

OPTIMIZING YOUR INVESTMENT: How to Retain the New Physician

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Does this sound familiar? "I worked 18 months to get a new partner for the Smith Group. Now, after a year, she's leaving!"

Fingers are pointing and feelings of frustration abound. Yet, everyone pays a price when a physician leaves. Often, there's a disconcerting feeling. Could we have—or should we have—done more to help her fit in, to ensure the community welcomed her, to help her with visibility and practice development?

Clearly, retaining a physician takes just as much time and effort as recruiting one. It takes someone to "own" the responsibility and develop and implement a streamlined plan so steps aren't overlooked—and so time isn't spent recreating the plan for each new physician.

Who's the best person to take over a plan like this? To decide, let's review the plan you currently have in place and compare it with the kind of plan that would work best for your organization.

THE ASSESSMENT

Many people play a role in lending support to a new physician—from various department members and office staff, to medical staff colleagues and partners. But often, their other responsibilities come first and leave little time for lending support. Couple that with the assumption, "I'm sure someone else is handling it," and you have the makings for a job no one is doing.

Take a look at how retention is handled at your facility. Evaluate who in the organization is charged with the responsibility. Then, conduct a mini-assessment of the current program and how it's progressing.

SMALL NUMBERS YIELD SIGNIFICANT REVELATIONS

The following four actions may yield small numbers at first glance. Look at them together, however, and you'll be able to spot trends for what's working, and what's not:

Calculate the number of new physicians added each year for the last five years. Do this for all the active staff.

- Look at the number of physicians who have left in the last five years. Be inclusive; some may have retired, others may have moved. Count them all. While the numbers are small, they can give you a percentage. As you look at the five-year trend, chart the peaks and valleys.
- Compare, by specialty, the list of those who've left with the list of the "hot specialties" where it's the most difficult to find candidates. Most lists will include cardiology,

pulmonary, critical care, and radiology at the top. In the last five years, how many physicians have you lost each year in these areas or key strategic areas for your facility?

- ❑ Count, too, how many physicians were recruited and stayed. Include those who have been on board longer than 12 months.

FIND THE REASONS WHY

The numbers are only half the story. The next step is to supplement them with your own market intelligence:

- ❑ Interview those who have stayed longer than 13 months. Learn what's working, what they like about the practice, and their biggest disappointment since joining. Sit back and let them talk.
- ❑ Evaluate the second group, those who have left. Review your "numbers" list and categorize those physicians according to "reasons for leaving," such as relocation, retirement, dissatisfaction, etc.
- ❑ Evaluate each person by specialty, group, and/or affiliation, and by how long they practiced and why they decided to leave. If you're not sure why the person left, ask others, or if possible, contact the physician and ask.

EVALUATE YOUR DEVELOPMENT AND RETENTION EFFORTS

The final portion of your mini-assessment is to evaluate the systems currently in place to develop and retain new physicians. This includes an evaluation of orientation, mentoring programs, and other methods used to welcome new physicians. Evaluate the hospital and clinic programs.

When evaluating the current system, explore what is in place to address all the aspects of "fitting in." This often includes clinical aspects, the business side of practice development, and the socialization needs of the physician and his/her family.

NOTE:

As you move through this process, pay attention to the roadblocks in the past. While you will use the information to change the process for the future, you may also be well served to look at your current population of new physicians and make immediate adjustments to your approach with them. For example, if the issue is about dollars, the data gives you the opportunity to adjust the incomes of others proactively—before they ask or before they leave. In addition to helping direct your recruitment plan, it's a valuable piece of your recruitment process.

THE PLAN: WHO OWNS IT?

Some organizations tie together the recruitment and retention processes. The recruiter knows the new physician and generally has good connections within the hospital and the community so they are a good retention choice, *if* they have a reasonable recruitment load.

For many organizations, the push to recruit has exploded and recruiters are tempted to push retention to the back burner. This is not a reasonable option. With planning and a streamlined approach, this can be a win-win situation. And remember being charged with the program does not mean doing it all, but rather allowing the recruiter to manage the process.

Some organizations have found success in assigning the new physician to a physician relations (sales) representative. This is a great solution if you have such a program in place. Consider introducing the physician liaison on one of the site visits. Gather and provide the physician's background, interests, and profile on signing so the liaison can smoothly assist with the Transition.

The office manager is equally important in the process. In the clinic, this person is often responsible for making sure the new physician is welcomed. Regardless of who initiates the process— hospital or clinic—both parties need to work together to ensure a unified approach.

What about the other physicians in all of this ownership? In the ideal world, they might develop a plan; but mostly, it just doesn't happen. This doesn't mean they're not actively involved. It only means someone else facilitates the process, develops the plan, and makes sure it's implemented. The key is not about who does it rather that *someone* is accountable for making sure there is a plan and that the plan is followed.

COMPONENTS OF THE PLAN

Retention can be divided into phases: the orientation period, Year One, and Year Two. Obviously, you'll find much more retention activity in the first three months of the orientation period, but don't stop there. Once the honeymoon is over, there's an ongoing need for support, validation, expansion of the physician's commitment, and general welcoming activity.

ORIENTATION—3 MONTHS

There are many things to learn in the first 30 days. Here are some ideas to help you develop a plan for your organization:

- Develop an orientation plan for the hospital and the clinic.
- List orientation activities by category. For example, clinical, rules, financial, patient-flow, office routines, social, education, and mentoring.
- Introduce the physician so (s)he can place names and faces with responsibilities.
- Spread out the "learning." Even the best and brightest human brains get overwhelmed.
- Give the physician some time to explore on his/her own
- If the physician approves, check in with his/her spouse.
- Ask a physician to be your medical staff mentor for this physician. It does not have to be someone in the same specialty or group.
- Provide a mentor job description.
- Detail the orientation phase on a calendar with something each week.
- Get other people in the hospital involved.
- At the end of three months, take the physician to lunch, or meet in his/her office. This can be a formal time to discuss how things are progressing, and also serve as an informal chance to chat about family and community. Bring well-developed questions to see what's working, where he/she still feels the need to gain additional insights, what's been different than expected, and if there were any surprises.

BOX: ORIENTATION PLAN

Develop an activity spreadsheet
Spread the activity across the time
Cover clinical, business and social needs
Have a mentor
Share the duties
Evaluate what works

Gaining Buy-in—Year One

After the first three months, the frequency and nature of the interactions will change. The most effective method is to plan for some "reminder" orientation basics:

- Give attention to those things that were covered in the initial orientation but now have become more relevant since the practice pace has picked up.
- Address issues that were mentioned in the lunch debriefing.
- Schedule "validation" reminders—or "touch points" to show the physician the organization values him/her. Deliver these at three- to four-week intervals between the third and twelfth months. These may include: a meeting with the VP of medical affairs; having the service-line leader buy doughnuts to say, "thanks for joining our

staff;" having the CME coordinator contact the new physician to learn of his/her interest in presenting.

As you work to develop the touch points, change up the activities to include some clinical, some rules-oriented, some educational, and some social. At the end of a year, schedule another lunch or meeting.

Remember: The retention planner doesn't have to take on all these responsibilities. The key is to simply make sure someone is following through with each task.

Getting Established—Year Two

For many physicians, the second year is a time of evaluation and reflection regarding their practice decision. That very reason makes it critical to continue the retention process. There's a tendency to assume that the physician who has been in practice for a year no longer needs the nurturing provided during Year One. While the frequency and type of activities will change, this isn't the time to withdraw support and assume things are fine.

- ❑ Shift the retention touch points to every six to eight weeks. Move from introductory activities to more integration activities.
- ❑ Understand how committees work and see if there is a need for "new blood" on some of the planning functions within the hospital.
- ❑ Communicate to the CME coordinator the physician's interest in presenting at grand rounds or a CME. Make sure the coordinator lets you know when he gets the physician on the schedule.
- ❑ Travel with the physician to any outreach activities. It's a good time to learn how things are going and what else the hospital or clinic can provide as a value-added.
- ❑ Exercise your social connections to the arts, music, or religious organizations. If the physician is interested in taking a more active role, make a phone call and position the physician with the decision-makers in the community.
- ❑ Arrange a meeting with the physician and the CEO sometime this year. This is an avenue for the physician to express his/ her views, and for your leadership to spend some quality time one on one with the physician.

Year Two ends with one more chance to be in contact at a formal and informal level. It's a great time to ask the new physician if (s)he's willing to help you with supporting other new physicians that might be joining the staff. It's also a prime time to learn what you could have/should have done different, done better, or not done at all.

CUSTOMIZE YOUR OWN TOOLS

There's no one perfect format for developing a physician retention plan. You may follow a format you like for recruitment planning, sales planning, or business development. Whichever way you choose, the key elements in this process are developing a timeline, tactics, accountability, and a desired outcome. Document what's been done and make sure others who have plan assignments know they have to document as well.

The first time you craft a plan, don't hesitate to get some help. Work with other departments or get an outside expert to oversee a strategy session that solicits buy-in and accountability from the team. Even the best plan won't survive if nobody takes—or feels—ownership in it.

AN OUTCOME WELL WORTH THE EFFORT

The first few plans you design may seem time-consuming—but the results will assuredly outweigh your effort. Now that there is a plan in place, each member of the team has an assigned task. Gone are the days of, "Oops . . . I should have called," or "I wonder how Doctor Smith is doing."

Even if you find glitches in the settling-in process, you'll find you can catch and manage them right away. This proactive approach means the new physician's needs are taken care of before issues blow up and become too big to handle.

Crafting a plan also means your organization can provide broad-based attention to the needs of the new physician. And furthermore, your new process will eliminate that feeling of "Could we have done something different to make sure she stayed?" With a carefully crafted and implemented plan, you'll rest assured you're providing the best environment you can for your new physician.



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