community/Environment Issues | Examples |
|---|---|
| *Hospital community* | |
| • What are the expectations of hospital administration? | • Production/capacity (RVUs, encounters/day)<br>• Coverage (nights?)<br>• PCP satisfaction<br>• Non patient care responsibilities |
| • What are the expectations of primary care providers? | • "Convenience" or "courtesy" services<br>• Communication (timeliness)<br>• Coverage |
| • What are the expectations of specialists? | • Availability for consultations<br>• Hospitalist as attending vs. consultant |
| • What are the expectations of nursing staff? | • Paging protocols<br>• Hospitalist availability |
| • What are the expectations regarding non patient care responsibilities? | • Is there protected time?<br>• Committee participation requirements |
| • What are the expectations regarding academic/teaching responsibilities? | • ACGME work hour restrictions impact |
| • Are there inequalities or harassment? | • Gender, race, sexual orientation |
| *Hospitalist community* | |
| • What are the expectations of individual hospitalists? | • Life long learning, personal development<br>• Work-home balance<br>• Compensation |
| • What are the expectations of the hospitalist group? | • Hospitalist role<br>• Practice tools<br>• Schedule flexibility |
| • How cohesive is the hospitalist group? | • Shared values<br>• Participatory decision making<br>• Team mentality |
| • Are there inequalities or harassment? | • Gender, race, sexual orientation |
| *Patient community* | |
| • What are the expectations of patients? | • Continuity of care<br>• Compassion |
| • What are the expectations of patients' families? | • Availability for meetings<br>• Responsibility for discharge arrangements |
| • What are the expectations of the general public/community? | • Role of the hospitalist<br>• Public emergencies or crises? |
| *Home community* | |
| • What are the expectations of hospitalists re: | • Ability to respond to interruptions |

| | |
|---|---|
| home-work balance? | • Time off for family emergencies<br>• Social support |
| *Environment* | |
| • Is there sufficient personal work area/office space? | • Work space<br>• Meeting area |
| • Is their updated support technology? | • Computer, phone, fax machine |
| • Is there sufficient support staff? | • Administrator, secretary<br>• Dedicated case manager |