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2010 Medical Staff Planning for Hospitals and Medical Groups

Physician recruitment remains a strategic priority for most hospitals and medical groups. Many hospitals use a medical staff plan as their guide to know which specialties to recruit and the number of physicians to recruit in each specialty. Jennifer Moody, Principal of AmeriMed Consulting, answered questions regarding benefits of the medical staff planning process, hospital and medical group participation in medical manpower planning, the importance of qualitative and quantitative elements in the plan, and federal physician recruitment requirements.

Q: What is the purpose of medical staff planning?

A: *Strategically-oriented facilities want a medical staffing blueprint they can follow to know how many and what types of physicians they need now and in the future. The medical staff plan does just that – it identifies the appropriate number of physicians for a hospital's or medical group's service area. The data must demonstrate to the current medical staff that bringing in additional physicians is for valid reasons so they will support recruitment strategies. The data must be persuasive to prospective candidates considering a practice in the area. And, for hospitals, the data must satisfy federal physician recruitment requirements (IRS, HHS and Stark).*

Q: Should hospitals of all sizes have a medical staff plan?

A: *Absolutely. Any hospital expecting to have medical staff changes should have a medical staff plan that supports recruitment in their service area. In years past, medical staff making changes in their practice averaged 6–7% per year. However, medical staff change in the range of 10–20% is becoming more common. This means physicians are going from private practice to employment models, eliminating inpatient practice, dropping call, and/or changing the mix or scope of their practices. The medical staff plan allows hospitals to take a broad view of the medical community so they can replace physicians leaving the community, recruit physicians with skill sets no longer provided by current medical staff (including inpatient specialists), and appropriately integrate new specialties. The process allows hospitals to assess risk to the community and gaps in coverage. Hospitals should include their medical staff plans as an essential part of their strategic planning process.*

Q: Should medical groups have a medical staff plan?

A: *Medical groups are not required under federal law to have a medical staff plan. However, if they are accepting physician recruitment assistance from their local hospitals, they should be cognizant that a hospital must meet IRS, HHS and Stark requirements. A new development for medical groups is that the Federal Trade Commission (FTC) has begun investigating several large medical groups perceived to have a monopoly or dominant position in a community or region.*

Q: What are the benefits of hospitals and medical groups working together through the medical staff planning process?

A: *Medical staff plans should be based on quantitative and qualitative data. For that reason every hospital should include physicians in the process. The old method of medical staff planning was ratio based – a certain number of physicians (by specialty) per 100,000 population. Plans today go beyond the quantitative data.*

By including medical staff in the planning process, the plan can include three qualitative elements: survey of the medical staff (input on patient referrals and practice volumes); a community survey (patient perceptions on access to healthcare as well as facility and physician quality); and physician focus interviews (to evaluate access in the physician's specialty, referral patterns, and "hot spot" concerns for the medical staff).

Physician involvement in the process ensures the hospital is meeting community need. It also ensures the hospital is aware of and meeting medical staff needs.

Q: How long does it take to prepare a medical staff plan and how often should it be updated?

A: *A plan should be completed within a 2–4 month period as otherwise, the data can become stale. Hospitals should work to complete their plans quickly. The medical staff plan should be updated every 2–3 years. However if the plan is more than 12 months old and the hospital is actively involved in physician recruitment projects, the hospital must show the data is still correct and they have a reasonable belief the community is being appropriately served.*

Q: Do you anticipate the OIG will be increasing hospital audits in the foreseeable future?

A: *The OIG has indicated they expect to increase enforcement of federal physician recruitment requirements and indicated earlier this year they would start making drop-in inspections the fourth quarter of 2009.*

If you would like additional information on the medical manpower planning process, please contact us.

AmeriMed Consulting is a healthcare consulting company specializing in strategic medical staff planning. They are located in Fort Worth, Texas and assist clients throughout the U.S.

Top 10 Ways to Lose a Candidate

1. Do not contact the candidate promptly when you receive the CV or resumé. This will highlight your lack of interest and allow another medical group to hire him or her before you.

Instead, make it a priority to review CVs and resúmes upon receipt. Respond to the candidate within 48 hours so he or she is aware of your interest.

2. In your first conversation with the candidate, discuss the negative rather than the positive aspects of the position.

It is important to stay focused on the benefits of the position for your organization and for the candidate's career growth.

3. Do not schedule a prompt interview and do not pay for the candidate's interview expenses.

Act promptly to keep the candidate's interest and make him or her feel important. Your competition will reimburse for interview expenses and so should you.

4. Ignore the needs of the candidate's spouse or significant other.

Instead, include this key person in the process; it will be appreciated and may be exactly what it takes to recruit the candidate.

5. Allow the candidate to eat dinner and tour the community alone.

A dinner with future colleagues or community members with similar interests and a community tour with a knowledgeable resident of the area will help the candidate get connected and able to envision life in your community.

6. Make sure the candidate does not have an opportunity to meet all the members of the practice or department members.

Instead, provide opportunities for the candidate to meet and greet, such as a luncheon with the department or group members.

7. Be lax in deciding on your interest in and follow-up with the candidate after the interview.

Your delay will allow another practice time to recruit the candidate. It will also leave the candidate feeling unsure about your level of interest.

8. Fail to promptly provide the candidate with a complete offer/contract when promised and let the candidate have as long as he or she wants to commit or decline.

At this stage in the recruitment process, it is critical that you deliver on your promises. Give the candidate a reasonable but established deadline to reply to your contract offer.

9. Renege on promises made – orally or in writing.

Instead, be diligent in recording the specific conditions to be met by the hospital or practice, and ensure they are included in contractual language.

10. Do everything you can to leave out that personal touch when working with the candidate.

Everyone has a need to be wanted. If you go the extra mile for your candidate, you have a greater chance of filling your open position and retaining that physician for the long run.

For more tips on how to successfully recruit a candidate, please contact us.

Increasing Future Reimbursement via Patient Centered Medical Homes

The latest buzz in primary care is the development of the Patient Centered Medical Home (PCMH). What is a Medical Home? The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association have jointly defined the medical home as:

"model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians. A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients, physicians and staff."

How can your practice be part of the NCQA Recognition Program and receive the designation of PCMH? The National Committee for Quality Assurance provides survey tools for practices to determine if they are appropriate candidates for inclusion in the Medical Home and Physician Practice Connections (PPC) programs. Application for recognition in these programs has strict requirements in the following areas:

- Access and Communication
- Patient tracking and registry functions
- Care management
- Patient self-management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting and improvement
- Advanced electronic communications

Applications are made to and recognition is awarded by the NCQA. Many private and public health plans and employers are considering projects to recognize and compensate practices as PCMHs. Practices earning this PPC-PCMH recognition may be eligible for additional payment in the future. NCQA's Physician Recognition Programs have recognized nearly 10,000 physicians nationwide for excellence. The NCQA is broadly promoting practices and health plans that have attained recognition as PPC or PPC-PCMH practices.

For more information about Patient Centered Medical Home, visit www.ncqa.org or www.acponline.org or www.aafp.org.

Certified Nurse Midwives Meet the Huge Demands of Women's Healthcare

Midwifery care is on the rise, given the continued decline in the number of physicians providing obstetric services. Therefore, there are higher patient-to-physician ratios, increasing operational costs and declining reimbursement. Faced with these challenges and impending healthcare reform, many Obstetric/Gynecological practices are hiring Certified Nurse Midwives (CNMs) to increase efficiency and address the needs of their patients.

Training and Education

Certified Nurse Midwives are registered nurses who have completed graduate level training in midwifery and have passed a national certification exam. By 2010, CNMs will be required to hold a graduate (Masters) degree. According to the American College of Nurse Midwives, there are more than 11,000 CNMs practicing in the United States and this number is expected to grow by 20–30% over the next 10 years.

Scope of Practice

Considered primary healthcare providers, CNMs most often provide comprehensive medical care for relatively healthy women from puberty to menopause and beyond. They provide an array of healthcare services including gynecological examinations, contraceptive counseling and family planning, labor and delivery care, postpartum care, well-women care, menopausal management and reproductive education. In many practices the CNM provides the majority of low risk obstetrical care, which allows the physician to concentrate on high risk cases and the more lucrative and complicated gynecological cases. Some CNMs have extended their scope of practice to include serving as first surgical assist at cesarean sections as well as performing circumcisions, colonoscopies, and ultrasonography.

The role of a CNM will vary between practices and hospitals. Some practices may choose to have the CNM provide only office-based care and education; others may utilize them for hospital rounds and first call; or some will fully utilize the CNMs' skills for delivery. However, it is ultimately the decision of each hospital to determine if they will credential a CNM to be the primary provider for births in their hospital.

Trends

Current trends indicate the obstetrical patient base growth rate far surpasses the rate of OB/GYN physicians entering practice. This, combined with the increasing number of retiring physicians or those giving up their obstetric service, makes for an even gloomier outlook for the OB/GYN specialty. It is likely CNMs will increasingly become a significant resource in bridging the gap by providing efficient, competent and cost effective women's healthcare services.

For additional information on how best to incorporate a CNM into a clinical practice, please contact us.

Locum Tenens: Everything Old is New Again

In its infancy, locum tenens was temporary staffing for primary care physicians in small, rural communities. As locum tenens evolved, hospitals, solo practices, single/multispecialty groups, HMOs, and community health centers have come to use locum tenens physicians for their temporary staffing needs. Just as the scope of facilities utilizing locums changed, the physician specialties in demand also changed.

In the 1990s when managed care was at its peak, primary care locum assignments were the most requested. By 2001, demand shifted to general surgery, psychiatry, anesthesiology, radiology, emergency medicine and other diagnostic specialists. Ironically, if we take a look at the last few years, we find the most requested specialties are once again family practice, internal medicine and hospitalists.

The type of physicians who are interested in providing locum tenens coverage has also changed over time. Years ago, most locum tenens physicians were retired physicians who missed the challenge of medicine and the gratification of providing quality medical care to patients. Today, locum tenens physicians range from just graduated residents who haven't made a decision on the type and location of permanent position, to retired physicians and many other physicians in between.

New physicians with spare time while they are building their practice, often accept locum assignments. Additionally, temporary assignments are also attractive to physicians who have been in practice for a number of years and have 4–6 weeks or more of vacation time. By accepting an assignment, they are able to explore new areas of the country and earn a few weeks extra pay.

Today, locum tenens physicians are in all stages of their careers. Many find it a welcome break from dealing with administrative headaches of running a practice because locum tenens allows the physician to focus 100% on patient care and not worry about insurance and billing problems, support staff, or malpractice insurance. The New England Journal of Medicine recently stated more than a third of the U.S. physicians worked locum tenens in 2008.

Staffing firms are anticipating an increase in locum tenens requests. With a recessionary economy, many hospitals and practices are reluctant to hire new physicians. However, illness, CME, vacations, sabbaticals, and retirements continue to affect their ability to provide services to their patient base. If you are experiencing a physician shortage and are interested in locum tenens coverage, please contact us.

Compensation Corner: **2009 Mean Compensation for Otolaryngology**

Mean Compensation \$397,000

Mean Compensation by Region:

East	\$375,000
Midwest	\$407,000
West	\$417,000
South	\$389,000

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