

RECRUITING FOR RETENTION

*The Recruitment and Retention Manual of the
National Rural Recruitment and Retention Network, Inc.*



Produced by:

The National Rural Recruitment and Retention Network, Inc.

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Recruiting for Retention

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Recruiting for Retention

Introduction

Primary care providers include: family medicine physicians, general internists, general pediatricians, obstetricians/gynecologists, primary care nurse practitioners, primary care physician assistants, certified nurse midwives. Mental health providers include: psychiatrists, health service psychologists, licensed clinical social workers, psychiatric nurse specialist, marriage and family therapists, licensed professional counselors. Dental providers include: dentists and registered dental hygienists. Registered nurses, pharmacists, physical or occupational therapists, medical lab or radiology technologists, and many other health professionals play a very important role in the health care system.

The importance of the primary care provider is particularly profound in rural areas where the loss of even a single primary care provider can cripple or collapse an entire health care system. The result is limited access to basic health care services for thousands of residents spread over hundreds of square miles.

Recruiting and retaining primary care providers has always been a challenge for rural areas. To successfully recruit and keep providers, rural communities must overcome a host of barriers such as isolation, boom and bust economic cycles, understaffed facilities, and overworked medical staffs.

Yet despite the importance of the primary care provider and the stiff competition for a limited supply of providers, surprisingly few communities go about recruiting and retaining these providers in an organized fashion. Many pay scant attention to factors influencing current rates of retention and jump into the recruitment process without clearly understanding what it takes in time, money and personality to find



the “right” provider for their community. When these communities do successfully recruit a provider, most admit luck played a big part in their success.

There is no single “right” way to recruit and retain primary care providers. Yet there are certain critical activities or steps that should take place to ensure timely placement and lasting retention of a quality primary care provider in your community.

Recruiting for Retention guides you step-by-step through the key elements of the recruitment process. From assessing need to integrating the provider and family into the community, *Recruiting for Retention* explains the most important steps in finding and **retaining** the ideal candidate for your community.

We break down the four parts of the recruitment/retention process – planning and preparation, generating candidates, screening candidates, and follow up – into 15 steps. For each step, you will learn tips and tools for making your recruitment effort a more manageable, productive and efficient process.

As its title implies, *Recruiting for Retention* will show you how to build provider retention during the recruitment process itself – long before the provider begins a practice in your town.

Finally, *Recruiting for Retention* identifies state, regional and federal resources that can most help you in your recruitment and retention efforts, as well as help improve health care delivery in your community.

Health care professionals are critical to the stability of medical services in rural and underserved areas. Although the rural health care system is built upon a



primary care foundation, hospitals, pharmacies, nursing homes, and other health care facilities also rely on other health care professionals. This includes nurses, physical therapists, radiologic technologists, medical technologists, social workers, pharmacists, and many others.

This manual, although focused on the recruitment of primary care providers, can provide an effective process for recruiting other health professionals. Recruiting in a systematic, organized manner, greatly improves the retention of qualified health care professionals. Recruiting the right candidate in the first place will minimize the risk of turnover and maximize limited recruitment dollars.

There are a few ways to approach *Recruiting for Retention*:

1. You can read the manual from cover to cover.
2. You can start with the Recruitment Action Plan. The Action Plan presents the recruitment/retention process in strategic plan form. After each action step, the reader is instructed where in the manual that action is fully discussed.
3. You can use the Checklist for Recruitment Readiness. Similar to the Action Plan, each item on the Checklist instructs the reader where to go for more information on that particular item.

Several of the tools (Recruitment Action Plan, Checklist for Recruitment Readiness, Budget Worksheet, etc.) can be printed separately. When printing, specify page numbers.

For additional information on any topic discussed in *Recruiting for Retention* or for primary care recruitment and retention training and assistance, contact the National Rural Recruitment and Retention Network, Inc. at (800) 787.251 or info@3rnet.org.



Recruitment Action Plan

The Recruitment Action Plan is a ready-to-use implementation plan complete with objectives and action steps for recruiting and retaining primary care providers. All you need to do is fill in the person responsible for carrying out each action step (Lead Person) and the date by which the action step should be completed (Deadline). After each action step is the page number in the manual where you can read more about that particular action.

step1: Assess need for additional providers and determine potential income for new provider.

Action Step	Lead Person	Deadline
1. Determine provider supply and demand (p.22).		
2. Determine potential income for new provider using the clinic and hospital CPT codes and average charge per CPT (p.30).		

step2: Gain support among key local stakeholders for the recruitment effort.

Action Step	Lead Person	Deadline
1. Meet and discuss recruitment needs with medical staff and secure their support for recruitment (p.34).		
2. Meet and discuss recruitment needs with stakeholders, such as school principals, bankers and other key community members, and get their support (p.35).		
3. Educate public on the recruitment effort and gain its support to help develop practice before provider is recruited (p.35).		
4. Inform organizations about your opportunity for assistance in recruitment, promoting your opportunity or identifying recruitment/retention resources for your community (p.66, 113).		



step3: Form Recruitment/Retention Committee and assign roles (p. 36).

Action Step	Lead Person	Deadline
1. Recruiter (p.38).		
2. Contact or Point Person (p.39).		
3. Coordinator (p.39).		
4. Candidate Interviewers (p.39).		
5. Spouse Recruiter or Spouse Interviewer(s) (p.40).		
6. Reference/Credential Reviewers (p.40).		
7. Promotion Developer (p.41).		
8. Site Visit Team (p.41).		
9. Site Visit Hosts (p.41).		
10. Contract Negotiator (p.41).		

step4: Develop competitive compensation and benefit package: itemize, and place a dollar value on total package.

Action Step	Lead Person	Deadline
1. Choose types of arrangements available. If income guarantee or salary, determine who can afford to provide the financial support (p.44).		
2. Develop benefits package, place dollar amount on monetary-type benefits, list non-monetary perks (p.46).		
3. Seek legal advice to determine if your package complies with state codes and is acceptable to the IRS and Office of the Inspector General, DHHS (p.44).		
4. Develop practice profile (p.42).		
5. Develop community profile (p.48).		
6. Identify barriers to provider recruitment and retention (p.66).		
7. Implement actions to address/minimize barriers.		



step5: Define your “ideal” candidate.

Action Step	Lead Person	Deadline
1. Develop a composite of the ideal provider candidate for your community and do a “desired characteristic” tally chart or plot on a “most preferred-least preferred” continuum to determine how closely each candidate matches your ideal. Then pursue those who most closely match your ideal. (p.52).		
2. Develop candidate and spouse interview questionnaires and reference questionnaires that ask specific questions helping you to determine how closely the candidate matches the ideal candidate for your community. <i>Example:</i> If being a team player with the nursing staff is an ideal characteristic for your community, ask the candidate to characterize how he/she interacts with hospital nursing staff (p.74).		

step6: Develop recruitment activity budget.

Action Step	Lead Person	Deadline
1. Develop recruitment budget (p.61).		

step7: Create a practice opportunity information package and promotional materials.

Action Step	Lead Person	Deadline
1. Develop classified ads, direct mail letters, and promotional packets that highlight the professional and personal aspects of your opportunity and community that you think will appeal to the “ideal” candidate you defined (p.48-52).		



step8: Develop and implement candidate generation strategies.

Action Step	Lead Person	Deadline
1. Generate a list of possible sources of candidates locally, statewide, regionally and nationally (p.67,113).		
2. Estimate cost of generating candidates through each source by gathering rate cards from journals, estimating postage and mailing list costs for direct mail efforts. Estimate costs involved with visiting residency programs and sponsoring meals, or sponsoring exhibit at provider conferences, etc. (p.60).		
3. Locate “free sources” of candidates and free locations to publicize your opportunity: local word of mouth, local providers, state medical and hospital associations, specialty – or midlevel provider – specific associations or academies, State Office of Rural Health, Public Health Service, State Cooperative Agreements, Area Health Education Centers, residency programs, medical schools, etc. (p.67,113).		

step9: Develop process for receiving candidate information and quickly following up on candidate inquiries.

Action Step	Lead Person	Deadline
1. Assign a key person to be responsible for receiving candidate information, sending follow-up packet to candidate, notifying the candidate screening team and sending the team the candidate’s information (p.39).		
2. Develop a chart that tracks the status of each candidate lead, i.e., first contact, follow-up mailing, initial interview, second interview, spouse interview, reference and credential check, site visit, follow up to site visit, contract negotiation, decision period, close to signing, signed, declined offer, inactive. Never let more than two weeks transpire between phone or in-person contact with the candidate (p.74).		



step10: Develop interviewing process.

Action Step	Lead Person	Deadline
1. Form the candidate and spouse interview team (p.39).		
2. Conduct mock interviews to test the questionnaire and provide the interviewers with interviewing skills practice (p.76).		
3. Prepare for potential questions asked by the candidates and spouses by answering “Questions Most Commonly Asked by Physicians” (p.80).		

step11: Develop process for conducting reference and credential checks.

Action Step	Lead Person	Deadline
1. Form the reference and credential check team (p.40).		
2. Check candidate’s credentials (p.82).		
3. Interview candidate’s spouse (p.85).		
4. Identify and interview at least two additional references not provided to you by the candidate (p.87).		



step12: Prepare for site visits.

Action Step	Lead Person	Deadline
1. Develop standard site itinerary to be modified to fit interests of each candidate (p.91).		
2. Educate site visit team members about the opportunity.		
3. Rehearse the site visit.		
4. Educate site visit team about each candidate.		
5. Develop draft contract or proposition letter (p.98).		

step13: Send follow-up letter and information.

Action Step	Lead Person	Deadline
1. Extend offer.		
2. Send candidate and spouse follow-up information packet to site visit (p.101).		

step14: Develop site visit follow-up process.

Action Step	Lead Person	Deadline
1. Contact candidate to confirm acceptance or rejection of offer (p.101).		
2. Develop/implement candidate and spouse integration plan when candidate accepts offer (p.102).		
3. Identify and assess reasons for being rejected if offer is declined by the candidate (p.101).		
4. Adjust recruitment process and practice opportunity to address reasons for rejection (p.101).		



step15: Develop and implement a primary care provider retention plan.

Action Step	Lead Person	Deadline
1. Keep Recruitment and Retention Committee involved from Step 3, retention committee (p. 106).		
2. Define schedule to meet with new provider on a monthly basis to assess integration progress.		
3. Talk with spouse and family about integration progress and decide how often to meet.		
4. Meet with all primary care providers on quarterly basis to discuss retention issues and address concerns.		
5. Conduct retention questionnaire with medical staff (p.109).		
6. Work with medical staff to develop long-range medical staff development and retention plan (p.109).		



Checklist for Recruitment Readiness

This list is designed to help you make sure you brought everything with you for your recruitment trip, before you leave. If you are uncertain about an item or have not completed it, refer to the page number immediately following that item for more information.

- Have adequate demand and revenue to support viable practice (p.17)
- Have evidence of local physicians' support for recruiting a new provider (p.34)
- Have support of other health professionals for recruiting a provider (p.34)
- Have evidence of community support for the recruitment (p.35)
- Have trained and motivated recruitment team (p.36)
- Have developed practice opportunity: practice and community profile (p.42)
- Understand the unique aspects of the community's opportunity (p.48)
- Have competitive compensation and benefits with non-monetary perks (p.44)
- Have sought legal advice on proposed contractual arrangement(s) (p.44)
- Understand the barriers to recruitment/retention of physicians to the community and have strategies for overcoming the barriers (p.66)
- Have reasonable expectations of provider, including coverage schedule (p.48)
- Have adequate clinic space, support staff, technology (p.43)
- Have adequate hospital technology for the specialty sought (p.43)
- Have well-prepared practice opportunity promotional materials (p.49)
- Have clear picture of the ideal candidate for the practice and community (p.52)
- Have a spouse recruiter (p.40)
- Have recruitment budget (p.61)
- Have organized candidate search process (p.67)
- Have organized candidate screening process (p.74)
- Have prepared answers for questions commonly asked by candidates (p.80)
- Have contacted appropriate organizations about promotion and sourcing needs (p.67)
- Have strategies for dealing with spouse and family needs (p.96)
- Have candidate site visit plan of action, including itinerary (p.91)
- Have draft service agreement or letter of intent prepared, if applicable (p.97)
- Have retention strategies for the new and existing providers (p.103)



Part One

planning and preparation

Planning and Preparation is the most important ingredient for ensuring a successful recruitment effort. It is also the part most often neglected.

Many communities jump into the recruitment process with little preparation. Often this results from surprise at the sudden loss of a primary care provider. Communities that jump into recruitment typically spend more money and time on recruitment and experience less retention success than those that prepare and systematically search for the right candidate. In addition, surprise at the loss of a provider often indicates a lack of active retention building efforts.

Keys to Successful Recruitment

- Preparation
- Action Plan (with assignments and deadlines)
- Continuity of Effort: Persistence
- Adequate Recruitment Budget: Process and Compensation
- Community Support and Involvement
- Adequate Human Resources – Enough of the Right People
- Optimism
- Realistic Expectations – Time, Competition

A warning signal suggesting lack of preparation for recruitment occurs when the first step to replace a provider is placing an advertisement in a national journal or hiring a recruitment firm. This strategy is usually expensive and often ineffective. The following six steps in planning and preparing for recruitment will help you avoid surprises and conduct a search that is less costly and more effective:

- Step 1: Assess your need for a primary care provider: physician, physician assistant or nurse practitioner.
- Step 2: Gain support for recruiting another primary care provider.
- Step 3: Form a community-based recruitment team and make assignments.
- Step 4: Define your practice opportunity.
- Step 5: Define the “ideal” candidate for your community.
- Step 6: Develop a recruitment budget.



step 1 assess need for primary care providers

Before you place the “doc wanted” ad, be sure you know whether or not you even need another doc. Even though you may perceive a primary care provider shortage in your community, spend some time considering why and if you need to recruit a primary care physician. You may find that a nurse practitioner or physician assistant is more appropriate or that local demand for primary care does not justify recruiting a new provider at all.

Once you have assessed *why* you may need to recruit, determine *if* you need another primary care provider.

Determining the number of primary care providers required to serve a given population can be a complicated process. The most common methods used to measure primary care provider need are the simplest. These methods compare the number of people living in a given service area to the number of primary care providers serving that area. While these methods, which include the federal Health Professional Shortage Area (HPSA) designation process, can provide you a general indication of need, they could be misleading. Simple “head counts” fail to take into account primary care utilization rates of different population groups within the service area.

For example, Community A, Elderville, and Community B, Nuggett, both have a population of 3,500 residents. But Elderville is a popular retirement community, while Nuggett is a gold mining boomtown. Consequently, seniors largely inhabit one community while mostly men between the ages of 18-45 inhabit the other. Which town will use primary care providers more? Which town do you think actually needs more primary care providers?



Typical Reasons for Recruiting a Primary Care Provider

- The local population has grown significantly during the last few years, or rapid growth is forecasted.
- The current primary care providers are overworked, and their practice loads are at a maximum capacity.
- One or more of the providers are nearing retirement.
- The loss of a provider due to relocation, death or disability.
- One or more providers are “scaling” down his/her practice in terms of clinic hours, patient load or scope of services.



The other option is to utilize a program from Rural Health Works (RHW), which is also recommended. RHW information and workshop schedules can be found at:

<http://www.ruralhealthworks.org/index.html>

While the above example may be extreme, it does demonstrate the major pitfall of determining need based solely on the *size* of your population.

An easy way to go beyond head count methods is called the “Demand-Based Needs Assessment.” This assessment accounts for both the *size* and demographic *make-up* of your service area population.

The Demand-based Needs Assessment uses the health and lifestyle of a given population to provide insight into local demand for primary care services. Research shows us that men and women of different age groups use medical services at quite disparate levels. We define these sex-age groups by lifecycles: prenatal, pediatric, adolescent, adult and geriatric. The size of your population and the proportion in each lifecycle group will determine how many patient visits local residents will make to a primary care provider during a given year. The number of primary care patient visits generated by your service area population is called *demand*.

Understanding your community’s demand for primary care enables you not only to determine how many primary care providers your community needs but also to project:

- How the providers will be utilized (i.e. service demand by patient type: geriatric, pediatric, obstetrics/gynecology, etc.);
- The number of primary care providers your community can financially support; and,
- To a degree, the impact the provider will have on hospital utilization and revenues.

How to Conduct a Demand-Based Needs Assessment

- A. Define Your Service Area
- B. Calculate Primary Care Provider Supply
- C. Calculate Primary Care Demand
- D. Measure Supply versus Demand





A. Defining Your Service Area

What population will the new primary care provider serve? Local recruitment teams often define their service area population by city limits or county lines. Be aware that such boundaries are geopolitical divisions and usually are not sensitive to actual consumer flow patterns. Think of the last time you factored in the county line when deciding where to have your car serviced. The same holds true for health care services.

A more accurate yet relatively simple way to determine your service area is to find out where most of the local primary care providers' and hospital's patients live by zip codes. Provider offices and hospitals that store patient records electronically can often determine local patient origin using zip codes in a matter of minutes, without compromising confidentiality. The process is obviously more arduous and time consuming when patient records are only kept in written documents. If you can access computerized patient origin records, gather patient data by zip code, age, sex, payor source (insurance company) and diagnosis. This will help you fully define your service area by

Lose a Primary Care Physician?

You may benefit from your loss.

You could qualify for Health Professional Shortage Area (HPSA) designation status through the federal government and be eligible to participate in a variety of federal programs, including:

- Incentive Payment for Physician's Services Furnished in HPSAs – gives 10 percent bonus payment to physician's providing Medicare-reimbursable services in geographic HPSAs.
- Higher "Customary Charges" for New Physicians in HPSAs – exempts new physicians opening practices in non-metropolitan geographic HPSAs from new Medicare limitations on "customary charges".
- Rural Health Clinics Act – provides Medicare and Medicaid reimbursement for services provided by physician assistants and nurse practitioners in clinics in rural HPSAs.
- National Health Service Corps (NHSC) – provides assignments of federally employed and/or approved physicians, dentists and other health professionals to designated HPSAs.
- National Health Service Corps Scholarship Program – provides scholarships for training of health professionals, including primary care physicians, who agree to serve in designated HPSAs.
- National Health Service Corps Loan Repayment Program – provides loan repayment to health professionals, including primary care physicians and midlevel providers, who agree to serve in the NHSC in HPSAs selected by the Secretary of Department of Health and Human Services.

To inquire about HPSA status for your community, visit the website address below and search by region, state, county, discipline, metro, status, and type, and also by date of last update or HPSA score:

<http://www.hpsafind.hrsa.gov>

<http://www.bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm>



geography and demography (population sub groups). Citydata.com can be helpful <http://www.city-data.com> in developing needs assessments. Of course, the standard for all demographic data is <http://www.census.gov/>.

Once you have defined your service area, obtain census breakdown information by age and sex for all residents in your service area. This information is typically available through state commerce departments or through vital statistic/health departments. Request the information for each zip code in your service area. Collecting census information by zip code is most practical because zip code boundaries follow logical transportation systems and represent sub-county areas.

If you are unable to get the information by zip code, ask for county data. There are four levels of county census data: county, county division, enumeration district and place (city or town). If your service area is smaller than your county or if it overlaps into parts of other counties, collect the information at the county division level and obtain statistics for each county division in your service area.

Next, request the smallest age-sex group range units possible. Ideally, you want the population separately broken out by male and female in the following age groups:

Male

- Less than 15 years old
- 15-24 years old
- 25-44 years old
- 45-64 years old
- 65-74 years old
- 75 years old and over

Female

- Less than 15 years old
- 15-24 years old
- 25-44 years old
- 45-64 years old
- 65-74 years old
- 75 years old and over

A breakdown such as this is important because demand estimates for health care services are based on different configurations of age and gender. Armed with your service area population figures, you are now ready to determine your service area's demand for primary care services.



B. Calculating Primary Care Provider Supply

According to the American Medical Association (AMA) Socioeconomic Characteristics of Medical Practice, family practice physicians spend an average of 48.8 hours a week in direct patient care (the work *week* consists of four days, and the work *year* consists of 48 weeks). Office visits account for 75 percent of this time or approximately 36.5 hours a week. These hours translate into an average of 111.8 office visits per week (28 patients per day). Therefore, the average family practice physician will provide roughly 5,400 office visits each year.

Patients in the United States made an estimated 1.1 billion visits to physician offices and hospital outpatient departments and emergency departments, a rate of 381.9 visits per 100 persons annually. (Number 8 August 6, 2008 Ambulatory Medical Care Utilization Estimates for 2006). For updated information the following website can be checked: <http://www.cdc.gov/nchs/data/nhsr/nhsr008.pdf>

To determine the office visits (or appointment slots) available to people in your service area, simply multiply the number of family physicians practicing in your service area by 5,400 visits. This formula translates the number of family physicians in your area into a *potential* office visit *supply* figure. If some of your physicians work less than full time, discount their visits per year by the percentage of full time they practice. For example, a semi-retired doctor only seeing patients in his/her office 16-20 hours per week, would account for 2,700 office visits ($5,400 \times .50 = 2,700$).

Many rural providers and rural health experts contend that 28 patient visits (also known as “encounters”) a day and 5,400 a year may be an unrealistically high estimate for a rural family physician who must also maintain a hospital practice, provide emergency room coverage, and handle the administrative side of a practice. Indeed, a rural physician handling this heavy a load, without adequate relief or time-off, may be a prime candidate for burnout.

For a comparison, let’s also look at the United States Department of Health and Human Services (DHHS) standard for determining office visit supply and demand per primary care providers. DHHS calculates 4,200 patient visits per primary care physician and 2,100 visits per physician assistant or nurse practitioner. Now, many of the same rural providers and rural health experts who contend 5,400 visits may be too high also believe 4,200 visits for a physician and 2,100 for a midlevel provider may be too low. Primary care physicians and mid-levels with these types of utilization numbers may have a difficult time staying in business financially.

Respecting the arguments for and against the AMA and DHHS figures, let’s settle on a mid-range office visit number to determine your office supply and demand: 4,800 visits per family physician and 3,000 visits per midlevel provider. Simply complete the equations below to determine the potential supply of office visits available through your primary care providers.



**FP = family physician*

*Patient Visits
Per Year*

*Number of
FP*

*Total Potential
FP
Office Supply*

$$4,800 \quad \times \quad \underline{\hspace{2cm}} \quad = \quad \underline{\hspace{2cm}}$$

**PA/NP = physician assistant and nurse practitioner*

*Patient Visits
Per Year*

*Number of
PAs/NPs*

*Total Potential
PA/NP
Office Supply*

$$3,000 \quad \times \quad \underline{\hspace{2cm}} \quad = \quad \underline{\hspace{2cm}}$$

Total Potential FP/GP + PA/NP Visit Supply =

The operative word here is “potential.” Some providers may want to see more patients than this average while others may prefer a lighter load. The best way to upgrade “potential” to “actual” is to get an annual office visit count from your providers themselves and plug these figures into the supply and demand formula appearing at the end of the next section.

C. Calculating Primary Care Demand

National statistics in 2002 show that each individual visits the doctor an average of 3.14 times a year (Introduction to the U.S. Health Care System by Steven Jonas). This is an estimate for *all* visits to *all* physicians. Multiplying this average by the total population of your service area will provide you an estimate of all physician office visits generated by local residents each year or local *demand* for physician services. However, we want to confine our demand estimate to primary care.

To determine office visit demand for a family physician, we need to take a closer look at your population. For this, you will need your census breakdown for your service area to complete the Age/Sex Utilization Worksheet on Page 25.

How to use the worksheet

1. Using your census information, fill in the population blanks according to the age and sex breakdowns.
2. Multiply by the utilization rate.
3. Multiply by the primary care adjuster.
4. Fill in the Total Visits.



Look at the Worksheet and not the different levels of utilization by age group within and between the genders. These varied utilization rates are probably the best argument for steering shy of quick head count when determining the need for a primary care provider in your community. Also note the Primary Care Adjuster. This reduces visits made to all physician specialties to those made to only primary care. This adjuster also is a source of scrutiny in terms of its applicability to a particular geographic location, which we'll discuss shortly.

Next, add your FEMALE visits and your MALE visits from the next page to determine your *Total Visits*:

$$\begin{array}{rcccl}
 \textit{Female Visits} & & \textit{Male Visits} & & \textit{Total Visits} \\
 \hline
 & + & & = & \hline
 \end{array}$$

You now have a detailed estimate of how many office visits each age/sex group generates each year using national utilization and adjuster rates.

There is some concern among rural health experts about the national Primary Care Adjuster used in this formula. Some consider the adjuster too low when applied to rural areas. Indeed, when this formula was tested in service areas in rural Idaho and Oregon, several practice sites had documented evidence that the total number of actual office visits made by the local population well exceeded the formula's total estimate. Given these concerns, developing an office *visit range* for your use is appropriate.

We'll use .80 as our "high range" adjuster. Why? It is commonly accepted that 80 percent of an individual's health care needs can be satisfied at the primary care level. Using the .80 adjuster, complete the "High Range" Age/Sex Utilization Worksheet on Page 26.



Age/Sex Utilization Worksheet - LOW RANGE (Income Worksheet)

FEMALES

Age	Population	Utilization Rate*	Primary Care Adjuster	Total Visits
< 15	X	2.3 X	.63 =	
15-24	X	2.6 X	.63 =	
25-44	X	3.4 X	.63 =	
45-64	X	4.1 X	.63 =	
65-74	X	6.0 X	.63 =	
75+	X	6.7 X	.63 =	

TOTAL FEMALE VISITS: _____

MALES

Age	Population	Utilization Rate*	Primary Care Adjuster	Total Visits
< 15	X	2.5 X	.63 =	
15-24	X	1.2 X	.63 =	
25-44	X	1.6 X	.63 =	
45-64	X	3.0 X	.63 =	
65-74	X	5.4 X	.63 =	
75+	X	6.4 X	.63 =	

TOTAL MALE VISITS: _____

TOTAL FEMALE + MALE LOW RANGE VISITS: _____



Age/Sex Utilization Worksheet - HIGH RANGE

FEMALES

Age	<i>Population</i>	Utilization Rate*	Primary Care Adjuster	Total Visits
< 15	X	2.3 X	.80 =	
15-24	X	2.6 X	.80 =	
25-44	X	3.4 X	.80 =	
45-64	X	4.1 X	.80 =	
65-74	X	6.0 X	.80 =	
75+	X	6.7 X	.80 =	

TOTAL FEMALE VISITS: _____

MALES

Age	<i>Population</i>	Utilization Rate*	Primary Care Adjuster	Total Visits
< 15	X	2.5 X	.80 =	
15-24	X	1.2 X	.80 =	
25-44	X	1.6 X	.80 =	
45-64	X	3.0 X	.80 =	
65-74	X	5.4 X	.80 =	
75+	X	6.4 X	.80 =	

TOTAL MALE VISITS: _____

TOTAL FEMALE + MALE HIGH RANGE VISITS: _____

*These utilization rates are obtained from the National Health Statistics Reports, Number 8, August 6, 2008 – Ambulatory Medical Care Utilization Estimates for 2006. For updated data, please go to <http://www.cdc.gov/nchs/products/ad.htm> and enter “outpatient utilization rates” into the search box.



Once you have completed both the high range and low range estimates, find the median total office visit estimate. Insert your figures:

Estimated Primary Care Office Visits

Low Range: _____

High Range: _____

Mid Range: _____ Primary Care Office Visit Demand

Example: If your low range estimate was 5,000 visits and your high range was 6,700 visits, the median would be 5,850 visits $((5,000 + 6,700)/2)$, and this number would represent your local primary care demand estimate.

D. Measuring Supply versus Demand

Now you can compare your primary care supply and demand and determine whether or not demand is great enough to support another primary care provider in your service area:

1. Insert your “mid-range” demand for visits from above in the appropriate space below.
2. Insert your Total Potential Office Visit Supply from Page 23 in the space below and subtract from the demand figure. The result is the unmet office visits or primary care demand.

Total Primary Care Office Visit Demand: _____

- *Total Primary Care Office Visit Supply:* _____

= Unmet Primary Care Demand:

What do the results tell you?

- If the number is 4,800 or more, you’ll want to consider recruiting another family physician.
- If the number is less than 4,800 but greater than 2,500, you may want to consider a physician assistant or nurse practitioner.
- If the number is above zero but less than 2,500, you may want to consider part-time provider options or looking to your current provider supply to determine if there is an underutilized practice.
- If the result is a negative number, your supply exceeds your demand.



Other Calculations

Estimating Hospital Utilization (If appropriate to your situation)

Family physicians spend approximately 13 percent of their time, roughly five hours a week, on hospital patient visits. The AMA estimates, on average, a family physician admits four patients a week to the hospital or 192 patients a year. The average family physician will also make 17.7 hospital visits each week or 849.6 visits per year. Using the AMA averages, you can see that the average number of office visits (5,400) will generate an average of 850 hospital visits per year.

To estimate the number of hospital visits a family physician in your service area might make in a year, refer back to your Total Unmet Primary Care Demand number from Page 27 and complete the following formula.

1. Total Unmet Primary Care Demand _____
2. Divided by Visits per Year 5,400
3. Multiplied by Average Hospital Visits x 850

**Total Estimated Hospital Visits Generated
by a new local family physician =**

Knowing the number of patients a family physician will admit to the hospital each year is useful in recruiting. Such knowledge gives potential candidates an idea of how much they might earn from their hospital work. The local hospital will also find such information quite helpful, especially when deciding how large of an income guarantee or salary it can offer candidates.

Estimating Practice Revenue

Physicians generate most of their revenue from two different locations – the office and hospital. Unfortunately, there is no uniform standard for determining physician fees in either setting. While Medicare and private insurers each have a set of established reimbursement guidelines, these guidelines are not necessarily consistent from one health plan to another. In addition, physicians establish their fee schedules according to a variety of factors such as geographic location, patient base, local economy, competition and practice costs. Because there are so many variables, it is quite difficult to determine a reliable average for physician fees.

Fees usually are determined according to “Current Procedural Terminology,” more commonly referred to as CPT codes. There are separate CPT codes for office and hospital visits. Each CPT code is a five digit number which has a distinct description of the service associated with that code. Each code is designed to measure the *level of service* rendered to a patient during a hospital or office visit. For example, CPT 99202 is



the code for an office visit for a new patient with Level 2 care. A CPT code list with estimated fee range for an area of the U.S. appears on the next page.

For office visits, there are five levels of care ranging from one to five for new and for established patients. For hospital visits, there are three levels of care ranging from one to three for new and for established patients. The higher the CPT number, the higher the complexity of care or medical decision making during the visit, the higher the fee.

Despite detailed descriptions and the universal acceptance of CPT codes, there is considerable difference in how physicians use the codes. Some physicians do not fully understand the different levels of service defined within the codes. Others charge the same fee regardless of the duration, complexity or risk of the visit. The result is that many physicians fail to maximize on patient reimbursement. Failure to maximize practice reimbursement (or in many cases failure to even recoup costs) can have a negative impact on practice viability and physician retention, especially in rural practices where financial margins can be rather thin.

Significant changes to the coding of office and hospital visits occurred since 1992. Visits are now termed “Evaluation and Management Services.” Actual code numbers and descriptions are also changed over time. The list on the following page presents examples of CPT codes. It is important to check with the staff responsible for coding in your health care facility to find accurate codes and fees.



CPT CODES: OFFICE OR OTHER OUTPATIENT VISIT
(CPT Code Examples) (CPT Fee Examples)
CPT Code Level Fee

New Patient Codes

<i>99201</i>	\$74.50
<i>99202</i>	\$110.00
<i>99203</i>	\$163.00
<i>99204</i>	\$232.00
<i>99205</i>	\$304.00

Established Patient Codes

<i>99211</i>	\$41.50
<i>99212</i>	\$69.00
<i>99213</i>	\$101.00
<i>99214</i>	\$157.00
<i>99215</i>	\$225.00

CPT CODES: HOSPITAL CARE

CPT Code Level Fee

Initial Hospital Care Codes

<i>99221</i>	\$190.00
<i>99222</i>	\$278.00
<i>99223</i>	\$356.00

Subsequent Hospital Care Codes

<i>99231</i>	\$101.00
<i>99232</i>	\$150.00
<i>99233</i>	\$250.00

Calculating Revenue

To determine the basic practice revenue potential of your community for a new physician or midlevel, follow these instructions to complete the CPT Revenue Worksheet on Page 32:

1. On the CPT Office Revenue Worksheet, insert your Total Unmet Primary Care Demand number from Page 27 in the blank space after each CPT code and under the “Office Visit Demand” column heading. Enter the same number after each CPT code.
2. Using the CPT Hospital Visits number from Page 28, insert this number in the blank space after each CPT code and under the Hospital Visit Demand heading. Again, you will use the same number after each code.
3. Determine a fee for each CPT code. You can obtain this information in a couple different ways: find out what your local physicians charge for each CPT code, or contact practice management experts with local medical associations.



CPT Office Revenue Worksheet

CPT Code	Office Visit Demand	Percent Times Used	Times Used	Fee per CPT	Revenue per CPT Code
99201	_____X	.004	_____X	_____ =	_____
99202	_____X	.028	_____X	_____ =	_____
99203	_____X	.046	_____X	_____ =	_____
99204	_____X	.043	_____X	_____ =	_____
99205	_____X	.0005	_____X	_____ =	_____
99211	_____X	.030	_____X	_____ =	_____
99212	_____X	.192	_____X	_____ =	_____
99213	_____X	.312	_____X	_____ =	_____
99214	_____X	.292	_____X	_____ =	_____
99215	_____X	.003	_____X	_____ =	_____

TOTAL OFFICE REVENUE = \$ _____

CPT Hospital Revenue Worksheet

CPT Code	Hospital Visit Demand	Percent Times Used	Times Used	Fee per CPT Code	Revenue per CPT
99221	_____X	.115	_____X	_____ =	_____
99222	_____X	.01	_____X	_____ =	_____
99223	_____X	.001	_____X	_____ =	_____
99231	_____X	.492	_____X	_____ =	_____
99232	_____X	.246	_____X	_____ =	_____
99233	_____X	.073	_____X	_____ =	_____

TOTAL HOSPITAL REVENUE = \$ _____



Technical Notes on “Percent Times Used”: New patients comprise 12.7% of all office visits (CPT codes 99201-99205) and close to 16.3% of hospital based ambulatory visits (CPT codes 99221-99223). Established patients or subsequent visits comprise 86.4% for office visits and 81.2% for hospital based ambulatory visits. The relative distribution of the types of visits by CPT (Percent Times Used) is obtained from Advance Data by equating the CPT code with the percent distribution of office and hospital outpatient visits and the duration of visit (Table 25 Advance Data No. 315 and Table 21 Advance Data No. 307).

CPT 99201 (10 minutes) – 1 to 5 minutes – 3.5% of all visits. (.035x.127=.0044)
 CPT 99202 (20 minutes) – 6 to 10 minutes – 22.2%. (.222x.127=.0281)
 CPT 99203 (30 minutes) – 11 to 15 minutes – 36.1%. (.361x.127=.0458)
 CPT 99204 (45 minutes) – 16 to 60 minutes – 33.8%. (.338x.127=.0429)
 CPT 99205 (60 minutes) – over 61 minutes – .4%. (.004x.127=.0005)
 CPT 99211 (5 minutes) – 1 to 5 minutes – 3.5%. (.035x.864=.0302)
 CPT 99212 (10 minutes) – 6 to 10 minutes – 22.2%. (.222x.864=.1918)
 CPT 99213 (15 minutes) – 11 to 15 minutes – 36.1%. (.361x.864=.3119)
 CPT 99214 (25 minutes) – 16 to 60 minutes – 33.8%. (.338x.864=.292)
 CPT 99215 (40 minutes) – over 61 minutes – .4%. (.004x.864=.0034)

CPT 99221 (30 minutes) – 0 to 30 minutes – 90.9%. (.909x.127=.1154)
 CPT 99222 (50 minutes) - 31 to 60 minutes – 7.9%. (.079x.127=.01)
 CPT 99223 (70 minutes) – 60 minutes or over – 1.1%. (.011x.127=.0013)
 CPT 99231 (15 minutes) – 0 to 15 minutes – 60.6%. (.606x.812=.492)
 CPT 99232 (25 minutes) – 16 to 30 minutes – 30.3%. (.303x.812=.246)
 CPT 99233 (35 minutes) – 31 to 60 minutes or over – 9.0%. (.09x.812=.073)

To arrive at an estimate for the Percent Times Used for new patients, take 12.7% of the individual CPT percentages, and for existing patients, use either 86.4% for office or 81.2% for hospital CPTs.



step 2 gain support for the recruitment effort

Once you determine that recruitment of another provider is necessary, the next step is to garner the support of local primary care providers. Without their support, you will have a difficult time attracting a new primary care provider. Most physician or midlevel candidates will want to practice where they are needed and welcome. Even if four of the five primary care providers practicing in a community support the recruitment effort, the prospective candidate will be likely to have contact with the provider who opposes the effort. Your job is to be able to honestly demonstrate to candidates that the recruitment effort is enthusiastically supported by *as much of the local medical staff as possible*.

When meeting with the medical staff, show them how you arrived at the decision to recruit another provider. Here is where an objective needs assessment such as the demand-based assessment is useful. Physicians and mid-levels practicing in the community will want to know how their practices will be affected by the presence of another provider. They need to be assured that adequate *unmet* demand exists to support another provider. Some may need to be convinced that a new provider will not need *his/her* patient base to survive.

You will also need to discuss with the existing providers the compensation amount and arrangement you are considering offering new candidates. If you plan on offering a new family physician more than what the existing family physicians earn, you want to address their concerns or demands before you start recruiting. Remember, the best way to avoid the trials of recruitment is by retaining your existing providers. Do not let the recruitment of a new provider lead to the loss of a valued existing provider.

Physician assistants and nurse practitioners in your community will be interested in your recruitment plans for reasons other than just income, especially if the plan calls for recruiting a new physician. Midlevel providers sometimes fear they are expendable in the local provider mix if priorities are assigned when developing a patient base for a new physician. Your assessment should account for the presence of local mid-levels. This can be presented to them as proof to their continued importance.

Once you gain the medical staff's support, go a step further and recruit at least one medical staff member to be an *active* member of your recruitment team. Surprisingly, the medical staff often sits on the sidelines or has a very small role in recruitment, even though the success of the recruitment effort is in their professional interests. Ask the medical staff to elect one member to be an active participant of the team. Assign the provider specific tasks that match his/her schedule, knowledge and talents, typically in reviewing credentials and checking references. This provider is responsible for keeping the rest of the medical staff apprised of the recruitment effort and of leading candidates.



You will then meet with other key care providers in the local health care system. Some of these individuals and organizations are highly dependent on local primary care providers. The hospital, nursing home, home health agencies, pharmacist and various therapists need physician referrals or supervision to stay in business.

In addition to health care providers, there are many other members of your community who have a stake in the success of the local health care system as well. Your job is to identify these *stakeholders* and make them aware of the importance of the primary care provider to the health care system and to the community's economy.

Examples of community stakeholders:

1. The local banker understands the economic value of the hospital's payroll to his/her bank. Understanding the importance of the primary care provider to the viability of the hospital may motivate him/her to provide start-up capital for the new provider's practice.
2. While the school principal knows that healthy kids make better students, he or she may not know that the primary care provider is the central member of a child's health management team. If you have the principal's support, he or she could talk with the candidate and spouse about the local education system, send the candidate information and/or provide a school tour during the site visit.

Therefore, before recruiting a new primary care provider, meet with and gain the support of recognized leaders of the various sectors of your community affected – economically and health-wise – by the health care system: retail trade, education, economic development, agriculture, senior citizens, parents' groups and so on. By gaining community support, you can:

1. Demonstrate to candidates the community's sincere interest in a new provider;
2. Begin building a patient base for the new provider before he or she begins practice; and,
3. Make the new provider and family feel more welcome in the community once they arrive.

Your meetings with the medical staff and stakeholders of the community should be immediately followed by public education activities that inform the community about the local primary care needs and plans to recruit another provider. These community education activities, such as press releases, presentations to civic groups and public information meetings, will create community interest in local health care and generate support for the recruitment effort. Community education efforts should also alert residents who currently leave the community for primary care of a new local provider alternative.





step 3 form a recruitment/retention team

Once you have the blessings of local stakeholders and the community, you need to transform that support into active participation.

Most successful recruitment efforts enjoy some level of community involvement in the recruitment process, and the recruitment team approach is the best way to involve the public. Community participation in the recruitment process demonstrates to candidates that more than just the hospital or clinic wants their services. It demonstrates to candidates that the community cares enough about local health care to actually be a part of its success. Community participation on recruitment teams also provides the first opportunity for the candidate and family to begin making personal links with the community, before they move to the community. This fosters their integration into the community and aids long-term retention. Remember, one of the biggest barriers to recruitment and threats to retention is provider and family dissatisfaction with the community. Provide ample opportunities for the candidate and the community to get to know one another during the recruitment process. For the candidate and family, knowing the community goes beyond descriptions about the community, it involves learning about the people who make it a community.

From a practical standpoint, the recruitment team approach cuts down on the amount of work for any one member of the team. The title “recruitment team” is more accurate than “recruitment committee” because “team” better defines what is needed for a successful recruitment effort – an organized group whose members each must complete different but interrelated tasks in order to achieve a shared goal.

Many members of the community will be interested in your recruitment effort, and some will be eager to help. You want people who are both eager and appropriate for certain tasks at certain points during the recruitment process. You also want to involve a diverse cross section of the community. The roster of successful recruitment teams usually includes:

Health Care Representatives

- Hospital administrator
- Clinic administrator
- Medical staff representative
- Medical staff member’s spouse



- Hospital director of nursing

Community Sectors

- Employers who recruit professionals
- Local economic development
- Schools
- Residents who match characteristics of candidate (and spouse) you seek
- The media
- Civic minded residents

Do not limit yourself to this list or be intimidated by it. It is merely a guideline to get you thinking about who in your community should be involved in the recruitment process.

Building a Recruitment/Retention Team

There should be no misconceptions about the work ahead for the Recruitment Team. You need to be explicit with potential team members about their role, their tasks and the time commitment needed.

To apply the team concept effectively to recruitment, each member must be assigned a specific job. This will keep team members focused and ensure efficient use of the team's time. By delegating tasks and sharing responsibility for success, you prevent the group from wasting its time before making decisions or from completing assignments by committee.

When complaints arise about not involving the community during recruitment, it is usually because the Recruiter fails to engage community members in the process. The Recruiter has a group of well-meaning individuals who really do not have any specific job except to meet every once in a while to talk about progress and show up for the site visit. To turn a committee like this into a team, the Recruiter must give the group a strong sense of purpose and clearly define each member's role and assign specific tasks.



Roles and Responsibilities of the Recruitment Team

The primary roles on the Recruitment Team make up the Core Group. These roles are the Recruiter, Contact Person, Coordinator, Interviewer(s), Spouse Recruiter, Reference and Credential Reviewer(s), Promotion Developers and Site Visit Team.

While the recruitment team positions are presented separately and may imply separate individuals to fill each position, in many successful cases the same person, albeit a talented person, filled more than one of these positions. In these cases, one person filled the Recruiter, Contact Person, Interviewer, and Site Visit Host positions. Even if you choose not to employ a Recruitment Team approach, the below descriptions will give you a good idea of the different tasks and the skills required for effectively completing various elements of the recruitment process.

Recruitment Team Core Group Members

RECRUITER: This position is responsible for making assignments and seeing they are completed. The Recruiter makes sure the Recruitment Team and recruitment process stays focused and on schedule. He or she is involved in or, at the very least, is well apprised of all activities of the Recruitment Team. This position needs a person who possesses good organization and leadership skills. When this position is combined with the Contact Person and Interviewer position, which often is the case, the person also needs strong interpersonal skills and salesmanship. Because of the importance of the Recruiter's role, the position usually requires at least 20 hours a week, especially if the position includes Contact Person and Interviewer responsibilities.

In rural facilities, this position is often filled by the hospital or clinic administrator, because it is usually one of these organizations that first recognizes the need to recruit and has the most to gain or lose by it. But the typical administrator has many complex and time-consuming responsibilities running the hospital or clinic. These primary responsibilities often prevent him/her from giving the recruitment effort the time it needs. Simply because medical staff development is part of the administrator's job description does not mean the administrator needs to be the actual Recruiter. In addition, some administrators may lack the interpersonal skills to coordinate the effort.

For these reasons, the administrator should carefully consider what would be best for the recruitment process. It may be better to find another Recruiter, allowing the administrator to keep the overall responsibility but leaving the day-to-day recruitment activities to someone else.

Steps in Effective Volunteer Management

- Define the need for volunteers
- Write a clear job description
- Design an orientation packet and training program
- Recruit
- Orient
- Train – provide coaching and support
- Match ability to job/tasks
- Make them feel part of the team and cause
- Recognize and thank volunteers often



CONTACT PERSON(S): The Contact Person, usually the Recruiter, will be the first personal contact the candidate will have with your community, because this person's name and contact information will be on all of your promotional materials . Therefore, the Recruiter should have strong interpersonal skills. He or she should possess charm, enthusiasm, persuasiveness, good listening skills, and knowledge about the community and practice opportunity.

The Contact Person may be the same person as the Recruiter, and in many cases, he or she is also one of the Candidate Interviewers. The primary responsibilities of this position include: *promptly* responding to a candidate's inquiries by email, phone, mail or in person, being available on evening or weekends when candidates often contact opportunity sites, and learning all aspects of the practice opportunity and community.

COORDINATOR: The Coordinator sends your opportunity packets to interested candidates, sends candidate information to the screening team and medical staff, and tracks the status of each candidate in the recruitment process, i.e., opportunity packet stage, interview stage, reference check, site visit, follow up, etc. The Coordinator warns the Recruiter when too much time (7-10 days) passes between dates of contact with each candidate – unless the Coordinator is also the Recruiter. Contacting candidates in a timely manner is critical.

CANDIDATE INTERVIEWER: The Candidate Interviewer is responsible for conducting phone interviews with all eligible candidates. The Interviewer's role is critical to the success of the recruitment and retention effort. He or she is responsible for gathering as much information about the candidate as needed by the Recruitment Team to decide how closely the candidate matches the community and the needs of the practice opportunity. The Interviewer can also be key to increasing eligible candidates' interest in the opportunity. A flair for sales or persuasive presentations can be helpful for an Interviewer.

Consider having two or more Interviewers on your team to 1) make sure you interview all likely candidates in a timely manner, and 2) do not overwork a single Interviewer. Interviewers must be personable, good listeners, accurate note takers and confident speakers. Persistence is also a valuable trait for an Interviewer, because tracking down and interviewing busy physician or midlevel candidates may take several attempts at different times on different days. Interviewers also need to be adaptable enough to schedule interviews at the candidates' convenience not theirs, which means plenty of evenings, including Sunday evening – the best time to find candidates at home.

Finally, the Interviewer should know what candidates look for in opportunities and be prepared to answer their questions about your opportunity. The section of this manual called "Questions Commonly asked by Physicians and Their Spouses" can assist them in this (p.80).



In many successful cases, one of the Interviewers has been a Contact Person. This allows you to immediately begin screening your candidates at the time of initial contact.

All Interviewers should be equipped with the same interview questionnaire, opportunity information, and instructions for conducting an interview, to ensure consistency from candidate to candidate.

SPOUSE RECRUITER: If you are from a rural area and have been involved in primary care provider recruitment, you know the role the spouse plays in the candidate's decision-making process. There needs to be at least one person on your team whose sole responsibility is recruiting the spouse. The Spouse Recruiter has several major responsibilities:

1. Coordinating all activities related to recruiting the spouse;
2. Determining the spouse's level of interest in the community versus the candidate's level;
3. Determining how well the spouse matches the community;
4. Providing whatever specific information the spouse needs about the community;
5. Attempting to satisfy the spouse's professional or career needs; and,
6. Providing the Recruiter and Recruitment Team with an accurate assessment of how sincerely interested the spouse is in moving to the community.

The Spouse Recruiter should have something in common with the candidate's spouse in order to establish a rapport, which is why you should see if a local physician or midlevel's spouse has the interest and personality to be a spouse recruiter. The commonality between the Spouse Recruiter and candidate spouse could also be as simple as the same age group and gender, similar education or social background, or a shared interest. Since the spouses will be as diverse as the candidates themselves, you will probably need a couple of people involved in the spouse recruitment effort. Spouse Recruiters need similar skills and attributes as possessed by Candidate Interviewers. Their sincerity, likeability and openness will be key to developing trust and will perhaps play *the biggest part* in attracting the spouse to your community.

REFERENCE AND CREDENTIAL REVIEWERS: The Reviewers should be from the health care sector. One of these Reviewers needs to have access to the National Practitioner Data Bank. They must have an understanding of medical education and background, certification and licensing processes, and the hospital privileging process. They should be persistent about verifying a candidate's record, even if it means asking sensitive questions. They will interview candidates' references using a tool developed by the Recruitment Team to determine how well the candidate matches the community from the reference's perspective. They will also verify that the professional claims the candidates make verbally or on their curriculum vitae (CV's) are accurate. The hospital administrator and one or more of the medical staff should be on the *candidate quality assurance* team. Some recruitment teams also use clinic or hospital staff to conduct reference interviews with their counterparts from the candidates' past hospital and clinic practices.



RECRUITMENT TEAM SUPPORT MEMBERS

The Support Member roles for the Recruitment Team provide you the best opportunity to involve a greater number of local residents in the recruitment process. The tasks involved in these roles are enjoyable and do not require a great deal of time to complete. To ensure consistency, members of the Core Group, especially the Recruiter, will work with the Support Members to help them complete their tasks.

PROMOTION DEVELOPERS: There should be a number of individuals in the Promotion Developers group. Their primary responsibilities are creating marketing materials about the community and practice opportunity, and determining the best places to market your opportunity. Local writers, artists, members of the media and professional or amateur marketers can put their talents and interests to work here. The group's efforts usually result in a brochure or packet of materials designed to describe and generate interest in your opportunity. Some have even developed promotional videos and audio tapes. Once these materials and the marketing plan are developed, the group's job is largely complete. Because of the nature of work and the limited time commitment it takes to complete the work, this position(s) is usually easy to fill with community members. Your job is to find the most talented volunteers.

SITE VISIT TEAM: This group hosts the candidate and his or her spouse during a site visit. It is critical that the site visit team include members who the candidates consider peers in their profession, age, social background and interests. Therefore, some members of the team are likely to change from candidate to candidate site visits. The Recruitment Team should have prior knowledge about the candidate and spouse to tailor the site visit itinerary and team roster to match their interests. Team members should have a good understanding of the practice opportunity and the community as well.

SITE VISIT HOSTS: The Site Visit Hosts are one or two members of the Site Visit Team. The Hosts are the moderators and guides for the visit. Because of the importance of their role, the Hosts should be members of the Core Group. Indeed, the Hosts often are the Candidate and Spouse Interviewers, since they have established the greatest rapport with the candidates prior to the visit. Good Hosts possess the same skills and personality traits as good Interviewers. If there is a Spouse Recruiter, he or she should be the Spouse Host. The best case scenario is when hosts include representatives from the health care sector and from the community. More detail on conducting the site visit can be found on page 91.

CONTRACT NEGOTIATOR: Who will "cut the deal?" This person needs to have the power to *negotiate* the offer with the candidate. A duly authorized representative of the organization underwriting the compensation package usually acts as negotiator. In most cases, this person is the clinic or hospital administrator. Flexibility, patience, thick skin, salesmanship and a sensitivity to the art of negotiation are valuable attributes for a Contract Negotiator. At various points during the recruitment process, the Contract Negotiator needs to establish rapport with the candidate. The negotiation session is not the best place to start building trust.



One important point must be established before negotiations. The days of “low-balling” an offer and then negotiating to a more appropriate compensation package are over. If candidates do not see a competitive offer to begin with, they will not pursue your opportunity, which makes negotiations not only moot but self-defeating.



step

4 define your opportunity

There are three separate components that define any practice opportunity: the practice setting, community and compensation. Yet while all opportunities include these three, it is how you define each that will set your opportunity apart from others. Once defined and combined, these separate components form the opportunity package you will promote to prospective candidates. A fully defined opportunity will:

- 1) Help you to understand the strengths and weakness of your offer versus the competition;
- 2) Help you better identify candidates who are right for your opportunity; and,
- 3) Help candidates better understand whether your opportunity and community is right for them.

You begin defining your opportunity by developing a profile for each of the components of the opportunity package.

Practice Setting Profile

The practice profile is one part of the professional opportunity you are offering. The other part is the compensation package. When defining the practice, describe in detail the following:

Type of Provider Sought – Clearly articulate the physician specialty or midlevel type you seek and the basic qualifications needed for the position. Summarize the qualifications needed:

- For physicians, what primary care specialty are you seeking?
- Are you seeking an MD or a DO or will either do?
- Do the candidates need to be board certified?
- Do you want experience or will a new graduate be satisfactory?
- Will you consider a foreign medical graduate?
- For mid-levels, do you want a nurse practitioner (if so, what type), a physician assistant or either?



- What educational background and certification do you require?

Responsibilities – What will a day in the life of your new primary care provider look like? Outline the scope of services you expect the practitioner to provide and when and where they will provide these services. List hours per week they'll provide clinic and hospital care. Describe the type and amount of clinical and administrative responsibilities at the office and the hospital. Describe the call expectations and coverage arrangements for the clinic, the hospital and the emergency room.

Patient Demographics – Who will comprise the provider's primary patient base in terms of age, gender, income, payer source, and most frequent diagnoses.

Patient Volume – Using your demand-based needs assessment and patient volumes of other providers in town, project the daily patient load for the new provider. What percentage will be new versus established patients?

Practice Setting – Is it a solo practice? Is it group, satellite, or hospital-based?

Clinic Facilities – Describe the size (dimensions and number of exam rooms), layout, age and condition of the physical plant. Describe the technology located in the clinic, including electronic medical records and health information technology. Describe the administrative and clinical support staff, and other human and technological resources at the clinic. Where is the clinic located in relation to the hospital and nursing home in miles and minutes?

Hospital Facilities – Describe the local hospital facilities in terms of number and types of beds, age and condition of the physical plant. List the technology at the hospital of interest and importance to the specialty or provider type you seek. Define the hospital in terms of scope of services, departments, clinical and administrative human resources and any special training and skills, linkages with tertiary sponsorship/ownership, and any unique or remarkable attributes that would be attractive to the type of provider you seek, such as telecommunication links with specialists or advanced care facilities, electronic medical records and health information technology. Finally, describe the hospital privileging process.

Medical Staff – Develop a list that shows the specialty or type, age, training orientation (MD or DO) and the length of practice in the community for each physician and midlevel

According to spouses of residents at the Family Practice Residency Program of Idaho in the Spring 1994, the most important things spouses want to learn about a community before they visit the community (not prioritized) are:

- Age, education background, and diversity of the population
- Proximity to large towns
- Culture – outside groups (theatrical, musical) that visit area
- Schools – diversity of curriculum, pupil-teacher ratios, sports programs, level of parent-school interaction, facilities (building and technology)
- Economy – ability to support another physician, stability of the economy, and population income



in your community, including visiting specialists and physicians and mid-levels who are not on the hospital medical staff. Include specialist referral or consultation resources as well.

Other Health Care Resources – List or describe other health care facilities, providers or services available in the community such as public health, mental health or substance abuse counseling, physical therapy and rehab, and dental care services. Describe in some detail the emergency medical system in terms of level of care, types of transport, and distance in miles and minutes (ground and air) to advanced care facilities.

Developing a Compensation Package

Once your expectations of the provider are outlined, you can determine what is reasonable and competitive to offer the “right” candidate in terms of compensation.

Compensation packages come in various sizes and forms. Size refers to the total dollar value of the offer, while form refers to the specific compensation arrangement. Both the size and form of your compensation package will impact the attractiveness of your offer. What’s more appealing to candidates today: an offer of \$182,000 which includes benefits or \$140,000 figure that doesn’t include the value of benefits? The answer should be obvious.

Most new providers will feel more comfortable with a guaranteed compensation amount for at least the first two years while they build their practices. A gross guaranteed salary with deductions from gross earnings will be very unattractive to new providers since the take-home amount is unknown each month.

You should exercise caution when developing hospital sponsored recruitment packages, and you should always seek legal counsel. Stark regulations are not easy to interpret and it is important that hospitals rely on local legal counsel and not on what other hospitals are doing. Failing to comply with laws affecting provider recruitment can bring stiff penalties. Non-profit hospitals can lose their tax-exempt status. Hospitals in violation of illegal remuneration fraud and abuse statutes can lose their Medicare/Medicaid provider status. They can also face heavy criminal and civil fines.

Compensation Arrangement

Salary – An organization, usually a hospital or clinic, simply hires and pays the primary care provider a set annual income. Under a salary arrangement, the provider is an employee of the organization and therefore is subject to all organization policies, procedures and executive’s orders, including where he/she refers patients for the hospital or specialized physician services.

Salary arrangements are more and more typical for physicians, nurse practitioners and physician assistants. Salary arrangements allow the organization, especially if it is a hospital, more control over the provider’s activities and behavior, including referral



patterns, with the least risk of violating federal or state laws and regulations governing referrals. On the down side, the salary structure may not provide practitioners enough incentive to maintain desirable productivity levels in terms of patient visits on a day-to-day basis.

Income Guarantee – In a guarantee arrangement between a hospital and a physician, for example, the physician usually is an independent contractor. The hospital simply guarantees the physician a predetermined annual income in exchange for certain responsibilities or services. The hospital does not actually pay the entire guaranteed amount, only the difference between the physician's patient revenues and the amount guaranteed. When the physician's patient revenues equal or exceed the guaranteed amount, the hospital does not pay anything. Again, check with local hospital counsel regarding Stark Regulations.

As with the salary arrangement, productivity incentive is an issue with income guarantees. To build in an incentive, some hospitals and clinics set up bonus arrangements for certain levels of productivity. For example, let's say the salary or income guarantee is \$140,000 per year or \$11,666 per month. Each month when the physician's clinic patient revenues exceed this amount guaranteed, the surplus revenue is placed in a pool. Each month when the patient revenues are less than the guaranteed amount, that amount is drawn down from the pool. At the end of the year, the physician is awarded all or a percentage of the surplus revenues remaining in the pool. This is just one simple example of building incentive into salary or income guarantee arrangements.

There are many other ways, some quite elaborate, to provide the practitioner a productivity incentive. However, try to keep the incentive plan as simple as possible. Complicated incentive strategies can actually be a disincentive. In addition, keep in mind that income guarantees and incentives are the most fertile ground for legal problems.

Fee for Service – In rural recruitment, the fee for service compensation arrangement is seldom part of the initial offer. Very simply, the practitioner's annual income is whatever he or she earns in patient revenues after expenses. Today, very few providers are interested in this type of arrangement, at least in the first two years of practice in a new community. Once the provider develops an adequate patient base, however, many physicians prefer switching to fee for service, because the earning potential is often higher than the salary or guarantee.

Percentage – This type of arrangement is most common when a provider is recruited into an existing practice with multiple providers. A certain percentage based on productivity, seniority or status (full partner or associate status) is guaranteed the candidate. Percentages are often used on top of salary or income guarantees to ensure the new provider is aggressive in building and maintaining his or her new practice.

Income averages for primary care providers vary widely from region to region, from rural to urban areas, and among primary care physician and midlevel types.



Compensation Surveys – Physician and other compensation surveys are very helpful, if not essential, to being competitive in recruiting a provider. Surveys may often be accessed on the internet or at no or little cost. For example, the 2008 AMGA survey is available at:

http://www.cejkasearch.com/compensation/amga_physician_compensation_survey.htm

However, care must be taken when using surveys. It is highly recommended that you check several surveys. *Modern Healthcare* publishes compensation surveys as do recruitment firms. Recruitment firm surveys should be viewed with care since sample sizes tend to be small and the firms’ motivation is frequently to make placements using large compensation figures.

Survey Example

The 2008 AMGA Medical Group Compensation and Financial Survey is a nationally recognized compensation survey designed to assist various management levels in evaluating and comparing current physician compensation and productivity levels, trends, and relationships between compensation and productivity. The report and its data can assist in making compensation-related decisions for a medical groups’ physicians, non-physician medical staff, and select administrative positions. The table below is a sample of the kind of data provided by AMGA.

Sample - 2008 AMGA Medical Group Compensation and Financial Survey

Specialty	Average	Starting	East	West	South	North
Family Medicine	\$190,182	\$130,000	\$160,985	\$204,950	\$194,733	\$181,416
Family Medicine with OB	\$200,565	\$135,000	\$191,203	\$214,473	\$159,004	\$201,156
General Surgery	\$337,595	\$222,950	\$295,500	\$337,814	\$309,476	\$364,167
OB/GYN	\$283,110	\$197,000	\$254,426	\$293,995	\$273,245	\$296,104
Internal Medicine	\$199,886	\$140,213	\$173,406	\$223,227	\$192,732	\$187,004

Compensation surveys are not always clear about sample size, and components included in compensation may vary from survey to survey. When reviewing compensation, you are reminded to talk with your CEO or CFO and review available information. Start with a Google search using descriptors of: physician compensation, physician salary surveys or specialty specific salary survey.



Benefits

A competitive compensation package includes more than just a competitive income. A strong compensation package also includes a good scope of benefits. Most benefit packages today for a primary care provider may include the following:

Benefits	Cash Value
Paid malpractice insurance	
Paid family health insurance	
Paid dental insurance	
4 Weeks paid vacation/2 weeks CME leave	
Holidays observed by clinics when closed	

Competitive benefits packages also include the following:

Short term disability insurance or sick leave	
Long term disability insurance	
Paid relocation expenses	
Life insurance	
Retirement plan/401(k) plan	
Paid professional dues	
State license fee and renewal fee	
Education loan repayment assistance	
Signing bonus, if used	
Practice management assistance	
Practice marketing assistance	
Housing allowance	
Other benefits	
Total Cash Value of Benefit Package =	\$



To present your compensation package in the best possible light, assign a dollar value to each benefit you offer in the blank space to the right of each benefit listed above and add this dollar amount to your annual income offer. You will be surprised how much more attractive your compensation offer will look to prospective candidates when you show them the total value of your package in hard dollars. A good benefit package will usually increase the size of your offer by at least 30 percent or more of the annual income. Don't short change your whole offer; price out your entire compensation package!

In your compensation package, articulate the non-monetary benefits or perks of your opportunity. While perks do not make up for a weak compensation package, they could tip the scales in your favor when comparing your opportunity to another. The value of perks is the positive professional atmosphere they create for providers practicing in your community. Check all the perks below that your opportunity potentially has to offer:

- Light call or coverage schedule (less than one out of every four days and one out of every five weekends)
- Teaching opportunities (preceptor)
- Established patient base
- Visiting specialists
- Office located close to hospital
- Remarkable hospital or clinic technology
- Medical staff of similar age and interest as candidate
- Desirable geographic location and climate
- Outstanding community attributes
- Decision making role in hospital and health care system
- Telecommunication links with specialists and advanced technology
- Community involvement and leadership opportunities
- Electronic medical records
- Health information technology

Community Profile

“When you've seen one rural town...you've seen one rural town.”

In many cases, there will not be a big difference between the professional aspects of your opportunity – setting, responsibilities and compensation – and the professional aspects of practice opportunities in surrounding rural communities. This means the candidate's decision whether or not to practice in your community will be driven by how the candidate, spouse and family feel about your community. Therefore, how you define and present your community to each candidate is vital to the success of your recruitment effort.

When profiling your community, imagine yourself a first-time visitor to the community who is contemplating a move to there. What would you want and need to know? Chances are the information that would be important to you would also be important to a



provider candidate. Develop a community profile for candidates, including the following information, as well as any other information you would like to add:

Demographics: Describe the population in terms of size, age groups, values, ethnic and religious diversity, educational and socioeconomic backgrounds of the residents, and so on. It would also be helpful to provide some insight into why people like to live in the community.

Location: Create a written and pictorial description of the community in scenic or aesthetic terms and in terms of miles and minutes to metropolitan areas, major highways, major airports, to well-known locations and recreation areas, and to other remarkable areas of interest. A description of local geography and climate is also important.

Economy: Describe the current and forecasted economic health of the area. Include a list that shows the major economic contributors in the area, major employers, employment rates and employment by sector, average income and so on. Also provide a description of the housing market in terms of availability, types and prices.

Local Organizations: Highlight the professional, social and civic organizations in the community, detailing their membership and the level of participation and support enjoyed by each group.

Shopping: Describe the various shopping and local consumer services available in the community and available within a 90-minute drive of the community. Does your community cover the basics: banking, groceries, clothing, automobile repair, household maintenance, hardware, restaurants, and so on?

Education: Describe the preschool through high school educational system in terms of grades, public and/or private, academic performance, class sizes and student-teacher ratios, educational facilities (computers, etc.), and extracurricular activities (music, art, academic, civic, athletic, etc.). Include information on post-secondary, undergraduate and postgraduate opportunities in the community and region, including colleges and universities (list their specialties), college outreach courses, and technical schools. Finally, indicate the community's attitude toward education, and how it demonstrates this attitude, i.e., tax support, attendance for parent-teacher conference, membership in the PTA or PTO, school awards and so on.

Culture: Relate some of the history of the area and its people. A list of the social activities, churches, media, museums, libraries, arts councils, amateur theatrical groups or activities, musical outlets, special events and celebrations, local entertainment resources (movies, dancing, etc.) and so on would also be helpful information. How does your community express itself? What exactly do residents do to reinforce who they are, their local identity, and their heritage?

Recreation: Describe what residents do in your area for fun and play and where they go (give miles and minutes from your community). Outdoor recreation along with scenery



and small population are strong selling points for your Contract Negotiator, so a written and pictorial guide to your area's outdoor recreation and scenery is a must.

Employment Opportunities: Provide a list of employment opportunities and challenging volunteer opportunities in the immediate area or within a reasonable commute for the spouse and family.

For more specifics on what information to include when profiling your practice, compensation package and community, see the sections titled "Questions Commonly Asked by Candidates and Spouses."

Packaging Your Opportunity

Now that you have fully defined your opportunity, you are ready to package that information. Packaging involves translating the three parts of your opportunity into promotional materials. While some communities have developed videos to promote their opportunities, the basic opportunity packet remains the staple in most communities' practice opportunity promotional effort.

The practice opportunity packet consists of the following:

- Cover letter
- Letter from the medical staff
- Practice opportunity description
- Promotional materials on your community or area

Cover Letter

The cover letter should be brief – two to three paragraphs at the most. It should introduce you to the candidate and spouse, direct the candidate to read the other materials in the packet, and invite the candidate to contact you (or the designated contact person). Of course, if you have talked with the candidate, you will acknowledge that discussion as well. The letter should be concisely written on the lead organization's official letterhead. Finally, all appropriate stakeholders, including the recruitment team recruiter and contact person, clinic and hospital administrators, and chief of the medical staff, should sign the letter.

Letter from the Medical Staff

This brief letter should be a warm invitation from the medical staff to the candidate to investigate your opportunity. The content of the letter should demonstrate the medical staff's approval of the recruitment effort and desire to bring in another primary care provider. All members of the medical staff should sign the letter.



The Opportunity Description

The practice opportunity description should be an informative promotional piece. Not only should the description fully explain your opportunity, it should do so in a concise and creative fashion. Primary care provider candidates receive written information on dozens of opportunities a week. If your description is not visually appealing, is too long or is just plain uninteresting, your opportunity probably will not be read, much less pursued, by many candidates. A good description contains the following elements in two pages or less:

- Attractive graphics or photos
- Attractive font type
- Attractive layout
- Use of short bulleted statements
- “An angle” or your greatest selling point or unique selling point that sets you apart from other opportunities
- Emphasis on the most attractive elements of your opportunity
- Details of the practice including setting and responsibilities, compensation, and the community aspects of your opportunity discussed earlier
- Day and evening contact information, including mailing address, phone number and FAX number.

The Spouse Perspective

QUESTION: What is it like for you and your children to live in a rural community and to be the spouse of a rural physician?

Laurie Thomson (husband, Jim, is a family practitioner in Emmett): It is a very positive experience for the kids to grow up in Emmett. There is a lot to do, and it is safe here. The kids ride their bikes to practices and walk to school, and I don't have to worry about their safety. It [being the spouse of a rural physician] can be stressful because Jim is not always home, but that is getting better.

Gary Thompson (wife, Joan, is a family practitioner): Being the spouse of a physician can be terrible because of the call schedule. Joan is on call every fourth day and on emergency call every day, so it makes it hard to get away. However, we do like living in a rural community.

Cherrie Johnson (husband, Steve, is family practitioner): I prefer to raise children in a rural area. It is important that I have family here though, because my husband is gone a lot.

Kitty Spencer (husband, Mark, is a family practitioner): There are things we gave up by moving here. But having grown up in a small community, I was more accustomed and prepared for it. It is tougher being married to a rural physician. Our lives are less private. We can't get “lost” as easily. I end up being a leader in the community whether I want to be or not.

Ann Haller (husband, Fred, is an internist): We moved here so we could raise our children in a rural community. My son knows how to canoe and swim and helped underprivileged kids in a project called “Hope”. They wouldn't be able to do these things if we hadn't moved here.



Promotional Materials (on your community and/or area)

Chambers of commerce, local tourism bureaus, local economic development organizations and state economic development agencies usually have many different kinds of promotional pieces describing your community or region. These include maps, brochures, flyers, posters and even videos. The more colorful your materials are, the more photos, the more creative, the better. If you have a lot to choose from, pick those promotional pieces that best reinforce what you believe the candidate and family will find appealing about your community.

Use your Opportunity Promotional Team to put together the opportunity packet. If, indeed, you tapped the creative heads of your community for this team, they will not disappoint you. A good writer or marketing type will know what to say about the opportunity and how to say it, and a good artist, graphic designer or layout person from your local newspaper will know how to present it. And as a team, they will have fun doing it while feeling a part of an important cause.



step 5 define the ideal candidate

You have defined who you are and what you have to offer. Now you need to define who you want to offer the position to. Who is the ideal person for your practice opportunity and for your community? What professional and personal traits does he or she possess? Communities that fail to clearly define the ideal candidate and those traits that make up the ideal candidate usually end up with the wrong provider – which means a provider of poor quality and/or a provider who does not stay long in the community.

The ideal candidate identification process begins with bringing together your entire recruitment team, other key stakeholders from the health care system and from the community at large for a 90-minute brainstorming session. The meeting should be held in a comfortable and casual setting with plenty of refreshments to keep the mood upbeat. For supplies, you need index cards, a flipchart stand and paper, extra pens or pencils, and masking tape.

Once everyone is situated, follow these steps:

1. Define for the group the term “ideal candidate.” This is someone whose professional and personal background is highly compatible with the needs of the health care system and with the personality of the community.



2. Ask each member to list on an index card:
 - a) The professional attributes needed for your opportunity and desired by the community, such as specialty; scope of clinical knowledge and expertise; educational background; years of practice experience; practice experience in a community similar to yours; bedside manner; work ethic; career goals; professional credentials and record; and working style with physicians, midlevel providers, nursing staff, hospital and clinic administration.
 - b) The professional attributes least desired by your health care system.
 - c) The personal attributes most desired and necessary for fitting into the community, including personality traits; recreation/social/cultural interests; social background; past places of residence; political leanings; physical health.
 - d) Attributes in the spouse and family most desired and necessary for fitting into the community; including: spouse's professional interests; personality traits; political leanings; recreation/social/cultural interests; social background; previous places of residence; educational background; educational needs of the children; recreation/social/cultural interests and needs of the children.
 - e) Least desirable personal attributes for the candidate, spouse and family.

Allow the participants five minutes of silent time for each area above to gather and record their thoughts. This accommodates different thinking speeds among the group members.

3. Let each group member share one item at a time from his/her list and go around the group until everyone has exhausted their lists. Allow group members to build on one another's ideas.
4. Record all the groups comments on a flipchart, placing the comments under the appropriate category:

Desirable Professional Traits

Undesirable Professional Traits

Desirable Personal Characteristics

Desirable Candidate, Spouse and Family Characteristics

Undesirable Candidate, Spouse/Family Characteristics



5. Allow the group to go over the lists to clarify, discuss, change and gain consensus on characteristics contained in each list.
6. Prioritize the characteristics by giving each participant five “sticky dots” for voting on professional characteristics and five “sticky dots” for voting on personal characteristics, including the spouse and family. Explain that each dot represents a vote, and participants can place all their dots on one characteristic, vote for five different characteristics under the professional and personal categories, or place any combination of dots on the characteristics such as three dots on one and two on another. Allow the participants five minutes to vote by placing their dots on the appropriate area of the flipchart.
7. Once all the votes are cast, count them up by each characteristic. You now have a prioritized list of the most desired characteristics and attributes of the candidate who will make the ideal provider for your community – and a list of the least desired traits.

You probably will not be surprised by the group’s final prioritized list of characteristics. You may have ended up developing a similar list entirely on your own. But, the objective of the ideal candidate identification process was not just to create a list, but to involve the community in selecting its next primary care provider. The closer your next provider matches their stated expectations, the more pleased the community will be with the provider, thus increasing patient utilization.

Chances are you will not find *the* ideal candidate. But you should strive to recruit the candidate who most closely fits your community’s ideal. The closer the candidate matches your ideal, the easier it will be to recruit and retain that provider.

The process of defining the ideal candidate also prepares you for the next two phases of the recruitment process: Searching for Candidates and Screening Candidates.

By better understanding the type of candidates you seek, you can target your promotional effort to appeal to this type of individual. By understanding the ideal candidate’s professional and personal characteristics, you can develop very specific candidate screening tools such as candidate, spouse and reference interview questionnaires, to determine whether or not the candidate possesses the traits of the ideal provider.



SPECIAL SECTION

What is a D.O.?

There are two types of complete physicians in the United States. One has a M.D. (doctor of medicine) degree, and the other has a D.O. (doctor of osteopathic medicine) degree. So what's the difference?

D.O.'s and M.D.'s are alike in that they both utilize all scientifically accepted methods of diagnosis and treatment, including the use of drugs and surgery. Educational requirements are the same, and in most instances, D.O.'s and M.D.'s are examined by the same state and licensing board. In other words, most boards of examiners make the same requirements for and give the same or comparable examination to M.D. or D.O. candidates. Osteopathic physicians are licensed to practice all phases of medicine in all of the 50 states of the Union.

Physicians and surgeons who are D.O.'s, do, however, have an additional dimension to their training and practice, one not taught in medical schools giving M.D. degrees. The D.O. recognizes the musculoskeletal system (the muscles, bones, and joints) makes up over 60 percent of body mass. He or she also recognizes that all body systems, including the musculoskeletal system, are interdependent, and a disturbance in one causes altered function in other systems of the body. Physicians and surgeons, D.O., use structural diagnosis and manipulative therapy along with other more traditional forms of diagnosis and treatment to care effectively for patients and to relieve their distress.

Virtually all students entering colleges of osteopathic medicine hold bachelor's degrees, and many have advanced degrees. In addition to a broad cultural background on the undergraduate level, an entering osteopathic student must have completed a required number of hours in physics, biology, and inorganic and organic chemistry.

All prospective students must take the Medical College Admission Test, with scores sent to the osteopathic colleges they wish to attend.



After graduation from a college of osteopathic medicine, a D.O. serves in one of more than 161 internships in hospitals with intern training programs. Currently 161 hospitals in all, as well as the osteopathic colleges, are accredited by the American Osteopathic Association. The AOA is recognized as the accrediting agency for osteopathic medicine by the federal government, the Council on Post-secondary Accreditation, and the respective state licensing boards.

Because of the osteopathic profession's high standards, AOA accreditation means automatic participation in government programs such as Medicare and Medicaid.

Osteopathic physicians and surgeons (D.O.s) may go on to specialize in any of the recognized and accepted medical specialties by taking residency programs in osteopathic institutions and applying to specialty boards.

Although the osteopathic profession is a minority in group size, statistics show that over 10 percent of the public, some 25 million Americans, turn to osteopathic physicians for their complete health care.

D.O.'s are not chiropractors. Neither are they bone specialists nor physical therapists. They are not M.D.'s because they graduated from colleges of osteopathic medicine, which were founded to award D.O. (Doctor of Osteopathy) degree. Only D.O.'s and M.D.'s are qualified to be licensed as physicians, and to practice all branches of medicine and surgery.

Some 65 percent of active D.O.'s provide primary health care to individuals and families. Two-thirds of all D.O.'s are located in towns and cities with less than 50,000 people. In many communities, D.O.'s are the principal providers of health care. The federal government, state governments and private and public health agencies have recognized osteopathic medicine as a separate but equal branch of American health care. As a result, osteopathic physicians have the same rights and the same professional obligations as allopathic (M.D.) physicians.

Excerpts taken directly from "What is D.O.? What is an M.D.?" and "Osteopathic Medicine" two public information pieces published by the American Osteopathic Association



SPECIAL SECTION

About Physician Assistants and Nurse Practitioners

Physician assistants and nurse practitioners are often referred to as midlevel providers or as physician extenders, although neither profession is overly fond of these generic labels. Because of the shift toward primary care in America, physician assistants and nurse practitioners are in greater demand than ever before. This, of course, is making physician assistant and nurse practitioner recruitment more difficult and more expensive.

In rural communities, physician assistants and nurse practitioners are most commonly found in solo satellite practices and in small primary care physician groups in larger rural towns. Utilization of physician assistants and nurse practitioners varies by state and locale. Licensure, supervision, or collaboration requirements affect the utilization of these health professionals.

Despite growing acceptance and utilization of physician assistants and nurse practitioners, many patients are still uncomfortable seeing such providers, and many physician and hospitals are uncertain about their capabilities and limitations. Of course, most of this discomfort and uncertainty stems from a lack of knowledge or familiarity.

The Physician Assistant Background

In the 1990's, demand for physician assistant or "PA" services rapidly increased nationwide. At that time, six jobs existed for every new PA graduate. Currently, although employment opportunities exist, the demand seems to have leveled off. There appear to be many more PAs looking for employment than actual vacancies.

Typically, a physician assistant must:

- Be a graduate of an accredited PA program;
- Be nationally certified by passing a national certifying examination (State requirements vary regarding ongoing needs for continuing education and/or ongoing national certification.);
- Be re-certified every "X" years;
- Complete "X" hours of continuing medical education every two years; and,



- Be under the supervision of a licensed physician.

It may not be necessary for the supervising physician to be located in the same building or even the same town. Some state laws allow the supervising physician to be away from the practice or in another town when the PA is seeing patients. Only those with current certification can use the credentials of Physician Assistant-Certified or “PA-C”.

Scope of Care

PA’s can provide a scope of care ranging from primary medicine to specialized surgical care, depending on their education and experience. A properly prepared PA can perform approximately 80 percent of the duties performed by most primary care physicians. PA’s perform physician examinations, diagnose and treat illness, set fractures, and assist in surgical procedures.

Education

PA’s are trained in accredited PA programs in the United States. These programs are located in medical schools, universities, teaching hospitals and in the Armed Forces. PA programs are accredited by the American Medical Association’s Committee on Allied Health Education and Accreditation.

The typical PA student has a bachelor’s degree and over four years of health care experience. A typical PA program is 24 months long. The first year in training is spent mostly in the classroom, providing students with in-depth understanding of medical sciences. The second year is devoted to clinical rotations. Once graduated, PA’s must pass a national certifying examination as a requirement for state licensure.

Source: Heidi Layer, PA-C, Idaho Academy of Physician Assistants, and the American Academy of Physician Assistants.



The Nurse Practitioner Definition

Nurse practitioners are registered nurses with advanced education and clinical competency necessary for the delivery of primary health and medical care.

Rules governing nurse practitioners differ depending on individual state laws. Typically, a nurse practitioner must meet the following requirements:

- Hold a current license in good standing as a professional nurse.
- Possess a baccalaureate degree in nursing from an approved nursing education program.
- Possess evidence of successful completion of a nurse practitioner program accredited by the National League of Nursing or the American Nurses' Association or its equivalent as determined by the State Board of Nursing.

Like the physician assistant, the supervising physician may not need to be on site to supervise the nurse practitioner. The supervising physician and nurse practitioner must meet on site at least once a month, hold regularly scheduled conferences, conduct a periodic record reviews and reviews of medical services rendered by the nurse practitioner. The supervising physician also must be available to the nurse practitioner in person or by telephone.

Scope of Practice

A nurse practitioner can provide the following cares and services:

- Evaluate the physical and psychosocial health status through comprehensive health history and physical examination, including the performance of pelvic examinations and pap smears;
- Initiate appropriate laboratory and diagnostic studies to screen or evaluate the patient's health status and interpret reported information in accordance with protocols and knowledge of the laboratory or diagnostic studies, provided such studies are related to and consistent with the nurse practitioner's scope of practice;
- Diagnose and manage minor illness and conditions;
- Perform uncomplicated deliveries if also a certified nurse midwife;



- Manage health care of the stable chronically ill patient in accordance with protocols for management of the medical regimen;
- Institute appropriate care which might be required to stabilize a patient's condition in an emergency or potentially life-threatening situation until physician consultation can be obtained; and,
- Repair minor lacerations with no nerve, tendon, or major vessel involvement, after consultation with the supervising physician.

The rural nurse practitioner is most commonly found in the family practice and preventive health care setting. Alone and/or with the supervisor physician's assistance, the rural nurse practitioner can assess health status, diagnose, develop a treatment plan, implement that plan, prescribe certain medications, follow up and evaluate progress, provide patient health education, facilitate patient participation in self-care, promote optimal health, and facilitate entry into specialized area of health care.

Sources: Idaho Nurses Association, State Board of Nursing, State Board of Medicine, and American Academy of Nurse Practitioners.



step 6 create a recruitment budget

Before you begin your candidate search and incur real recruitment costs, you need to develop a recruitment budget. The budget worksheet that follows gives you an idea of all the different types of costs involved in the recruitment process over and above the compensation package.

Recruitment Budget Worksheet

Date: _____ / _____ / _____

Provider Specialty Sought: _____

Length of the Budget Period: _____ months

Recruitment Period: _____ / _____ / _____ through _____ / _____ / _____

Estimated Total Recruitment Budget for Period: \$ _____

A. PROMOTION/PUBLICITY

1. Promotional Materials

- a. Talent fee (i.e. graphic artist, photographer, writer, video) \$
- b. Printing (display ads, brochure, flyer, duplication) \$
- c. Materials (stationary, envelopes) \$
- d. Other \$

Total Materials: \$ _____

2. Advertising (list each internet site, journal or other media used)

- a. \$
- b. \$
- c. \$

Total Advertising: \$ _____



3. Professional Recruitment Assistance (recruitment firms, candidate sourcing services, etc.)

a. \$

b. \$

Total Recruitment Professional Assistance: \$ _____

4. Direct Marketing

a. Mailing lists \$

b. Postage \$

c. Other \$

d. Other \$

Total Direct Marketing: \$ _____

5. Person-to-person Recruitment

a. Residency program visits (include travel) \$

b. Conference recruitment displays (include travel) \$

c. Other \$

d. Other \$

Total Person-to-Person Recruitment: \$ _____

6. Other Promotion/Publicity

a. Toll-free number \$

b. Give-aways for conferences or interviews (pens, calendars, etc.)\$

c. Other \$

Total Other Promotion: \$ _____

TOTAL PROMOTION AND PUBLICITY EXPENSES \$ _____



B. CANDIDATE SCREENING EXPENSES

1. Phone Interviews (30-45 minutes per call or about two hours per candidate)
 - a. Out-of-state candidates \$
 - b. Out-of-state spouses \$
 - c. In-state candidates \$
 - d. In-state spouses \$
 - e. Other \$

Total Phone Interviews: \$ _____

2. Credentials Checks

- a. Background Check \$
- b. Credential Verification (5-10 minutes/call) \$
- c. National Practitioner Data Bank IF your facility is allowed to query it.
Otherwise, ask provider to do a self-query.
- d. Other \$

Total Credentials Checks: \$ _____

3. Reference Checks

- a. Phone references (15 minutes per call) \$

Total Reference Checks: \$ _____

TOTAL CANDIDATE SCREENING EXPENSES \$ _____

C. SITE VISIT AND PERSONAL INTERVIEWS

1. Out-of-state candidates and spouses
 - a. Airfare \$
 - b. Ground transportation \$
 - c. Lodging \$
 - d. Meals \$

2. In-state candidates and spouses

- a. Mileage reimbursement \$
- b. Lodging \$
- c. Meals \$
- d. Other \$

Total In-State Candidates/Significant O/Spouses: \$ _____

2. Site visit social gathering

- a. Caterer/sponsored meal \$
- b. Other \$

Total Social Costs: \$ _____

TOTAL SITE VISIT EXPENSES \$ _____

D. PERSONNEL

1. Current Personnel

- a. Time away from primary duties \$
- b. Bonus pay for extra duties \$
- c. Other \$

Total Current Personnel: \$ _____

2. Temporary Personnel

- a. Hired local recruitment recruiter \$
- b. Locum tenens coverage until new provider is recruited \$
- c. Other \$

Total Current Personnel: \$ _____

TOTAL PERSONNEL EXPENSES \$ _____



E. OTHER COSTS

1. \$

2. \$

3. \$

TOTAL OTHER EXPENSES \$ _____

TOTAL RECRUITMENT BUDGET \$ _____

Potential Barriers to Recruitment and Retention

When you have completed the preparation portion of your recruitment effort, but before you begin searching for candidates, you will want to take an objective look at your opportunity. What are the real strengths of your opportunity? Are they clearly promoted? What are the weaknesses of your opportunity? Can you improve upon these weaknesses?

The following checklist is designed to assist you in identifying weaknesses or barriers to recruiting and retaining providers in your community. Do any of these barriers exist in your community? Do you have other barriers not listed here? For every barrier you check or add to the list, try to develop a strategy for removing or minimizing that barrier.

- No or low compensation/guarantee
- No malpractice insurance assistance
- No or few benefits
- Heavy call schedule (over 1 day in 4)
- Poor physician retention history
- Large out-migration of local patients
- Hospital/medical staff have poor community image
- Older hospital facilities (physical plant and/or technology)
- Inadequate clinic facilities
- Lack of basic consumer services and amenities
- Large Medicare/Medicaid population
- Competing health care system in community
- No other local physicians
- Health care leadership in turmoil
- Interpersonal conflicts between hospital (administration, board and/or staff) and physicians
- Lack of experienced practice managers in your office
- Poor clinic billing and coding practices
- Lower quality education system
- No local K-12 education system
- Severe climate
- Religious homogeneity
- Aging medical staff
- Large uninsured population
- Interpersonal conflicts among physicians
- Few professional opportunities for spouse
- Lack of housing
- Hospital experiencing financial troubles
- Depressed local economy
- Lack of extra-curricular activities for family
- Poor collections history
- No obstetrics back up
- Community is located over three hours from regional medical center
- Recruitment effort not supported by all local physicians
- Inexperience in physician recruitment

Most Common Barriers

- Excessive call and coverage schedule
- Few professional opportunities for spouse
- No or low compensation guarantee
- Few benefits

See 'Roadblocks to Recruitment' (pp. 124-125).



PartTwo

searching for candidates

step **7** generate candidates

Community Development

Announcing your opportunity locally is the first step in the candidate search. You can then proceed to the statewide, regional and national levels in that order. This gives you every chance to keep recruitment costs down in the event a local source can alert you to a good candidate lead. As a general rule, the farther your message travels, the more expensive that message is to deliver. So begin your search by tapping local sources of candidates such as the local stakeholders described earlier. The most likely sources of referrals are local physicians and mid-levels that may know of a colleague interested in your opportunity. Local residents, especially patients of the practice, may have a friend or a relative who would enjoy practicing in your community.

The organizers of the recruitment plan should involve many members of the community to publicize the recruitment needs. There are multiple benefits to broadly disseminating information regarding recruitment:

- The community will be notified that there is interest in increasing capacity. Many times, a community member may have a relative who is involved in the health professions.
- In addition, most people want to support their health professionals. Encouraging them to participate strengthens not only the recruitment process, but the retention of the new community member.

On the state level, the following organizations could help in promoting your opportunity and/or generating candidates:

- your local medical association or local chapter of the Academy of Family Physicians
- hospital association
- State Office of Rural Health
- State Office of Primary Care
- State Office of Public Health
- State Department of Labor
- Area Health Education Center
- medical schools



- residency programs
- nurse practitioner and physician assistant programs
- your state's 3RNet Organizational Member*

On the regional level, contact:

- your United States Public Health Service Regional Office
- National Health Service Corps (NHSC)
- area medical schools and residency programs
- area nurse practitioner or physician assistant programs

The last section in this manual contains a listing of resources. Refer to Page 113.

Internet

In recent years, the internet has radically changed most of our lives. The growth of internet recruiting sites have changed the scope and range of our searches and heightened the mobility of our workforce. The same is true for recruitment of health care professionals. When surveyed, graduating residents indicate that as much as 75% of their search efforts have been dedicated to the internet. Based upon that information, no recruitment campaign can develop a representative pool of candidates that results in a successful placement without a presence on the internet.

There are a number of different types of sites on the internet that propose to help recruit providers, with different costs and effectiveness. Most websites charge an annual or per posting fee, while some may be free with membership in an organization.

- **Low cost/no cost** - Membership in organizations such as the Association of Staff Physician Recruiters(ASPR), the National Association of Community Health Centers(NACHC) and the Academy of Family Physicians(AAFP) may provide for access to a national posting board (though targeted to their members) for low or no cost to the advertiser. In addition, many for-profit corporations will open sites that are free in hopes that you will make use of their Locum Tenens or permanent placement services.
- **Fee for service sites** – included in this group are those sites that charge an annual membership fee and those that charge posting or service fees. In addition, many of them offer other functions that are available as part of the package membership fee or that can be purchased off of a menu of services available.
- **Functions** –Each of the sites performs searches in a different way or with a different array of services. Some provide a searchable database that can be accessed as part of the membership, or at a supplemental charge, and many of them will notify you if a candidate accesses your posting. In many cases, you may be notified when a candidate selects your posting or indicates some other type of interest in your opportunity.



When deciding on which sites to use, rely on experts in the field, like other recruiters in your “network” who have used internet sites in the past. Always check references for websites, even if only using them on a one-time basis. You will want to ask some of the same questions for websites as those recommended for recruitment firms (p.73).

3R Net

The (3RNet) National Rural Recruitment and Retention Network is a not-for-profit organization that assists health professionals in locating practices throughout rural America. It is the largest and only website dedicated to providing a venue for rural and underserved communities to find providers. You can log onto their web site at <http://www.3rnet.org> and find out whom to contact in your state for recruitment assistance. The 3RNet is comprised of other not-for-profit organizations, including State Offices of Rural Health, Area Health Education Centers, cooperative agreement agencies and State Primary Care Associations. These organizations have information on rural practice sites in their states and can utilize the 3RNet web site to post vacancies. In some states, the participating organization may assess fees for assistance. For information about the 3RNet: contact 800-787-2512 or email info@3rnet.org.

Classified Advertising

Classified ads used to be the most commonly used form of advertising for promoting practice opportunities around the country before the advent of internet based advertisements. They are usually placed in regional or national medical and professional journals. Using newspapers’ classifieds to promote your opportunity is not wise. The cost can be excessive, and primary care providers generally do not peruse the classifieds seeking work. Print classifieds may be bundled with other services, such as web classifieds or internet posting boards, to enhance their penetration in the market and make them a better value overall.

To improve the results of your advertising, apply the simple AIDA model when drafting your ads and designing all your promotional materials:

1. Get the candidate’s **A**ttention
2. Generate **I**nterest in your opportunity
3. Create a **D**esire for more information on your opportunity
4. Urge them to take **A**ction right away.

There is no evidence that elaborate or complicated display classified ads in journals generate more candidates than simple classified ads in the same journals. Display ads may be useful in situations where you are recruiting for multiple providers and are actually marketing the entire community, since they lend themselves to attractive graphics and pictures of rural scenery. However, since display advertisements are much



more expensive, you may want to stick to simple classified ads – concisely and creatively written, of course. Regardless of the type of ad used, any print ad should include an e-mail address, your website and an “800” number if you have one. If it is necessary to cut space or cost, leave off the physical address of the site.

An advertisement should pique the reader’s interest and help him or her determine whether or not to consider your opportunity.

Avoid writing ads like this, which all too frequently litter the classified sections of today’s medical journals:

“Rural southwest Texas practice seeks BC/BE, FP/GP, MD/DO.... Must do OB... Competitive salary. Contact...”

An ad like this may save you a few dollars with its brevity, but is sadly lacking in “punch” or attention-grabbing qualities. This ad will not excite potential candidates due to the lack of any interesting information about the opportunity or your community. It is essentially a waste of money, since a well-composed ad, though costing a little more, might bring you the right candidate if carefully crafted. Pull out your opportunity description information and promote a couple of the really positive and unique attributes of your opportunity.

Direct Mail

Direct mail can be an effective method of directly reaching targeted individuals and identifiable groups. A direct mail effort could be as broad as all physicians practicing in the United States or as narrow as a single physician in a specific town.

The acronym “BLT” is helpful in developing lists, which can target physicians who were Born, Licensed or Trained in your state or surrounding states.

Direct mail lists containing physician names and addresses can be purchased through direct mail houses that have contracts with the American

Tips for writing a good classified ad

- Use a short, catchy headline; consider bold or colored type if available.
- Write the ad as if you were speaking about your opportunity to your ideal candidate face to face.
- Remove words like “a” or “the” if they do not seem necessary.
- Use only commonly accepted abbreviations.
- Only use the name of your town in the contact information. Unless your town is a familiar destination such as San Francisco, the name means nothing to most candidates. Creatively and briefly describe the area instead.
- Once your ad is written, compare it to the AIDA model. Does it fit?
- When candidates respond to your ad, ask them why they responded, what they liked about the ad and what information in the ad was not particularly helpful.
- Place your ad in journals or newsletters targeted at the specific primary care provider type you seek. For example, the *American Family Physician* or *AFP* is the journal for the American Academy of Family Physicians, and thus read by many primary care providers. In contrast, *JAMA* and *New England Journal of Medicine* are highly regarded but read mostly by many specialists you do not need to reach. You would be paying to advertise to an audience that included few potential candidates.
- Always include an e-mail response address, your website and/or “800” number, if you have one, to allow for quick and simple responses.



Medical Association. The AMA will provide you with a list of licensed contractors upon request. Some specialty academies and societies such as the American Academy of Family Physicians also sell mailing lists. These lists are usually for single use only. That is, the vendor has you sign a contract agreeing to only use the mailing list once. Some claim they salt the lists with erroneous addresses to detect repeat mailings. In addition, some State Medical Boards will provide a list of physicians in your area, or in your state, for a nominal fee. Though they may be inexpensive, these lists are notoriously inaccurate, as the information on them comes at the time of renewal and may be a few years old. From experience, we urge you to shop around before purchasing a list from a vendor. Prices and quality of results may vary greatly.

To increase the effectiveness of your direct mail effort:

1. Use your ideal candidate composite to determine how to target your direct mail effort based on ideal candidate characteristics. The direct mail house tracks candidates using a variety of demographics, so its representatives can help you translate these characteristics into a targeted mailing list. Try to get as specific as possible. Not only will this shorten the list and keep your total cost down, it will definitely generate more qualified candidates per one hundred addresses.
2. Make your direct mail piece attractive but brief. Again, apply the AIDA model when drafting your direct mail materials. A colorful postcard may be all you need if you have included a way for candidates to access information about the opportunity and your community. Remember to clearly show your contact information, including website, e-mail address and relevant info that you would like the candidate to submit initially. The sooner you respond to the candidate, the more likely he/she will respond.

Do not be discouraged by a low response rate to your direct mail effort. The standard for a successful direct mail effort is a 2-3 percent response rate. If you do not have a large pool of potential candidates, you may want to carefully consider the cost and potential benefits of this approach.

Other Sources of Candidates

Working with an organization that participates in the 3RNet is usually a very inexpensive way to obtain detailed information on candidates. In addition, they can promote your opportunity to candidates nationwide.

Other sources may include medical associations, medical schools and residency programs, state loan repayment programs, and recruitment firms.

Each state should develop and maintain an up-to-date list of resources (see Part Five of this manual) for entities assisting in recruiting. This could include job fairs, “meet the residents” lunches or other direct contact programs, pipeline program information, instructions on using email effectively to correspond with candidates and useful web sites, among others.





Is rural living for you?

Not everyone is cut out for rural life. Even fewer are cut out to be primary care providers in rural communities. Although visions of “A River Runs Through It” or dreams of a slower pace of life attract many providers to rural areas every year, few actually stay.

How can you as a recruiter interested in not just attracting a provider, but keeping the provider as well, identify a provider who will be a happy and successful rural practitioner and one who will not? Short of a complete personality inventory, there is probably no sure way. But the following checklist from the American Academy of Family Physicians written for family docs considering rural practice could prove helpful. You may want to figure a way to work it into your candidate screening process.

If you can check most of these statements, you may be suited for rural practice.

- I want to practice the full range of family practice.
- My family and I would enjoy a rural lifestyle.
- I am willing to assume a position of leadership in the community.
- I am willing to take an active role in civic and community groups.
- I can handle intermingling of my personal and professional roles.
- I want to fulfill a vital community need.
- I am challenged by rural health issues and see myself as an “agent for change.”
- I enjoy being involved in my patients’ lives.
- I would enjoy a close-knit community.
- I am adept at developing linkages between physicians and facilities.
- I don’t mind a busy practice as long as there’s a balance in my life.
- I believe that rural practice will give me back more than I put in.

To this list, you may want to add:

- My spouse and I are familiar with rural life and appreciate the pros and cons of rural living.
- I am comfortable practicing the full scope of family medicine isolated from specialized consultation and technological resources.
- I am confident in my emergency medicine skills and knowledge.



Recruitment Firms

While we do not discourage the use of recruitment firms, we do urge caution when contracting with them. While some are good at finding candidates, few have a good track record when it comes to retention, particularly in rural areas. Before contracting with a recruitment firm:

- Use contingency firms versus retained firms whenever possible. Contingency firms only charge a fee when a placement is made. Retainer firms require a fee up front, regardless of placement. Make them show you that they can successfully recruit for you before you hand over a significant portion of your recruitment budget.
- The motive and incentive for recruitment firms is the placement fee and not necessarily your satisfaction or the retention of your provider. Keep in mind that many recruiters are only paid by commission. If you are going to use a recruitment firm, understand your professional relationship and make sure your best interests are the recruiter’s, as well.

Before contracting with a recruitment firm, contact other recruiters in your area and/or the 3RNet Organizational Member in your state and ask the following questions:



- What other communities have used this firm?
- Will the firm adjust to your situation?
- What is the firm's retention record for its candidates?
- How cooperative has the firm been in recruiting a second provider in instances where the first provider left prematurely.

When using a recruitment firm:

- Carefully screen all ads placed for your position. Who or what is being promoted by the ad—your vacancy or the recruitment firm?
- Carefully screen all candidates. Although you expect the recruitment firm to screen all candidates, they will screen them based upon their criteria and you may see an issue that will be a problem at your site. This also gives you that well-known “gut check” opportunity that will sometimes lead you to do a little more digging than usual.
- Be watchful of high compensation packages requested of you by the firm. High income guarantees are not only unnecessary, they are often borderline illegal. There is a *big* difference between recruiting a provider and buying one. Call other communities to help you decide on a competitive compensation package. Sure, the more you are willing to offer, the better chance of a placement. But can you afford the high offer? What will the other local primary care providers who may be making much less think about your high offer?
- Have the firm give you regular progress reports on the recruitment activities they have conducted on your behalf.
- Make sure you recruit the candidate you want and not just the candidate the recruitment firm says is a good match. If you are not sure, you have not been involved enough in the recruitment process. The average placement fee charged by recruitment firms today should be motivation enough to stay on top of all the candidates and the actions of the firm itself.



Part Three

screening candidates

Screening candidates includes interviewing the candidate, interviewing the spouse, checking references and credentials, and conducting the site visit.

Once you begin receiving responses to your promotional efforts, you will need to track the candidate's progress through your recruitment process. The purpose of tracking is to avoid letting too much time lapse between contacts with the candidate until your work with the candidate is concluded. If too much time lapses, another community is sure to sign the candidate first. One simple way to track each candidate's progress is to use a chart like this one below. The chart can tell you at a glance the status of each candidate in the recruitment process, the last time contact was made with the candidate, and the source of the candidate.

TRACKING LOG			
Candidate Name	Greg Walker	Mary Smith	John Doe
Specialty	FP	IM	FP
First Contact	8/5/12	9/15/12	9/30/12
Source	AFP Ad	3RNET	AMA
Packet Mailed	8/6/12	9/16/12	10/1/12
Second Contact	8/13/12	9/23/12	10/13/12
Initial Interview	N/A	10/1/12	10/20/12
Second Interview		10/25/12	NA
Spouse Interview		11/1/12	
Reference/Credential Check		11/15/12	
Site Visit		12/4/12	
Follow-up to Site Visit		12/8/12	
Contract		12/15/12	
Disposition	Not really interested	Signed	Does not meet our requirements
Start Date	NA	2/1/13	NA

The steps in the candidate screening portion of your search usually follow this order of events after the candidate responds to your promotional efforts by phone, mail and/or FAX:

1. Call or email the candidate immediately to acknowledge receipt of their inquiry.
2. Send the candidate your opportunity packet with cover letter, requesting their CV if they have not already sent it.



3. Review each CV immediately to determine whether this candidate matches your needs and wants. Do you also have what the candidate seeks?
4. Conduct phone interview with the candidate.
5. Interview the spouse to determine his or her level of interest in your opportunity/community/area.
6. Conduct an on-site interview, request references, have 'release of information' form signed, and make offer (give contract or letter of intent) to desirable candidates. Consider due diligence with candidate (p.128-130).
7. Send follow-up letter to candidate after site visit.
8. Interview references. Some think that interviewing references by mail provides a more accurate portrait of the candidate.
9. Conduct a credential check to verify the candidate's qualifications and authenticity.
10. Conduct follow up interview or site visit.
11. Finalize contract negotiations.
12. See "Screening CVs Made Easy" by Chloe Skinner (p.125).

What Motivates Candidates?

You can improve your recruitment skills by better understanding what motivates candidates' practice location choices. This information will allow you to better evaluate your chances with various candidates and highlight the aspects of your opportunity that matter the most to candidates. What will motivate your candidate's decision? The phone interview should tell.

Common Motives for Selecting a Practice Location

Professional Motives

- Access to hospital facilities, support facilities or personnel
- Avoiding professional isolation, maintaining contact with colleagues and access to continuing education
- Avoiding excessive workloads and obtaining coverage
- Opportunities to join group practices
- Adequate income

Personal Motives

- General preference for rural or urban lifestyle
- A desire to locate in or near one's hometown
- A desire to locate near family and friends
- Climate or geographic preference
- Tastes for recreational, cultural, or social opportunities
- Preferences regarding involvement in the community



step 8 interview candidates

Before you begin interviewing candidates, you need to develop an interview questionnaire. The questionnaire should be well thought out and unique to your opportunity. Remember, the purpose of the interview is to determine how closely the physician and his/her family match the opportunity, practice and community. Therefore, the questionnaire should include questions that help you determine the following:

- How closely each candidate's professional and personal attributes match the attributes of your ideal candidate
- Degree of interest in your opportunity
- Ideal practice setting in professional and personal terms
- Most important factor in selecting a practice
- Depth of knowledge about your opportunity
- Training background, emphasis. Why did you select the program?
- Experience and exposure to procedures and patients common to your area
- Professional goals and aspirations
- Professional strengths
- Weakness or limitations
- Location of other opportunities they are considering
- Desired compensation arrangement, amount and benefits
- Spouse and family background
- Whether or not to invite candidate and spouse for a site visit

A similar interview questionnaire should then be developed for the spouse as well.



Before contacting candidates, it is a good idea to rehearse your part of the interview first:

- ❑ Conduct mock interviews with local medical staff members to work out the rough spots in the interview and get accustomed to how medical providers may respond to your questioning. Ask for a critique of your interview style and the questionnaire.
- ❑ Prepare yourself for questions the candidate may ask you during the interview. A fact sheet with a brief answer to each question appearing in “Questions Commonly Asked by Candidates and Spouses” on Page 80 will be useful during the phone interview.

As mentioned earlier, all candidate interviewers should be personable individuals who possess good communication and listening skills, and have knowledge of the opportunity and the community.

The candidate phone interview will follow these steps:

1. Call the candidate within one week after sending your opportunity packet.
2. Ask the candidate if now is a good time to conduct an interview and discuss your opportunity. If not, arrange a time. The initial interview may last 30 to 45 minutes, depending upon the time available.
3. Ask the candidate if he/she had an opportunity to review the opportunity packet, and answer any questions he/she has.
4. Go through your interview questions, keeping the interview in a conversational tone. Do not feel obligated to follow the exact order of your questions. Allow the interview to flow naturally. But before you end the interview, make sure you have answers to all your questions.
5. Write down what they say and how they say it, when you feel the candidate’s tone or attitude is worth noting.
6. Answer any questions posed by the candidate. Prepare by reviewing “Questions Commonly Asked by Candidates and Spouses.” (p.80)
7. Avoid talking about specific income amounts until you are certain the candidate meets your standards. A simple yet honest answer to the “How much?” question is “What we offer the right candidate will depend on how well he or she matches our needs, but a ballpark figure for income and benefits would be about \$ _____.” The “ballpark” figure still leaves you negotiating room with candidates who may have somewhat higher or even lower income expectations than you intend to offer. Refer to Page 46, which outlines income ranges for various physician specialties. It will also help eliminate those candidates whose income demands far exceed your comfort level. Remember,



the negotiating game begins the minute you promote your opportunity and build expectations about your opportunity. If you give a candidate the impression that the dollar figure quoted in your written materials or during the interview is cast in stone, you may unwittingly lose candidates who would have agreed to sign for just a few thousand dollars more than this figure.

8. Arrange a time for a spouse interview. Alternatively, you can choose to interview the spouse during the same call, if he or she is willing.
9. Thank the candidate and spouse for their time, give them a date by which you will get back to them, and encourage them to contact you when questions about your opportunity come to mind.

Immediately after the interview, write down the areas where the candidate's attributes and interests matched and did not match your opportunity and community. Within two days of the interview, send the candidate a brief note thanking him or her for the time and provide the candidate any additional information you could not provide during the interview. In the note, you should also describe in more detail aspects about your opportunity and community that will appeal to the candidate, based on what you learned during the interview.

These are some sample questions for evaluating particular traits of a candidate related to professional and patient relations. Some of these are also excellent questions to ask references:

How would your patients or colleagues describe you?

*What frustrates you most when dealing with patients and family?
When dealing with nursing staff? When dealing with other medical staff
members? When dealing with hospital administration or boards?*

*Describe how you handle pressure situations in terms of carrying out your
responsibilities and interacting with patients, colleagues, and support staff.*

*Describe a situation where you dealt with a dissatisfied or angry patient and/or
family member of a patient and how you handled that situation.*

*Give examples of work teams that you have served on and describe your role on
those teams.*

*Describe a mistake you made in dealing with people. How would you do it
differently now?*

*Tell me about a time when you stuck to a company policy even when it wasn't
easy?*



What do you feel is the most significant limitation to your working style and what have you learned from it?

What aspects of your work do you consider most crucial?

Some helpful interview preparation tips:

- ❑ Develop a well-structured initial candidate or spouse interview that takes no longer than 30 minutes. You can ask about 10 questions in this amount of time.
- ❑ Focus on behavior questions – technical knowledge will be determined through the CV information, credential check and references.
- ❑ Avoid asking repeat questions – questions likely to elicit a repeat of a previous answer.
- ❑ Rehearse the interview with a local primary care provider (or spouse if planning to interview candidate's spouse).
- ❑ Modify or remove questions that do not elicit the answer you want after using it in several interviews.





Questions Commonly Asked by Candidates and Spouses

Sources: *National Health Service Corps, Utah Department of Health, and Idaho Rural Health Education Center.*

To properly prepare yourself for an interview, simply answer each question below before each interview. The exercise will sharpen your knowledge of your opportunity relative to what's most important to the candidate and spouse.

Questions Related to the Medical Situation

1. Why is there a need for a new provider?
 - a. Do all the local primary care providers, other physicians and other key health care providers support the recruitment effort?
2. Is the community currently without a primary care provider?
 - a. How long has it been without one?
 - b. Why did the last provider leave?
 - c. Where do people now go for primary care?
3. What are the major health concerns of the area?
4. How well do the primary care providers and other physicians in the area work together?
5. What steps are involved in getting a license to practice medicine in your state?
5. How far away is the nearest hospital?
 - a. What facilities, support services and personnel does it have relative to my specialty?
 - b. Is there an emergency room?
 - c. What is the financial status of the hospital?
 - d. What is the hospital's scope of care?
 - e. Are there relationships established with regional medical centers?
 - f. How would nursing homes in the area relate to the practice?
6. Where are physicians available for consultations and referrals?
 - a. Are there medical schools, training centers, and/or group practices accessible for telephone consultation or patient referrals?

Questions Related to the Practice

1. What geographic area is served by the practice?
 - a. How many patients are anticipated?
 - b. What is the payor mix of the patients: Medicare, Medicaid, private insurance, uninsured?
 - c. What are the call and coverage arrangement, emergency room, office, and hospital?
2. What locations are available for the office?
 - a. What is the condition of the facility?
 - b. What clinical technology and office equipment are located in the office?
 - c. Does the facility have adequate waiting room space, office and consultation space for each provider, at least two examination rooms per practitioner, records and storage areas?
3. What type of support staff exists at the office?
 - a. Are there administrative support personnel?
 - b. Are there clinical support personnel?
4. Which services will the practice provide and which will be provided by other sources?
 - a. Where is the nearest pharmacy?
 - b. Where are the nearest labs and x-ray facilities?
7. What emergency transportation is available?
 - a. How long does it take for ground and air emergency transport to reach a regional medical center?
8. What are the opportunities for continuing medical education and professional enrichment in the area?
 - a. Who is responsible for arranging and paying for coverage while I am away on CME leave?
9. What type of support will you provide me in developing my practice?
 - a. What type of practice management assistance can you provide?
 - b. What activities will you engage in to help me increase my patient base?



Questions Related to the Community Setting

1. What is the potential for a financially successful private practice in this area?
 - a. Is the economy sound?
 - b. Is the community growing?
2. Are there appropriate employment opportunities available for my spouse within reasonable commuting time?
 - a. Can your organization help find a suitable position for my spouse?
 - b. Are daycare centers available?
3. What opportunities are there for my spouse to obtain additional education or training?
4. What types of housing are available in the community and surrounding areas?
 - a. What are the prices and interest rates?
 - b. Are there rentals large enough to accommodate a family?
5. What is the local school situation in the area?
 - a. Are the school facilities and education resources modern?
 - b. What is the teacher-pupil ratio?
 - c. What are the extra-curricular activities?
 - d. What is the community's attitude toward education?
 - e. What percent of the high school graduates go on to college?
 - f. How do the schools' test scores rank against state and national averages?
 - g. What are the core curriculum and elective courses at the schools?
 - h. How far to the nearest college or university?
 - i. Do universities or colleges offer outreach courses in your community?
6. What churches are in the area?
7. What are the social, recreational, entertainment and cultural activities and opportunities in the area?
8. What kind of environment does the community offer?
 - a. What are the values of the community?
 - b. Is there ample infrastructure for the community like police, fire protection, emergency services, public utilities, water and sewer, and local government?
9. What shopping and other consumer services are available locally?
 - a. Does the community meet basic consumer needs like groceries, clothing, restaurants, pharmacy, general merchandise, banking, automotive repair, plumber, electrician and so on?
 - b. How far to the nearest large city, its size and shopping and consumer amenities?
 - c. How far to a major airport?
 - d. What type of media serves the area?



step 9 conduct a credential check

The objective of the credential check is to confirm the accuracy of claims made by the candidate in his or her CV and correspondences regarding his or her professional and educational background. The credential check can be conducted before or after the interview. However, by conducting the check after the interview, you have the opportunity to verify claims made by the candidate during the interview. Regardless, check the candidate's credentials early in the process in order to avoid wasting time and resources on unqualified candidates.

The credential check should be conducted by a medical expert on your recruitment committee. You can also hire an independent agency to conduct the credential check for a reasonable fee, if you feel it would be a better use of your Recruitment Team's time and money.

If you choose to conduct the credential check yourself, begin the process by contacting the Board of Medicine in your state. The Board of Medicine can provide instructions on contacting licensing boards in states where your candidate claims to be licensed and on accessing detailed information about a candidate from these boards. Once you hear back from these boards, ask the State Board of Medicine whether the candidate has the basic qualifications and record needed for licensure in your state.

Common reasons for rejection of a provider applying for licensure are license revocation in another state, crime, and repeated occurrence of medical or professional wrongdoing.

Too often local recruiters wait until they are actually ready to sign a candidate before contacting the Board of Medicine and then discover that the candidate is unqualified to practice in that state. In these instances, local recruiters sometimes blame the Board of Medicine for ruling out a good candidate. However, contacting the Board early on in the candidate screening process would have saved the time and money wasted on the candidate.

Remember, many physicians and midlevel practitioners are licensed or certified to practice each year. If a Board finds a candidate unqualified, the candidate should no longer be considered an option for your community. The Board of Medicine is an ally in your recruitment effort that helps you ensure quality. Ask them questions whenever there is doubt regarding a candidate's credentials.

When hiring or granting health care privileges to a health care provider, hospitals are required by the federal Health Care Quality Improvement Act of 1986 to query the National Practitioner Data Bank. The National Practitioner Data Bank collects



information about malpractice payments, licensure disciplinary actions, clinical privileging restrictions by hospital and other health care entities, and professional membership restrictions. The purpose of the Data Bank is to facilitate peer review and the credentialing of health care providers.

The Data Bank is a source of much controversy among health professionals. Many argue that the problems the Data Bank create, such as breaches of confidentiality or reporting errors that may permanently blemish a provider's record outweigh the benefits. Nonetheless, the Data Bank is a single source for a great deal of credentialing information on candidates that can be accessed for a low fee. However, the Data Bank is only accessible to hospitals, medical boards, and physicians for their own records.

When conducting a credential or background check, you will want to verify the following information:

Licensure

Sources of Verification:

- State Board of Medicine
- Boards of Medicine in states where the candidate claims he or she is licensed – Ask these boards if they provide additional professional conduct information on providers licensed in their states.
- The National Practitioner Data Bank – Accessible to hospitals, physicians and medical boards

Undergraduate Education

Sources of Verification:

- Registrar's office of the school(s) attended to confirm: candidate's attendance at the school(s), dates of attendance, graduation date and degree area. The school(s) may also provide information about the candidate's academic performance, honors, extracurricular activities and so on. Some schools require written authorization from the candidate before sharing student records.

Medical School Education

Sources of Verification:

- Registrar's office of the school(s) attended to confirm matriculation at the institution(s), dates of attendance, graduation date and academic record



Internship (if applicable)

Sources of Verification:

- The institution(s) where the candidate claims to have conducted his or her medical internship to confirm: dates of attendance, completion date and any performance records.

Residency Training

Sources of Verification:

- The director's office of the residency program(s) attended by the candidate to verify: dates of attendance and completion date, particular areas of training emphasis, such as rural rotations, and academic and professional records.

Board Eligibility/Certification

Sources of Information:

- Certifying board for that particular specialty
- The Federation of State Medical Boards
- State, county or local medical societies

Legal

Sources of Information:

- Malpractice Suits – The county clerk at the courthouse in any county where the candidate has practiced.
- Driving/Criminal Records – Ask the candidate to obtain and provide you their driving and criminal records – offer to pay any administrative fees.

Credit

Sources of Information:

- Credit Bureau – Get the candidate's written permission and social security number.



step 10 interview the spouse

Most recruitment efforts hinge on the candidate's spouse, because the spouse's opinion of your opportunity and community often drives the candidate's final decision. Therefore, it is extremely important that you expend as much effort on recruiting (and retaining) the spouse as you do on the candidate. Because of the important role the spouse plays in the decision making process, we urge the use of a Spouse Recruiter. This person is specifically in charge of coordinating a complete spouse recruitment process similar to that for the candidate. This will ensure the spouse gets the proper attention, increase the likelihood of the spouse supporting the match, and help integrate the provider and spouse into the community.

Spouse recruiting begins with gathering information about the spouse. Ask the candidate for his/her spouse's resume if the spouse has professional interests. Then, contact the spouse to arrange and conduct an interview.

A personal interview with the spouse early in the effort may save you a lot of time, money and effort chasing a candidate whose spouse is not interested in living in a rural area. You may find candidates who say they are "very" interested in your opportunity, but whose spouses are not even aware of your opportunity – or even know that relocating is a possibility.

If you are not using a Spouse Recruiter, the spouse interview should be conducted by someone who:

- Possesses good interpersonal skills;
- Knows the community and opportunity; and,
- Shares common background or interests with the spouse.

Your interview with the candidate should provide you enough insight into the spouse

The most important factor in deciding on a practice location from the spouse's perspective (*not in rank order*)

- Loan repayment
- Income guarantees
- Housing and real estate
- The physician partners
- Extra curricular activities for children
- Environmental conditions
- Schools and curriculum for children
- Employment opportunities for him/her
- Weather
- Shopping
- Stability of the medical community
- Intrinsic feel the community has – need to meet the "real" town during the recruitment process to experience the town's routines and people

Source: spouse of physician residents at the Family Practice Residency Program of Idaho, Spring 1994



to identify a suitable spouse interviewer. Several communities have successfully used spouses of their current physicians or midlevel providers to act as Spouse Interviewers or the Spouse Recruiters.

The objective of your spouse interview is to determine how closely the spouse matches the characteristics of your ideal candidate's spouse. You will want to conduct an interview using a questionnaire that helps you determine the following about the spouse:

- ❖ Professional needs, including professional or career goals
- ❖ Personal education needs
- ❖ Personal interests, including recreation, social, cultural and hobbies
- ❖ Personality traits
- ❖ Socioeconomic background, including rural background
- ❖ Housing preferences
- ❖ Expectations from the community
- ❖ His/her ideal community
- ❖ Family profile, such as interests/needs of children
- ❖ Family needs, including education, recreation, extracurricular activities
- ❖ Most important factors in deciding on a community
- ❖ Geographic and climate preferences
- ❖ Location of family and closest friends
- ❖ Knowledge of your opportunity
- ❖ Why your community interests him/her

Of course, another objective of the interview is to determine whether or not to invite the candidate and spouse for a visit to your community. If you do extend the invitation, the information gathered from the interview will be invaluable when creating an itinerary of stops that will most appeal to the spouse.

Tips for Interviewing candidates, spouses and references

1. Prepare questions in advance, drafting questions based on your ideal candidate composite.
2. Test your questions and rehearse the interview with a colleague – ideally one of your local medical staff members.
3. Take accurate notes during the interview, noting what the interviewee says and how he/she says it.
4. Avoid asking certain background or “off the record” type questions that are illegal, including questions related to: age, race, gender, marital status, religion, garnishment records, child care provisions, contraceptive practices, childbearing plans, height and weight, and physical or mental disabilities (American with Disabilities Act).



5. Listen attentively so the interviewee knows his/her responses are important to you. Avoid answering questions for the interviewee, finishing his/her statements, or making editorial comments (good or bad).
6. Allow the interviewee ample time to contemplate a response. Silence is not a bad thing.
7. Paraphrase responses to ensure you understood the interviewee's answer. If you did not understand the response, ask him/her to rephrase it until you do.
8. Strive for a conversational tone. Relax and let the interview flow. A relaxed interviewee is likely to be more open than one who feels like he or she is being interrogated. Do not feel compelled to follow the order in which your questions appear on the questionnaire; let the conversation dictate the order. But keep the conversation focused and make sure all your questions are answered.
9. Answer all questions posed by the interviewee honestly. If you don't know the answer, tell the interviewee you will get the answer to him/her shortly after the interview.
10. Check your notes immediately after the interview is completed to fill in and clarify any incomplete notes, which could lose all meaning to you within a few days.
11. Send a thank you letter to the interviewee, including any additional information they requested. If interviewing both a candidate and a spouse, send separate letters to each of them.



step 11 check references

Because of the perceived legal ramifications, many references refuse to provide information of any depth or substance, and often those checking references do not really push the issue. Consequently, reference checks are probably the most neglected part of the screening process. Yet a thorough reference check will usually provide you with a critical, objective perspective on how well the candidate matches your opportunity. For example, references can describe the candidate's work ethic, bedside manner, professional interactions with medical staff and support personnel, and personal



commitment to medicine and his or her patients. What a reference does *not* say about a candidate and how the reference speaks of him or her is often quite telling.

Legal Reference Checking

Today, references are harder to get and more disconcerting to give than at any time in the past. Lawsuits filed by former employees claiming an employer's reference defamed him or her have received a great deal of publicity. To protect yourself and to best understand the position of former employers, you should keep in mind two legal principles when conducting reference checks: qualified privilege and negligent hiring or referral practices.

Qualified Privilege

Under this legal theory, employers have the right to share job-related information about former workers, even when the information is negative, if a legitimate business need exists. This qualified privilege protects employers from defamation claims related to reference inquiries, provided the employer:

- Discloses truthful, accurate, and documented information about past employees' job performance or job-related characteristics (not their personal lives);
- Responds only to specific inquiries made by persons with a legitimate business-related need to know;
- Avoids disclosure of any information to uninvolved third parties; and,
- Does not act with deliberate malice or disregard for the truth.

Negligent Hiring or Referral

Under the negligent hiring principle, an employer has a duty to exercise reasonable care when hiring employees who might pose a risk of injury to the public or to fellow employees due to incompetence or impairment. Negligent referral theory obligates employers to disclose negative information about former employees when the information has bearing on the job in question.

To reduce the risk of negligent hiring, employers should contact both personal and professional references of potential employees. References should be checked during or immediately following the candidate interview/site visit to obtain additional information on the top one or two finalists.

When contacting former employers by telephone, it is helpful to use a checklist. The items on the list should bring out the job elements you have already determined are crucial for success in the position (ideal primary care provider candidate composite). The questions asked should be phrased in such a way that the former employer is asked to



describe, not rate, the applicant in terms of your list of relevant job behaviors. Allow enough space on your form, so that you can paraphrase or directly quote the remarks made.

Appropriate Areas for Reference Inquiries

Appropriate Topics

Factors related to successful job performance including:

Skills needed for the job
Ability to work with people
Quality of work
Amount of work done
Ability to follow directions
Judgment
Timeliness
Accuracy
Reasons and circumstances for leaving or seeking other employment
Attendance and punctuality (with some exceptions)
Management or supervisory skills, if a part of the job
Ability to respond to supervision, criticism or correction
Confirmation of information provided on the application or during interviews

Inappropriate Areas for Questioning

Areas not related to actual on-the-job performance, including
Religious beliefs or activities
Political beliefs or activities
Marital status
Number and ages of children
Residence, and with whom residing
Past legal actions, such as worker compensation claims, discrimination charges, or safety complaints
Attendance problems related to disability, compensable injury, or state or federal Family Medical Leave programs

Source: Idaho Department of Employment



Decision Point

After you have completed the candidate and spouse phone interviews, credential checks, and reference check, you have three choices:

1. Reject the candidate. If you reject the candidate, simply write a brief letter thanking him or her but stating that you are no longer interested at this time. Do not feel compelled to provide a reason.
2. Invite the candidate and spouse for a site visit to your community. Invite only the candidate on the site visit if you can answer Yes to the following statements:
 - a. I am certain the candidate is sincerely interested in our opportunity.
YES NO
 - b. I am certain the candidate and spouse resemble our ideal candidate (or match the needs of our opportunity and the characteristics of our community), and the community would be comfortable with this provider.
YES NO
 - c. I know the candidate and spouse well enough that I can design a site visit itinerary that appeals to their specific needs.
YES NO
 - d. The candidate is qualified to practice medicine in my state.
YES NO
 - e. The local medical staff believes the provider is qualified to practice in the community and seems to match their needs and wants.
YES NO
3. Gather additional information from/on the candidate and/or spouse. If you answered No to one or more of the statements under Number 2 above, continue interviewing the candidate, spouse, and/or references; or continue checking the candidate's credentials until you can answer Yes to all the statements above or until you reject the candidate.



step 12 conduct a site visit

There are two goals for the site visit: to confirm whether or not the candidate and spouse approximate your ideal candidate enough to make them an offer; and to provide the candidate and spouse every opportunity to assess your community to decide whether they would accept an offer.

Too often, communities use the same general itinerary for every candidate, which ignores the fact that each candidate has uniquely different interests in your opportunity and community. The most effective site visits are those that tailor the itinerary to the candidate and spouse's interests and preferences. Of course, this can only be achieved when you know enough about the candidate and spouse to decide what would interest them about your opportunity and community.

Site visits should last one to two days. Avoid shorter site visits, because they make it too difficult to show all aspects of your community and opportunity. Short site visits usually create the wrong impression and result in candidates making decisions based upon partial information or misconceptions. Site visits are typically conducted on weekends, for the sake of convenience. However, the ideal situation is a two-day site visit that includes at least one business day. Two days affords the candidate and spouse a better feel for daily life in the community and in the practice setting.

If possible, avoid conducting a site visit with a candidate and spouse who are also planning to visit other opportunities in your state or in neighboring states on the same trip. While such multiple-site visits may save each community on the tour some money, you risk paying for candidates who simply use the multiple-community site visit as an expense-paid tour of your state. The sincerely interested candidate will find time to make the trip just to your community, especially if you pay for the trip. The site visit is too important to risk sharing the candidate and spouse's attention with the competition.

The site visit should balance professional and personal venues. In general terms, a properly organized site visit itinerary will include ample time to:

1. Tour and experience the community – first with an escort and then alone – allowing the candidate and spouse to see the pros and cons of your community.
2. Tour the clinic location of the practice.



3. Meet and visit with each physician one-to-one, unless it is a very large practice, in which case it may be more appropriate to select several key members of the medical staff to meet with one-to-one.
4. Visit at length with the lead medical staff member on the Recruitment Team.
5. Tour the hospital and meet key hospital staff members, especially the administrator and the director of nursing.
6. Tour other relevant health care facilities.
7. Visit places of particular interest to each candidate and spouse – ask them before the site visit.
8. Have a social gathering with the Recruitment Team.
9. Conduct a business interview between the recruiter, contract negotiator, the benefits recruiter at the practice site, and the candidate.
10. Ask the spouse what he or she would like to do or see while the candidate is involved in itinerary stops of professional concern. In case he or she does not have a long list of interests, create an itinerary to be led by the spouse recruiter.

A sample site visit itinerary appears below.

Site Visit Itinerary

R.U. Willing, M.D. and spouse, Ann

Note: Candidate and spouse are accompanied by the Site Host at all itinerary stops, except when candidate and spouse are provided private time.

Thursday

5:00 p.m. Pick up candidate and spouse at airport and travel to rural community.

7:00 p.m. Check in at motel in rural community.

Use the drive time to explain the opportunity in more detail, introduce them to your state or area, go over the itinerary and find out if they want to make any other stops not included on the itinerary.



Friday

- 8:00 a.m.** Meet for breakfast
- Chief of staff
 - Hospital and/or clinic administrator (if not hosts)
- 9:15 a.m.** Conduct brief drive-through of the community to orient candidate and spouse to community
- 9:30 a.m.** Tour the hospital
- Visit with Director of Nursing Service
 - Visit with Board Chairman
 - Introduce to other key hospital personnel
- 10:30 a.m.** Tour clinic location of the practice opportunity.
Visit each physician or midlevel one-to-one, allowing at least 15 minutes per visit
- Visit clinic director
 - Introduce to other clinic staff

Spouse Itinerary:

Friday

- 9:30 a.m.** Tour of elementary school (or school appropriate to spouse's children's ages)
- Visit principal and/or school counselor, teachers for grades appropriate to the age of the candidate's children
- 10:30 a.m.** Meet with the medical staff's spouses at one of spouse's homes

If spouse followed a different itinerary on the first morning, he or she should rejoin the candidate for lunch, providing the spouse an opportunity to meet the medical staff and hospital representatives.

- Noon** Lunch at hospital board or conference room
- Medical staff
 - Board chair or representative
 - Director of Nursing Service
- 1:15 p.m.** Meet with candidate and spouse to discuss morning's activities

This brief meeting serves two purposes: 1) provides you the chance to address any questions or concerns they have from their morning visits while the concerns are fresh in their minds, and 2) assess and adjust to any changes in the candidate and spouse's level of interest in the opportunity.

- 2:00 p.m.** Tour other health care facilities and/or meet other providers in the community or key civic leaders
- 3:00 p.m.** Conduct guided tour of community
- Shopping/consumer services
 - Restaurants
 - Neighborhoods and subdivisions
 - Immediate countryside
 - Scenic locations
 - Unique sites and places that appeal to the interests of the candidate and spouse
 - Stops requested by candidates
- 5:00 p.m.** Drop the candidate and spouse off at the hotel

Provide them a vehicle for touring the community by themselves.

In the months when sunset is between 5:00-6:00 p.m., you may want to adjust the itinerary stops to allow the spouse some daylight hours to see the community on his/her own.

- 7:30 p.m.** Dinner at local supper club
- Medical staff and spouses
 - Hospital board representatives
 - Clinic and hospital administrator
 - Key civic leaders

If the candidate and spouse have an opportunity to visit with the dinner guests earlier in the day, the dinner will be more relaxed for all involved, especially the candidate and spouse. A word of caution: existing medical staff and spouses may use the dinner as a rare opportunity to spend some quality time with one another, unwittingly ignoring the candidate and the spouse. A little coaching or rehearsing before hand may help dinner guests remember the primary purpose of the site visit and dinner.

Saturday

- 8:00 a.m.** **Breakfast – Discuss the previous day’s events and address any concerns**
- Site visit hosts
 - Realtor
 - Any medical staff members or other key person who could not meet with candidate and spouse on previous day



Advise the realtor that he or she is responsible for being a guide on what will be a “tour of homes” which matches the particular interests of the candidate and spouse. This is not a home sale opportunity. However, the realtor should be ready to answer questions regarding mortgages, lending rates, resale market, current and future market values, seller motivation, and so on.

Noon	Lunch Meet with any key persons who have not had an opportunity to meet with candidate and spouse at an earlier time during the site visit
1:00 p.m.	Self-guided Tour of Community Providing the candidate and spouse a vehicle
3:00 p.m.	Business Interview Administrator of recruiting organization and the candidate meet to discuss the opportunity and the details of the offer. Present a letter of intent or draft contract if the candidate interests you and indicate the number of days he/she will have to consider your offer.
5:00 p.m.	Return to the airport

Take advantage of the return drive to draw out and address any concerns that may be preventing the candidate and spouse from pursuing your opportunity.

Give the candidate and the spouse a gift or memento of their visit to your community – something unique to your community would be ideal.

7:15 p.m. Flight departs

Other Possible Itinerary Venues

Personal Venues

- An airplane tour of your area.
- An opportunity to experience a popular activity in your area that is of interest to the spouse and/or candidate, i.e. horseback riding, whitewater rafting, hunting, fishing, boating, cross country or downhill skiing, and so on.

Professional Venues

- A visit to the regional medical center and key consulting and referral specialists in the regional medical center community used by your medical staff.
- Spouses of family practice residents on site visits.



Other Suggestions:

- ❑ Avoid busy itineraries that prevent the candidate and spouse from getting the feel of the community.
- ❑ Introduce the candidate and spouse to other newcomers to the community.
- ❑ Show the candidate and spouse the business district and different neighborhoods to witness daily life in the community.
- ❑ Avoid being “too slick” or too contrived.
- ❑ Show the good points but also be honest about the community’s problems or bad points.
- ❑ Expose the spouse to daily life in the community, because it will be the spouse not the physician who will need to fill their day with whatever the community has to offer.

Common Site Visit Issues

Overwhelming the Candidate

Caught up in the excitement and the importance of the event, some communities overwhelm the candidate and spouse by having too many people escorting the candidate around town. It is entirely possible to have the candidate and spouse meet key individuals and experience broad-based support without packing the whole community into a van. At most, two or three individuals from the Recruitment Team should act as hosts with one host specifically assigned to the spouse. Ideally, these hosts should include the candidate and spouse interviewers, who should have already developed a rapport with the candidate and spouse. The third host could be an interviewer, the recruiter or an administrator from the agency who will sign the provider.

Dealing with Children on Site Visits

You should let the candidate and spouse know that their children are welcome, but do not feel compelled to pay the entire family’s travel expenses, especially if there is more than one child. Flying a family of four or five can break the typical rural community’s recruitment budget. Candidates who are truly interested in your opportunity will either leave their children at home or pay for all or some of their children’s travel expenses. If the candidate has small children, you should tactfully suggest that they not come on the site visit. You can say that young children are invited, but that you have found that the constant care required by very young children often reduces the effectiveness of the visit for both parties.

If children do come, you should make arrangements for a babysitter and/or involve the children in local activities that will interest them. This will allow the candidate and spouse to concentrate on the site visit.



Making the Offer

Communities sometimes lose sight of the fact the site visit is more than a “get acquainted” visit and actually neglect to make an offer to attractive candidates. The site visit is, above all, a “sales” opportunity and getting acquainted is only part of the sales pitch.

During the business interview portion of the site visit, try to further determine how well the candidate matches your ideal candidate and how interested the candidate is in your opportunity. Use the interview as a face-to-face opportunity to draw out from the candidate his or her reservations about your opportunity. In sales, this process is known as identifying objections. If a candidate ultimately rejects your offer, he or she had reasons for doing so. Therefore during the interview and other appropriate times of the site visit, you must encourage the candidate and spouse to articulate their concerns and reservation, so you can address them *before* they leave the community.

If a candidate rejects your opportunity and you don’t know why, you failed to learn enough about the candidate during the site visit. You may have also failed to properly present your opportunity and community to the candidate. Candidates often reject an opportunity over an issue that could have been easily addressed had it been known. A simple but pointed question that must be asked at some point during the site visit is “What concerns must be addressed before you would practice in our community?” The answer to this question will provide some important insights into your chances for signing the candidate.

Finally, after you make an offer to an attractive candidate during the site visit, do not expect or force the candidate to make a decision on the spot. You will allow the candidate a specified amount of time after the site visit to make his or her decision. If you do not provide the candidate some sort of deadline by which to make a decision on your offer, he or she usually will delay the decision until lured away by another community.

To make an offer during the visit:

1. Prepare a contract or letter of intent before the site visit that clearly outlines the responsibilities and obligations of the practitioner, but leave blank the compensation amount and arrangement to allow for negotiation.
2. Present the contract or letter of intent to attractive candidates during the business interview of the site visit.
3. Explain the entire contract or letter of intent and make sure candidates have complete understanding.
4. Negotiate and settle upon the compensation amount and arrangement during the business interview, if possible.
5. Give the candidate one to two weeks to decide, asking him/her to please list reasons why they reject the offer, if he/she chooses not to accept.



Sample Letter of Intent

Dear Dr. R.U. Willing,

On behalf of Sam True, M.D., and the administration and medical staff of Rural Hospital, we are pleased about your interest in helping patients in the Rural, Oklahoma, area and practicing at the Family Medicine Clinic.

Please accept this letter as a description of the compensation and benefit package we discussed during your site visit to our community February 7, 2000. Keep in mind that this is a preliminary letter of agreement. It may not be all-inclusive. We can discuss further details and incorporate them into our final agreement.

Our discussion included the following parameters:

1. A first-year salary of \$140,000
2. Four weeks' vacation and 10 days for CME (prorated the first year)
3. Reimbursement for approved CME sources (including travel expenses) up to \$4,000 per year (prorated the first year)
4. Health insurance for you and your family
5. Disability insurance
6. Life insurance
7. Retirement program participation
8. Malpractice insurance
9. Practice management and marketing assistance
10. Relocation allowance up to \$10,000

In addition, Dr. True and Dr. Welby will facilitate the implementation of the call coverage plan discussed over lunch. This plan calls for the following:

- ◆ Every second weekend off, occasionally every third weekend off, depending on all physicians' CME and vacation plans
- ◆ Coverage every fourth or fifth night for your clinic patient practice
- ◆ Sharing emergency department call along with all Rural Hospital active staff, every fourth night

Again, although there may be some details to work through prior to our signing a contract, we want this letter to serve as a formal offer of our position. By your signing and returning this letter, we will assume your acceptance of this position, and we will cease further recruitment efforts and begin formalizing the final letter of agreement.



Dr. Willing, Rural Hospital must continue its search efforts in order to recruit a family physician to meet the needs of our community. In that effort, we may extend practice agreements to other interested candidates. A signed agreement is thus binding or valid, subject to another candidate's prior acceptance. We look forward to your response by March 29, 2013.

Dr. True and everyone at Rural Hospital are looking forward to working with you. We eagerly await your reply.

Sincerely,

Hope Thisworks, Recruiter
Rural Oklahoma, Recruitment Team

Date: _____

R.U. Willing, M.D.

Date: _____

Adapted from: "Physician Recruitment and Retention: Practice Techniques for Exceptional Results," Roger G. Bonds and Kimberly A. Pulliam, American Hospital Association, Chicago, Illinois.



What goes into a contract?

Employment Agreement Suggested Content

Introduction

- Effective date
- Parties involved
- Purposes: intention, goals and objectives of the agreement

Term

- Effective dates
- Fixed or self-renewing

Employment Status

- Full time or part time
- Permanent or temporary
- Probationary or trial period

Physician Issues

- Minimum/maximum office hours
- Evenings and/or weekends
- Hospital responsibilities
- Satellite sites
- Nursing homes
- House calls
- Emergency department responsibilities
- Off-hours duty/on-call situations
- Supervision of midlevel providers
- Obstetrical services
- Licensure
- Board certification
- Hospital privileges
- Appointment scheduling protocols
- Assignment/control of patients
- Professional liability insurance
- Policies and guidelines: administrative, financial, personnel
- Quality assurance and utilization review
- Performance evaluation
- Procedures for changes in “status quo”

Execution of the Agreement

Compensation and Benefits

- Compensation arrangement type(s): straight salary, bonus, incentive plans, risk sharing, clinic revenue, ownership of accounts receivable
- Loan repayment
- Pay schedule
- Payroll deduction services
- Direct deposit
- Extra duty pay
- Social security
- State unemployment
- Worker’s compensation
- Federal unemployment
- Pension/retirement plans
- Private office space
- Paid holidays, vacation, sick leave, personal leave, education leave, funeral leave, disability leave, maternity/paternity leave, leave without pay
- Insurance: health, life, disability, professional liability, common carrier transportation
- Professional dues, subscriptions, fees, books, journals, tapes
- Tuition assistance, conference fees, travel and educational benefits
- Automobile and mileage expenses
- Parking
- Professional courtesy discounts
- Dependent care assistance
- Flexibility of benefit plans/salary reduction
- Incentive plans
- Fiscal policies and procedures
- Administrative policies and procedures
- Performance evaluation criteria
- Principles of practice

Signatures/Effective date



Part Four



follow up and follow through

step 13 follow-up letter

Send a thank you letter containing any additional information requested by the candidate or spouse within a week after the site visit. Some communities include a copy of the latest local newspaper that contains a well-timed article about the candidate's recent site visit to the community.



step 14 follow-up negotiations

The designated contract negotiator should contact the candidate to discuss his or her decision at the end of the agreed upon time period (usually one to two weeks). If the candidate is still undecided, the negotiator must identify and address the candidate's reservations right away. This may require another site visit or simply sending the candidate more information. In some instances, the negotiator may want to travel to the candidate's home to further discuss the opportunity face-to-face.

When the candidate rejects the offer...

You should learn something new about the appeal of your opportunity and effectiveness of your recruitment effort every time your offer is rejected. This means your opportunity and recruitment effort should improve with each candidate. Communities that fail to modify their opportunity or adjust their recruitment process are those still recruiting today. One simple question should get the answers you need to improve your recruitment effort each time you are rejected: "Why didn't we get this candidate?" Too many communities skip this self-assessment.

If you have been recruiting for some time and have not assessed your opportunity or recruitment process recently, ask, "Why can't we recruit a physician or midlevel?"



Develop a strategy to address or minimize every reason you identify. For example, many rural communities lose candidates because the spouses perceive small towns as lacking professional opportunities for them. Indeed, most rural communities perceive the same thing. However, a closer look at the community and the spouse's professional or educational backgrounds may reveal a number of non-employment or volunteer opportunities that may be quite interesting or challenging. Income in many cases will not be a major concern to spouses, so they may be quite open to other avenues for utilizing his or her skills and knowledge.

Use the following steps to identify and manage barriers to recruitment:

1. Identify reasons why the offer was rejected.
2. Determine whether the reasons for rejection can be rectified before continuing the recruitment process. If so, make changing them a priority.
3. Find ways to minimize the impact of barriers or problems that cannot be completely addressed, such as "trade-offs." For example, "We are not located near a regional medical center or specialists, but we are linked to them and Health Net/Virtual Medical Center via telecommunications links."
4. Turn failure into a learning process.

When the candidate accepts the offer...

1. Close the Deal. Send the candidate a final draft of the contract with all negotiated points included to enable him/her to sign the contract as soon as possible. Encourage the candidate to have an attorney review the contract. An outline of suggested content for an employment agreement between an organization and a primary care provider appears on Page 100.
2. Facilitate Relocation – To make the provider and family's move and integration into your community as smooth as possible, assist them with the following:
 - Attaining licensure
 - Attaining privileges at all appropriate hospitals
 - Making moving arrangements
 - Locating financing for purchasing a home or finding a suitable rental property
 - Getting the children enrolled in school
 - Finding employment or opportunities for the spouse
3. Build a Patient Base – A special public gathering to welcome the new provider and his or her family to town is a great way to increase community awareness of the new provider. You should begin a regular promotional effort



to inform the community about the new provider long before he or she begins practice as well.

4. Plan Ahead – Develop and implement a retention plan with the new provider and spouse.



step 15 develop and implement a retention plan

If you recruited a provider using the *Recruiting for Retention* approach or similar process, you have already matched the candidate's characteristics to the attributes and needs of your community. Congratulations, you have already done a considerable amount of retention building. You have built a solid foundation for retention. Without such a foundation, all ongoing retention-building activities will have little impact on retaining a provider. The closer the practitioner and spouse's interests match the community, the more likely the provider and community will be satisfied with one another over the long run.

Once the new primary care provider begins practice in your community, you need to implement strategies that accomplish the following objectives:

- ❑ Welcome and orient the new practitioner and spouse to the medical community.
- ❑ Welcome and fully orient the practitioner, spouse and family to the community.
- ❑ Anticipate and address concerns or issues that may encourage the physician, spouse or family members to want to leave the community.
- ❑ Allow ample time for the practitioner to enjoy life beyond the practice.
- ❑ Reduce the sense of professional isolation and career stagnation often experienced by rural providers.

How these objectives are accomplished depends largely on the community, the new provider and spouse, and their children. But the common thread that runs through all



these objectives is the need to communicate regularly with the provider and spouse. Some specific retention activities that have proven helpful in rural communities are:

- Providing practice management and marketing assistance
- Assisting in securing start up loans
- Holding regular professional progress evaluation meetings with the provider to discuss morale and professional satisfaction concerns and issues
- Sponsoring periodic social gatherings of the medical staff, their spouses and families
- Assigning a mentor to orient the new provider and help integrate him or her into the medical community
- Assigning someone to orient and help integrate the spouse and family to the community
- Keeping the call schedule light – one out of every four days or less, if possible
- Funding career and personal development opportunities for the provider and spouse
- Providing opportunities for peer interaction outside the community
- Developing telecommunication links to practitioners in other communities and to medical education and support resources

Retention building activities such as these should be ongoing. They should be applied to all primary care providers in the community, as well as to other valued health professionals. You should always be aware of how satisfied or dissatisfied a provider

The Spouses perspective ...

QUESTION: With all the opportunities available, what keeps you in this particular community?

Ann Haller (husband, Fred, is an Internist): Our roots are here now. The people in the community are very much a part of our lives. People bring us huckleberries and cinnamon rolls, which is something you don't get in larger communities. There are a lot of benefits in a rural community. The support system is much better. It is more "homey".

Gary Thompson (wife, Joan, is a family practitioner): We moved around a lot already for Joan's medical school and residency, so we don't want to move anymore..

Laurie Thomson (husband, Jim, is a family practitioner in Emmett): Number One, the friendships we've made. Number Two, the recreational opportunities available here like water skiing, snow skiing, and hunting.

Kitty Spencer (husband, Mark, is a family practitioner): Friendships, people we've become acquainted with. You become more familiar with a lot of the people around you. You become involved in community groups. That's what holds us here. I wouldn't even think of moving to an urban area anymore!



and spouse are with the practice or the community. If you are unsure how they feel, ask them.

When a medical provider leaves your community, learn something from your loss. Determine the reasons behind his or her decision to leave and try to address them before you begin recruiting a replacement.

With the loss of a provider, you should first of all learn that recruitment is an ongoing task. Very few practitioners remain in one community or practice location for their entire career. American society is becoming more transient and primary care providers are only following the trend of their generation. Since they are in such high demand today, primary care providers are especially apt to be lured away from rural areas with promises of less work and more pay. Too many communities are surprised by the loss of one of their primary care providers and are not prepared to quickly replace him or her. Delays in recruiting a new provider cause a decrease in the access to care for residents and place the entire rural health care system at risk because of diminished revenues and referrals. Even when you have your full complement of providers, continue to cultivate relations with potential candidates by:

- ◆ Becoming a rural training site for medical students, primary care residents, and midlevel provider students;
- ◆ Staying in touch with these residents and students after they finish their rotation in your community and long into their careers;
- ◆ Encouraging medical staff members to cultivate a rapport with potential candidates at continuing medical education conferences;
- ◆ Bringing in locum tenens (temporary coverage) providers who may be willing to consider permanent practice opportunities;
- ◆ Subscribing to candidate sourcing services.



Carrying out Retention Activities

One way to improve provider retention and share the retention activity workload is to use a committee approach. The task of primary care provider retention is often assigned (directly or implicitly) to the hospital or clinic administrator. While this may fit the administrator's overall job description, the administrator should not be solely responsible for provider retention. Often during the course of a business day, the administrator's chief function –business aspects of health care delivery – clash with the provider's primary function – the clinical aspects of health care delivery. Over time, these sometimes opposing roles can create tension between the administrator and clinician, thus inhibiting open communication. Open communication is essential to retention.

The committee approach can help diffuse such potential difficulties and bring new ideas and personalities to the table. The committee does not have to be large. It should include a medical staff member, hospital and clinic administrators, and a few key community members. As part of your ongoing retention plan, include someone to focus on provider spouse/family retention.

To lay a retention development foundation, the committee should complete the Barriers to Recruitment and Retention Checklist on Page 66 and develop strategies to address or minimize each identified barrier in your community. You may also want to review the retention research findings on Pages 111 and 112. The committee should conduct a quick retention assessment by asking the following:

Spouses on Improving Spouse Recruitment and Retention

Kitty Spencer (Kitty and her husband, Mark, a family physician, have been in the same community for over 12 years): They [communities seeking physicians] need to court the spouse almost more than the physician. I had to consider the environment for the children. The biggest considerations are quality of life, educational opportunities and cultural opportunities. It is a surprise to most people that there are great educational and cultural opportunities to be had in a rural community like local arts and entertainment programs, community college, library, and, of course, all the recreational opportunities.

Ann Haller, Ph.D. (Ann and her husband, Fred, an internist, have been in the town for over 18 years): Pay as much attention to recruiting the spouse as you do the physician. "Show" them the school system, the supermarket, the churches. Don't just make them a list of places but take them there personally. It is hard for new people to just drive up to a new church and walk in when they have never been there before and don't know anyone.

Laurie Thompson (Laurie and her husband, Jim, a family physician, have been in their town for over 11 years): Hook them up with people in the community. Get them together for lunch, dinner and informal gatherings. It is important for them to connect with somebody. We often have people stay at our home when they are visiting which I feel helps the bonding process. It is also important to get the kids involved with other kids their age. I take them to the schools and let them meet the principals and the counselors. I try to make sure I take the wives to Boise to show them the shopping and explain the different cultural activities that are available. The hospital administrator and myself act as the hosts.



Does anyone in the community relate to the provider on a personal level?

YES NO

Does the provider feel there is emotional support from partners and the community?

YES NO

Are the provider's family and spouse included in social events?

YES NO

Is the family happy – do they have a sense of belonging to the community?

YES NO

Can the provider find adequate time for family and recreation?

YES NO

Are there any unmet expectations and are the original contract terms being met?

YES NO

Are referral patterns established and appropriate?

YES NO

Does the community utilize the provider's scope of services fully?

YES NO

Do on-call providers need additional professional support or professional enrichment?

YES NO

Does the provider have a retirement plan?

YES NO



The committee should apply these questions to each provider in the community. If the group cannot provide a positive answer or is uncertain about the answer for any of the questions, a duly appointed representative of the committee should meet with the provider and together develop retention strategies.



CONFLICT...

Conflict among local health care providers or between providers and administrators is a major threat to retention for all involved. When conflict exists, all parties must somehow be focused on resolving conflicts as quickly as possible. In some cases, it may be necessary to engage an outside mediator. In other cases, all that may be needed is a basic understanding of conflict and conflict resolution.

Sources of Conflict

- Value Differences
- Perceptual Differences
- Different Goals/Objectives
- Personality Clashes
- Scarce Resources
- Role Pressures
- Poor Communication Skills
- Unresolved Situations

Steps to Conflict Management

1. Identify and define the conflict
2. Each person involved in conflict states his/her point of view and restates the other persons' points of view
3. Brainstorm solutions
4. Evaluate solutions
5. Choose a solution agreed to by all parties
6. Implement a solution
7. Follow-up/evaluate progress

Source: Donna Taylor, Human Capital Developers, Athens, Georgia.



During the first two years in practice, a committee member, should meet monthly with the new provider. They should discuss personal and professional adjustment to the practice and community. Someone should also meet with the spouse on a monthly basis to discuss his or her and the children's adjustments to the community. Finally, a social event that includes the provider, spouse, and the rest of the medical staff and their spouses should be held. In the following years of practice, similar activities should be conducted, at least, on a quarterly basis. The Retention Questionnaire on Page 107 could be the perfect starting point for your long-range retention development effort.

As with recruitment, do not trust retention to fate. The stakes are too high. Keeping a consistent group of primary care providers is important to continuity and quality of care, and to developing community confidence in the local health care system. The loss of a primary care provider is also real in terms of time and money. Communities can spend many months and spend \$50,000 to \$100,000 each time they recruit a physician. In addition, the cost of not having a provider in the health care facility and community may be extensive. The costs may be reviewed at Rural Health Works: <http://www.ruralhealthworks.org>



Compared to what is at stake, the cost of keeping a provider – a little organization, time and communication – should be affordable to any community.

The demand for primary care providers is growing every day. There may be over 30,000 primary care practice opportunities nationwide. Competition is fierce. Such demand only heightens the recruitment and retention obstacles already facing rural communities.

Still, regardless of the competition, those who are prepared and who recruit with an eye on retention will be the most successful competitors.

The Retention Questionnaire

You, as a health care provider or facility administrator, or as someone in charge of recruitment and retention, should ask yourself some very important questions about the characteristics of your employment position and that of your employees and associates.

As a provider, you need to analyze your feelings about your work and the surrounding community, to be able to respond honestly to questions posed by prospective applicants. This will also help you understand your own situation and maintain your sense of mental and physical well-being.

As an administrator or someone responsible for provider recruitment and retention, you should make it part of your job to check the retention status of the providers in your community. You can then address their needs and improve their retention.

In either case, all those involved should be sharing their perceptions about job satisfaction. Problems, once identified, can be isolated, discussed and dealt with. Use the following questionnaire to establish a basis for discussion of the retention policies existing in your organization or community. Then, tailor the questions to your medical staff and follow up with one-on-one or group dialogue. If problems are present or impending, deal with them immediately and constructively. Use the information gathered to set up a proactive community intent on keeping all its providers and increasing its chances of recruiting new providers.

Insure adequate income potential:

1. Giving consideration to your expenses, lifestyle and cost of living in the community, how much money do you realistically require and are you making it now?
2. What would you like to be making in the future?
3. What sort of benefits and professional perks do you value most, whether you are receiving them now or not?



Practice Issues

1. How much input do you have into decision-making and policies that affect your position? How much do you want?
2. What is your perception of your responsibilities and workload?
3. Do you need more help with coverage or assigned tasks?
4. If you have a supervisor, what is your assessment of your relationship, especially in regard to your performance evaluation?
5. Are the support staff, physical plant and technology for your clinic and hospital practice adequate? If no, why?

Community Issues

1. What is your overall perception of the community in which you live?
2. Consider all aspects of your community, including schools, housing, culture, recreational opportunity conveniences, religious services, politics and people. What do you want, need or expect from the community that you are not receiving?
3. If you have a family, how can the community better address their needs?
4. How can the community, including other medical providers or facilities, better support your role as a health care provider?
5. How do you perceive the patient population served by your practice with regard to their acceptance, appreciation, responsiveness and support for your practice? Your needs?

Goals Issues

1. What are your personal and professional goals both short term and long term?
2. Do you feel that you can attain these goals within your present practice situation and within this community?



Research on Provider Retention

Two studies provide some valuable, objective insights into what factors most affect primary care physician retention. The findings of these studies should provide an information foundation you need to assess provider retention in your community and to develop concrete retention (and recruitment) strategies for your primary care providers.

Factors Influencing Retention of Physicians in Rural Areas

The table below shows the results from a survey on factors influencing retention conducted in eastern Kentucky. 132 rural eastern Kentucky physicians responded to the survey. The issues were rated from 1 (very important) to 5 (not important).

<u>Issue</u>	<u>Score</u>
Availability of relief coverage for vacations, holidays and family emergencies	1.3
Quality of public elementary and secondary schools	1.6
Compatibility with others in the medical community	1.7
Availability of quality housing	1.8
Readily available consultation with specialist via <i>telephone</i>	1.9
Availability of practice partners	2.0
Income potential in excess of \$100,000 per year	2.1
Employment opportunities for spouse	2.3
Help with retiring educational loans at start of practice	2.3
Technical help with the business aspects of running the practice	2.3
Readily available consultation with a specialist <i>in the community</i>	2.6
Easy access to medical library resources/support	2.8
Availability of health education opportunities	2.8
Accessibility of cultural opportunities such as musical events and theater	2.9
Availability of continuing education opportunities near home	3.1
Availability of physician extenders	3.2
Opportunities to participate in the education of future medical professionals	3.2
Readily available consultation with a specialist via <i>television</i>	3.7

Journal of Rural Health, Fall 1994. Researchers: Malcom P. Cutchin, MA, James C. Norton, PhD., Mae Marie Quan, MSED, David Bolt, MA, Sarah Huges, BSN and Barry Lindeman, MBA.



Another study looked at retention from the perspective of income and lifestyle requirements. This study revealed the following:

Income Requirements

1. If the physician is well established in the community, and if his/her personal life is stable, inadequate income is seldom the cause of departure.
2. Income is more likely to be a problem for the spouse than the physician.
3. Widely disparate levels of income among physicians are a greater problem than the absolute level of income.
4. Level of debt is a greater problem than level of income.
5. Many physicians fail to appreciate the basic relationship between income and the number of patients seen per day.
6. The productivity/income of a practice is more dependent on the number of minutes spent in seeing a patient than the number of minutes spent per patient.
7. The productivity/income of a practice is more dependent on the efficiency of the office staff than the physician.
8. Generally, the efficiency of the office staff conforms to the style and preference of the physician.
9. Generally, the payment system penalizes the physician who tries to provide services to the poor and the elderly.

Lifestyle requirements

1. Generally, the coverage arrangement is the most important component of “lifestyle.”
2. An “on-call” schedule of more than one night in four and one weekend in four is unstable.
3. Achieving a “1 in 4” schedule requires at least four providers who are “interchangeable” in terms of responsibility and scope of care capabilities.
4. Such coverage can be attained by cross coverage with other groups, but with great difficulty because of these issues:
 - a. Practice style
 - b. Quality of practice
 - c. Personality, acceptance by patients
5. Proper cross coverage requires access to patient data base.
6. Proper cross coverage requires frequent discussions and/or meetings regarding the process and the patients.
7. Proper cross coverage requires that most of the components of a “group without walls” be developed.
8. Groups without walls should be a major objective of practices (and communities) with less than four interchangeable providers.

Source: “Developing a Locum Tenens Program and Other Retention Strategies,” E. Harvey Estes, Jr., M.D., Kate B. Reynolds Community Practitioner Program.



PartFive



National Recruitment Resources

3RNet - National Rural Recruitment and Retention Network

Tel: 800.787.2512

Fax: 608.687.3993

Email: info@3rnet.org

<https://www.3rnet.org>

National Health Service Corps, 1.800.221.9393

<http://www.nhsc.gov>

HPSA Classifications: <http://bhpr.hrsa.gov/shortage/muaguide.htm>

Bureau of Health Professions Area Resource File (ARF):

<http://bhpr.hrsa.gov/healthworkforce/data/arf.htm>

Data set includes county level estimates for the entire US of the number of physicians; February 2000 release: <http://www.arfsys.com>

Bureau of Health Profession National Sample Survey of Registered Nurses:

<http://bhpr.hrsa.gov/healthworkforce/reorts/rnsurvey/default.htm>

Bureau of Labor Statistics Current Population Survey: www.census.gov/cps

Bureau of Labor Statistics Employment Projections: <http://bls.gov/emp/>

Bureau of Health Professions US Health Workforce Personnel Factbook:

<http://bhpr.hrsa.gov/healthworkforce/reports/stateresponse/keyfindings.htm>

Cooperating State Employment Security Administrations have labor market information offices that publish and disseminate ES-202 data for their states:

<http://www.bls.gov/bls/ofolist.htm>

Bureau of Labor Statistics Current Population Survey and Employment Projections and Occupational Employment Statistics:

<http://www.bls.census.gov/cps/datamain.htm>

Bureau of Census American Fact Finder: <http://www.census.gov>



Recruitment Resources

3RNet - National Rural Recruitment and Retention Network

Mike Shimmens, Executive Director
228 Little Creek Lane, Jefferson City, MO 65109
573.635.1525
<https://www.3rnet.org>

National Rural Health Association

One West Armour Blvd., Suite 203
Kansas City, MO 64111
816.756.3140
816.756.3144 fax
<http://www.nrharural.org>

National Health Service Corps

800.221.9393
<http://nhsc.bhpr.hrsa.gov/>

Rural Assistance Center

PO Box 9037
Grand Forks, ND 58202
800-270-1898
800-270-1913 fax
<http://www.raconline.org/>

National Rural Health Resource Center

600 East Superior Street, Suite 404
Duluth, MN 55802
218.727.9390
218.727.9392 fax
http://www.ruralcenter.org/id=mcrh_recruitment

Office of Rural Health Policy

Tom Morris, Director
Room9A-55, Parklawn Building
5600 Fishers Lane
Rockville, MND 20857
301.443.0835
301.443.2803 fax
<http://www.ruralhealth.hrsa.gov/>



Advanced Practice Nursing & Physician Information on the Web

3RNet - National Rural Recruitment and Retention Network

800.787.2512

<http://www.3rnet.org>

National Health Service Corps

800.253.9511

<http://nhsc.bhpr.hrsa.gov/>

Indian Health Service

800.892.3079

<http://www.ihs.gov>

American Nurses Credentialing Center

<http://www.nursingworld.org/ancc>

American College of Nurse Practitioners

202/466/4825

<http://www.nurse.org>

American Academy of Physician Assistants

703.836.2272

<http://www.aapa.org>

American Nurses Association

205.554.4444

<http://www.ana.org>

American College of Nurse-Midwives

202.728.9860

<http://www.acnm.org>

American Academy of Nurse Practitioners

512.442.4262

<http://www.aanp.org/default.asp>

American Association of Colleges of Nursing

<http://www.aacn.nche.edu>



Physician Information on the Web

3RNet - National Rural Recruitment and Retention Network

800.787.2512

<http://www.3rnet.org>

National Health Service Corps

800.253.9511

<http://nhsc.bhpr.hrsa.gov/>

Indian Health Service

800.892.3079

<http://www.ihs.gov>

American Medical Association

800.621.8335

<http://www.ama-assn.org>

American Osteopathic Association

<http://www.osteopathic.org>

American Hospital Association

<http://www.aha.org>

American Academy of Family Physicians

800.274.2237

<http://www.aafp.org>

Annals of Internal Medicine

800.523.1546

<http://www.acponline.org>

AIM DocFinder

<http://www.docboard.org>

ABMS Certified Doctor Home Page

<http://www.certifieddoctor.org>

AMA Physician On-Line Doctor Finder

<http://www.ama-assn.org/aps/amahg.htm>

Immigration: American Immigration Center

<http://Us-immigration.com>



Association of Staff Physician Recruiters

<http://www.aspr.org>

Health Care Administrator and Recruiter's Guide to the Internet

<http://www.healthcarehr.com>

Medscape

<http://www.medscape.com>

Credentials Verification & Resources

Primary source verification of board certification - <http://www.certificats.org>

List of docs disciplined & sanctioned - <http://questionabledoctors.org/>

Stark II, Immigration, & Other Legal Issues

Human resources law index - <http://www.hrlawindex.com>

Federal agency - <http://uscis.gov/portal/site/uscis>

American Immigration Center - <http://us-immigration.com>

Law firm specializing in immigration law - <http://www.ingber-aronson.com>



Physician, Physician Assistant and Nurse Practitioner Background Check

Note: You may need the candidate's social security number and driver's license number to gain access to some of the information listed below.

1. Licensure

Physician and Physician Assistants

- A. State Medical Board or <http://www.docboard.org>
- B. Ask the licensing board whether the agency offers a service that would reveal any problems the candidate might have had.
- C. The National Practitioners Databank (authorized by the 1986 Health Care Quality Improvement Act and managed by the UNISYS corporation) contains information on medical malpractice payments as well as any negative actions levied on licensure, clinical privileges, or professional society membership. A form must be completed and mailed to the Databank.

To receive forms call the help line: 800.767.6732

National Practitioners Databank
% Public Health Service
Room 805 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
<http://www.npdb-hipdb.hrsa.gov>

Nurse Practitioners

State Board of Nursing

2. **Undergraduate:**

Call the registrar's office at the school given by the candidate; confirm that the candidate did attend this institution, the dates of attendance, their graduation date, and degree program. The school may also have information on extra-curricular activities, scholarships and other information so be sure to ask. You may need a signature from the candidate to get an official copy of the transcripts.



3. **Medical or Nursing Schools:**

Call the registrar's office for the school that is given; confirm that the candidate did attend this institution, the dates of attendance, and the graduation date.

4. **Residency:**

The Residency Program Director's office can verify residency status, completion, and date of completion. You may also inquire if the candidate had (has) any distinguishing problems or was outstanding in a particular area—try to gain as much information beyond just dates and status if possible. Some residency programs have photos and informational accounts of the residents hobbies, family status, etc. that may be handy—be sure to ask if these are available.

5. **Certification:
Physician**

A. Verify certification through the appropriate specialty certifying board.

American Board of Family Practice

Submit written request with physician's name, address, and date of birth, with check (payable to ABFP) and self-addressed stamped envelope to:

Verification Department
American Board of Family Practice
2228 Young Drive
Lexington, KY 40505-4292
606.269.5626

<http://www.aafp.org>

American Board of Internal Medicine, Inc.

2634 Market Street
Philadelphia, PA 19104-2675
215.243.1500

B. Verify physician board certification by phone:

American Board of Medical Specialties
800.776.2378

<http://www.certifieddoctor.org>

C. State, county local medical societies can provide information on board status of their members.



Physician Assistant

- A. Inquiries regarding PA Certification may be addressed to:
National Commission on Certification of Physician Assistants
2845 Henderson Mill Road NE
Atlanta, GA 30341
404/493/9100
- B. For information about the PA profession or a list of current members contact your state physician assistant academy.

Nurse Practitioner

- A. Verify certification through the American Nurses Association
American Nurses Credentialing Center - ANA
600 Maryland Av SW, Suite 100W
Washington, DC 20024-2571
800.284.2378
<http://www.nursingworld.org/ojin>
- B. For information about nurse practitioners and current membership contact your state nursing association

6. Legal:

- A. Malpractice Suit—Information on past malpractice suits or any legal action involving the candidate may be obtained from the District Clerk at the Courthouse in any county in which the candidate has practiced. These records are public information.
- B. Driving/Criminal Record—It is a good idea to ask the candidate to obtain their own driving and criminal records—this can usually be done for a small fee.

7. References:

- A. Call the professional references provided by the candidate and use the reference check question sheet for interviewing them. Be sure to let the candidate know you will be calling their references so that the references will be prepared for your phone call.



Mailing Lists and Sources of Candidates

American Medical Association

800.621.8335

<http://www.ama-assn.org/catalog>

Directory of Physicians in the United States

Physician's Name, Address Medical School, specialty, year of graduation

Graduate Medical Education Directory also known as the Green Book

Over 7,000 accredited residency programs

American Academy of Family Physicians

800.274.2237

<http://www.aafp.org/residencies>

Family Practice Residency Program Directors

Family Practice Physicians and Residents

Military Gateway

919.781.3567

<http://www.militarygateway.com>

Public Health Service Physicians

American Medical Information, Inc.

800.888.8717

<http://www.infoUSA.com>

Physicians and Surgeons Database

US physicians with address, specialty, states of licensure, year of graduation

US Pharmacists and Dentists

American Osteopathic Association

312.280.5800

<http://www.am-osteo-assn.org>

Yearbook and Directory of Osteopathic Physicians

List of all US DOs by state

Directory of Osteopathic Physicians in Training

Lists interns/residents by specialty and state with graduation dates

American Board of Medical Specialties

800.521.8110

ABMS Directory of Certified Medical Specialists

Lists of all Board Certified Medical Specialists

Lists of all Board Certified physicians



American College of Physicians-American Society of Internal Medicine

Annals of Internal Medicine, The Hospitalist

<http://www.acpoline.org/counseling/hosps.htm>

190 N. Independence Mall West

Philadelphia, PA 19106-1572

800.523.1546

215.351.3768 (Display)

215.351.2667 (Classified)

PracticeLink.com

Medical employment web site

800.776.8383

<http://www.practicelink.com>

Online opportunity information, links to your own web site

Clinician's News (Targeted to Advanced Practice RNs and PAs)

Clinician's Publishing Group

2 Brighton Road, Suite 300

Clifton, NJ 07012

973.916.1000

American Nurse

American Nurses Association

8515 GeorGIN Ave, Suite 400

Silver Spring, MD 20910

202.651.7211



Primary Care Provider Advertising Options

American Family Physician

500 Route 17 South
Hasbrouck Heights, NJ 07604-3121
201-288-4440
813.445.9380 fax
Classified Ads

Physician Recruiter

P.O. Box 30327
Portland, OR 97294-3327
503.221.1260
<http://www.info@therecruiter.com>
503.221.1545 fax

Family Practice News

International Medical News Group
IMNG Classifieds
360 Park Ave South, 9th Floor
New York, NY 10010-1710
212-989-5800
Classified Ads

Unique Opportunities

214 South 8th Street
Louisville, KY 40202
800.888.2047
Display ads, targeted at residents
<http://www.uoworks.com>



Roadblocks to Recruitment

A Collection of Real Life Obstacles from In-House Recruiters

1. Some specialties are very much in demand and supply is very short .
2. The recruiting practice has unrealistic expectations about the candidate pool.
3. Lack of timely follow-up for ANY reason.
4. Looking for the “perfect” candidate (he/she does not exist). Inability to compromise on candidate criteria.
5. The practice has not done a strategic plan that includes the process of recruitment and retention – lack of homework required to compete.
6. The recruiting practice does not respond in a timely manner to candidates, or lacks general follow through and generally undermines.
7. Let’s just look at two more candidates before we make an offer, OK?
8. Poorly defined opportunity and not enough information for candidates or recruiter.
9. No contract or letter of offer.
10. No partnership track or too long to partnership (if appropriate) or buy-in to practice is too high.
11. Recruiting for call coverage only.
12. Those responsible for recruitment, including the physicians, are not prepared to interview.
13. No statistics available on practice potential and past financials, and/or managed care environment.
14. Community need is not strong enough to support practice (just because the Board feels there is a need, it does not necessarily mean the community or the Medical Staff supports the need).
15. Sabotage of recruitment effort by one of the recruiting physicians or others in the community.



16. Compensation and offer is not competitive, or potential income for future earnings is below average, or the recruiting facility insists it is only competing with others just like it.
 17. Lack planning for sourcing, screening candidates, interviewing, orientation, start.
 18. Poor interviewing and little regard for cultural fit in the practice and/or community.
 19. Not taking the candidate's family into consideration.
 20. Family members are over-involved in the practice.
 21. Cost of malpractice insurance and malpractice climate in a state.
 22. Recruitment staff is overburdened with other responsibilities or too many opportunities to recruit for effectively.
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CV SCREENING MADE EASY

Chloe Skinner in ASPR Newsletter

Whether you are an experienced veteran or a new rookie of the recruitment game, the task of weeding through a pile of CV's in response to your latest sourcing campaign can be daunting. The first few are exciting, but then they start coming in faster than you can process them, given all of the other responsibilities that many of us carry in addition to recruiting.

At least, this was my experience. The obvious thing seemed to be to take them all on a first-come, first-served basis and call all those who looked promising. But what if I were missing a really great candidate whose CV came in after I had spent my time working through the possible rejects? How could I pare down the workload to a manageable size and select the best matches for the position?

After giving this some thought, and in consultation with our medical director, we came up with the idea of developing a CV screening tool. We listed all of the requirements for medical group and medical staff membership as the basic criteria all candidates must meet. Then we listed several "red flags" that would prompt us to question the candidate's history, such as "changed residencies," "frequent moves," etc. Next, we instituted a rating scale and made an arbitrary cut off point. In our scale, everyone begins with 100% automatically, by just submitting their CV. Then for every negative answer to the questions on the screening tool, the candidate loses 5%. After scoring everyone, we



select those with a 90% rating or above and begin contacting those rated at 100% first and work through the now much more manageable pile in order of their rating.

The tool works great. It saves time, is objective rather than subjective, and eliminates the concern of missing the best match for the position. We have revised and refined the tool over the years until it works well for us when recruiting for our medical group. We also review the tool and change it as needed to accommodate the desires of other groups we assist in recruitment activities. We find that about 90% of the time the doctors we contact as a result of using this screening tool are a good match for our jobs. And since our medical group is committed to selecting quality providers, we are under no pressure to deviate from the criteria the group has established.

PHYSICIAN APPLICANT QUALIFICATIONS REPORT
(Step #1: CV Screening Against Predetermined Minimal Group Membership Criteria)

PROVIDER'S NAME: <i>John Doe, M.D.</i>	RATING: <i>100%</i>	MEETS 90% STANDARD? <i>YES</i>
SPECIALTY: <i>General Nonsense</i>	DATE AVAILABE: <i>August, 2014</i>	SCREENED BY: <i>Super Recruiter</i>

CRITERIA	CIRCLE ANSWER		COMMENTS
	Yes	No	
1. Does candidate have an MD or DO degree from a U.S. recognized medical school?	Yes	No	Where? <i>Hanneman University School of Medicine</i> Date Completed? <i>2010</i>
2. Has candidate completed both internship and residency in the U.S.?	Yes	No	Where? <i>Internship @Cedars-Sinai Medical School/Los Angeles in General Nonsense 2011; Residency@ National Naval Medical Center @ Bethesda, MD; Chief Resident @ Bethesda</i>
3. Has candidate completed a full residency in the specialty for which the candidate is applying?	Yes	No	Number of years required: <i>4</i> Number of years completed: <i>4</i>
4. Is the candidate board certified or board qualified for four years or less in specialty in which candidate is applying?	Yes	No	<i>Diploma American Board of Surgery</i>
5. Is the candidate a U.S. Citizen, permanent resident, or have a Green Card?	Yes	No	<i>Permanent Resident. Family immigrated when he was 3 years old. Grew up in Southern California.</i>
Candidate must meet 100% of criteria 2,3,4, and 5 to qualify. Does applicant qualify?	Yes	No	If no, end process. Send "continue search" letter. If yes, continue to screen for red flags.



“RED FLAG” ITEMS	CIRCLE ANSWER		COMMENTS
a. Does candidate have ties to the area?	Yes	No	If yes, what? <i>Has friends in Seattle</i>
b. Has candidate made multiple moves and worked in multiple practices within a short period of time (in other than a locum tenens capacity?)	No	Yes	<i>Is currently in the Navy</i>
c. Has candidate practiced at multiple locations and/or hospitals during solo practice?	No	Yes	
d. Are there gaps in time between positions, or suspicious time intervals in candidate’s CV?	No	Yes	
e. Is the candidate currently doing something not trained to do?	No	Yes	
f. Has the candidate changed residency programs, or have there been any incomplete residencies?	No	Yes	
g. Does candidate have a license in the state where he/she currently resides?	Yes	No	California State Medical License #00000
h. Does cover letter and/or CV contain misspellings, grammatical errors, or is it poorly formatted?	No	Yes	
Subtract 5% for each answer circled in the right column for questions “a” through “h” above. Does candidate meet standard selection criteria of 90% to 100%? <i>100%</i>	Yes	No	Enter overall score and qualification above. If qualified, initiate interview and complete Provider Preference Worksheet. If not qualified, initiate continuing search letter or notify recruiter.



Dear Doctor:

As part of the recruitment process, <Hospital/Clinic> completes a background check, reference checks and queries the National Practitioner Data Bank.

Please complete the enclosed Disclosure Questionnaire and Authorization & Release form and return them in the enclosed envelope. Please provide us with a list of references (with names, addresses and phone numbers) who can attest to your clinical skills and training. We understand that physicians in practice will be concerned about confidentiality, and we will work with you to protect your needs.

If you have any questions or need additional information, please contact:

<NAME>, Medical Staff Recruitment
Some Clinic Somewhere
1600 Kentucky Ave.
City, State, Zip
800.555.1212
<EMAIL>@someclinic.org

Thank you for your assistance and your continued interest in <Some Clinic>, and you will be glad to know that <Clinic> is an EEO employer that maintains a drug free work place.

[Signed]



DISCLOSURE QUESTIONS

PLEASE PROVIDE A COMPLETED, SIGNED AND DATED EXPLANATION ON A SEPARATE SHEET IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE.

<CLINIC/HOSPITAL> offers of employment are contingent upon successful completion of the referencing process, the National Practitioner Data Base query, the required drug screening, criminal and background checks, appropriate state licensing and successful completion of the credentialing/privileging process. Prior to employment, the appropriate state professional license and the credentialing/privileging process must be completed and approved.

1. Yes No Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?
2. Yes No Has your DEA registration ever been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?
3. Yes No Has your membership, participation, clinical privileges, or employment ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
4. Yes No Have you ever voluntarily or involuntarily relinquished your membership, participation, clinic privileges, or request for privileges, employment, professional license, or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?
5. Yes No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?
6. Yes No Has your certificate or participation in any private, federal, (i.e. Medicare, Medicaid, etc.) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?



7. Yes No Have you ever been convicted of a felony?
8. Yes No Have you ever had any professional liability claims or lawsuits brought against you, directly or indirectly, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?
9. Yes No Has your professional liability carrier ever refused or canceled your coverage?

ATTESTATION SIGNATURE AND DATE

I hereby certify that all the information on this form, and any supporting documentation, is complete, true and accurate.

Signature _____ Date _____

Name _____
(Please print)

<CLINIC/HOSPITAL> IS COMMITTED TO PROVIDING EQUAL EMPLOYMENT OPPORTUNITY TO ALL EMPLOYEES AND APPLICANTS FOR EMPLOYMENT WITHOUT REGARD FOR RACE, CREED, COLOR, SEX, AGE, NATIONAL ORIGIN, HANDICAP, MARITAL STATUS, STATUS WITH REGARD TO PUBLIC ASSISTANCE, OR VETERAN STATUS, AND IN COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS.



AUTHORIZATION FOR RELEASE OF INFORMATION
<Hospital or Clinic Name>

By signing this Authorization to Release Information, I, the undersigned, hereby consent to the inspection by <CLINIC> and its designated representatives of all records and documents that may be material to an evaluation of my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, financial condition or any other matter that may be considered material to my qualification for employment/staff affiliation. I understand that this may include the inspection and/or verification of educational and training records, professional organizational and/or association records, work experience, current and past licensure records, certification records, professional liability insurance records, and contact with personal and/or professional references, National Practitioner Data Bank query (requires DOB and social security number) and any other records or third parties that may have direct bearing upon my application.

Additionally, I, the undersigned hereby release from liability all representatives and agents of aforementioned organization for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from liability any and all individuals and organizations who provide information to this facility's representative(s), in good faith and without malice and I hereby consent to the release of such information.

A copy of this Authorization to Release Information shall be as binding as the original.

Signature

Date

Please print name

Social Security Number

Date of Birth (NPDB only)

End Page

