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Recruiting for Retention

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Recruiting for Retention

Introduction

Health care professionals are critical to the stability of medical services in rural 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 including 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 which can be used for recruiting other health professionals. If the recruitment process is completed in a systematic, planned manner, retaining qualified health care professionals is enhanced. Recruiting the right candidate in the first place will minimize the risk of turn-over and maximize limited recruitment dollars.

Primary care providers include: family and general physicians (practitioners), general internists, general pediatricians, obstetricians/gynecologists, physician assistants, nurse practitioners and certified nurse midwives.

The importance of the primary care provider is particularly profound in vast rural areas where the loss of even a single primary care provider can cripple or collapse an entire health care system and deter 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, and understaffed and overworked medical staffs.

Today, even though managed care penetration on the east and west coasts have made it somewhat easier to attract qualified providers to more rural locations, challenges still exist.

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. Scant attention is paid to factors influencing their current providers' retention, and most jump into the recruitment process not 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, and luck will always be part of the success formula. 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 for finding *and retaining* the most 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 basic steps. For each step, you will learn tips and tools for making your recruitment effort a more manageable, productive and efficient process.

As the name implies, Recruiting for Retention provides insights on 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.

There are a few ways to approach Recruiting for Retention. One, you can, of course, read the manual from cover to cover. Two, 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. Three, 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.) are included on a disk that can be found on page 113 in the last section on Resources. The files are in two formats: Microsoft Word (*.doc) and ASCII text (*.txt).

For additional information on any topic discussed in Recruiting for Retention or for primary care recruitment and retention training and assistance contact the Idaho Rural Health Education Center at (208) 336-5533 ext 235.

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.

Step 1: Assess need for additional providers and determine potential income for new provider.

Action Step	Lead Person	Deadline
1. Determine provider supply and demand (p.15).		
2. Determine potential income for new provider using the clinic and hospital CPT codes and average charge per CPT (p.25).		

Step 2: 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.31).		
2. Meet and discuss recruitment needs with stakeholders and get their support (p.32).		
3. Educate public on the recruitment effort and gain its support to help develop practice before provider is recruited (p.32).		
4. Inform organizations about your opportunity for assistance in recruitment, promoting your opportunity or identifying recruitment/retention resources for your community (p.64,111)		

Step 3: Form Recruitment Committee and assign roles. (p. 33)

Action Step	Name
1. Coordinator (p.35)	
2. Contact or Point Person (p.36)	
3. Clerk (p.36)	

4. Candidate Interviewers (p.36)
5. Spouse Recruiter or Spouse Interviewer(s) (p.37)
6. Reference/Credential Reviewers (p.37)
7. Promotion Developer (p.38)
8. Site Visit Team (p.38)
9. Site Visit Hosts (p.38)
10. Contract Negotiator (p.39)

Step 4: Develop competitive compensation and benefit package: itemize, and place 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.41).		
2. Develop benefits package, place dollar amount on monetary-type benefits, list non-monetary perks (p.43).		
3. Seek legal advise to determine if your package complies with state codes and is acceptable to the IRS and Office of the Inspector General, DHHS (p.41).		
4. Develop practice profile (p.39).		
5. Develop community profile (p.45).		
6. Identify barriers to provide recruitment and retention (p.63).		
7. Implement actions to address/minimize barriers.		

Step 5: 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, and then pursue those who most closely match your ideal. (p.49).		
2. Develop candidate and spouse interview questionnaires, and reference questionnaires that asks specific questions which help you to determine how closely the candidate matches the ideal candidate for your community. For example, 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.72)		

Step 6: Develop recruitment activity budget.

Action Step	Lead Person	Deadline
1. Develop recruitment budget (p.59).		

Step 7: 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 promote the professional and personal aspects of your opportunity and community that you think will appeal to the “ideal” candidate you defined (p.39,45-49,64-68)		

Step 8: 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.64,111)		
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.59).		
3. Locate “free sources” of candidates and 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.64,111)		

Step 9: Develop process for receiving candidate information and quickly following up candidate inquiries.

Action Step	Lead Person	Deadline
1. Assign a traffic director (clerk) responsible for receiving candidate information, sending follow-up packet to candidate, and notifying the candidate screening team and sending the team the candidate’s information (p.36).		
2. Develop a chart for tracking where each candidate lead is in your recruitment process, 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. Make sure that never more than two weeks transpire between phone or in-person contact with the candidate (p.70).		

Step 10: Develop interviewing process.

Action Step	Lead Person	Deadline
1. Form the candidate and spouse interview team (p.36).		
2. Develop candidate and spouse interview questionnaires that asks questions which help you determine whether the candidate possesses the preferred characteristics possessed by your ideal candidate (p.72).		
3. Conduct mock interviews to test the questionnaire and provide the interviewers with interviewing skills practice (p.73).		
4. Prepare for potential questions asked by the candidates and spouses by answering “Questions Most Commonly Asked by Physicians” (p.76).		

Step 11: Develop process for conducting reference and credential checks.

Action Step	Lead Person	Deadline
1. Form the reference and credential check team (p.37).		
2. Check candidate’s credentials (p.79).		
3. Develop a questionnaire for candidate references that asks the references questions which help you learn if, from the references point of view, the candidate possesses the characteristics you defined for your ideal candidate (p.84).		
4. Interview candidate spouse (p.82).		
5. Identify and interview at least an additional two references not provided to you by the candidate. (p.84)		

Step 12: Prepare for site visits.

Action Step	Lead Person	Deadline
1. Develop standard site itinerary to be modified to fit interests of each candidate (p.89).		
2. Educate site visit team members about the opportunity. (p.88)		
3. Rehearse the site visit.		
4. Educate site visit team about each candidate.		
5. Develop draft contract or proposition letter (p.96).		
6. Send candidate and spouse follow-up information packet to site visit (p.99).		

Step 13: Develop site visit follow-up process.

Action Step	Lead Person	Deadline
1. Contact candidate to confirm acceptance or rejections of offer (p.99).		
2. Develop/implement candidate and spouse integration plan when candidate accepts offer (p.100).		
3. Identify and assess reasons for being rejected when offer is declined by the candidate (p.99).		
4. Adjust recruitment process and practice opportunity to address reasons for rejection (p.100).		

Step 14: Develop and implement a primary care provider retention plan.

<u>Action Step</u>	<u>Lead Person</u>	<u>Deadline</u>
1. Create retention committee (p.104).		
2. Meet with new provider on monthly basis to assess integration progress.		
3. Meet with spouse on monthly to assess spouse and families integration progress.		
4. Have quarterly social for medical staff and spouses.		
5. Meet with all primary care providers on quarterly to discuss retention issues and address concerns.		
6. Conduct retention questionnaire with medical staff (p.107).		
7. Work with medical staff to develop long-range medical staff development and retention plan (p.101).		

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.31)
- Have support of other health professionals for recruiting a provider (p.31)
- Have evidence of community support for the recruitment (p.32)
- Have trained and motivated recruitment team (p.33)
- Have developed practice opportunity: practice and community profile (p.39)
- Understand the unique aspects of the community's opportunity (p.45)
- Have competitive compensation and benefits with non financial perks (p.41)
- Have sought legal advice on proposed contractual arrangement(s) (p.41)
- Understand the barriers to recruitment/retention of physicians to the community and have strategies for overcoming the barriers (p.63)
- Have reasonable expectations of provider, including coverage schedule (p.44)
- Have adequate clinic space, support staff, technology (p.40)
- Have adequate hospital technology for the specialty sought (p.40)
- Have well-prepared practice opportunity promotional materials (p.48)
- Have clear picture of the ideal candidate for the practice and community (p.49)
- Have a spouse recruiter (p.37)
- Have recruitment budget (p.59)
- Have organized candidate search process (p.64)
- Have organized candidate screening process (p.70)
- Have prepared answers for questions commonly asked by candidates (p.76)
- Have contacted appropriate organizations about provider needs (p.65)
- Have strategies for dealing with spouse and family needs (p.93)
- Have candidate site visit plan of action, including itinerary (p.89)
- Have draft service agreement or letter of intent prepared, if applicable (p.96)
- Have retention strategies for the new and existing providers (p.101)

Part One

Planning and Preparation

Part One is the most important ingredient for ensuring a successful recruitment effort. It is also the most neglected part. There are six steps in planning and preparing for recruitment: conducting a needs assessment, gaining support, forming a recruitment team, developing the practice opportunity, defining the ideal candidate and developing a budget.

Many communities jump into the recruitment waters with little preparation. Communities that plunge into the deep end without considering the depth or current usually find themselves swimming upstream the entire way. These communities typically spend more money and time on recruitment and enjoy less retention success than those that gradually wade into the candidate pool.

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

There are two symptoms of what we'll call "plunging". One, you are surprised about the "sudden" loss or pending loss (less than six months notice) of one of your providers. Two, your first step to replace the provider is placing an advertisement in a national journal or hiring a recruitment firm. If you were surprised, this means you were not actively engaged in retention building efforts. And "Symptom Two" is usually an expensive and often ineffective knee-jerk reaction to "Symptom One".

Treatment: Granted you cannot reverse the effects of Symptom One,

but you can prevent the symptom from recurring, prevent Symptom Two altogether and, ultimately, improve recruitment and retention if you follow these six steps in the order they appear:

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 midlevel provider is more appropriate or that local demand for primary care does not justify recruiting a new provider at all.

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 through 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.

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 (largely because of their simplicity) to measure primary care provider need are those that 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 includes the federal Health Professional Shortage Area (HSPA) designation process, can provide you a general indication of need, they could be misleading, for 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 boom town. Consequently, one community is largely inhabited by seniors while the other is inhabited mostly by men between the ages of 18-45. Which town will use primary care providers more? Which town do you think, then, actually needs more primary care providers?

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

One relatively simple way to go beyond head count methods is called the “Demand-Based Needs Assessment”. This assessment accounts for both the *size* and demographic *mix* 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 varying levels. We define these sex-age groups by lifecycles: prenatal, pediatric, adolescent, adult and geriatric. The size and actual lifecycle “mix” of your population 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 to not only 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.

Conducting a Demand-Based Needs Assessment

Steps

- 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 careful! Such boundaries are geo-political 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 document form. If you can access computerized patient origin records, gather patient data by zip code, age, sex, payer source (insurance company) and diagnosis. This will help you fully define your service area by geography and demography (population sub groups).

Once you have defined your service area, obtain census breakdown information by age and sex for all residents in your

Lose a Primary Care Physician?

You may benefit for 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 HPSA – exempts new physicians opening practices in non-metropolitan geographic HPSAs from new Medicare limitations on "customary charges".
- Rural Health Clinics Act – provides Medical 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 service obligated physicians, dentists and other health professionals to designated HPSAs.
- National Health Service Corps Scholarship Program – provided 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.bphc.hrsa.gov/databases/newhpsa/newhpsa.cfm>

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 by female in the following age groups:

Male

- Less than 15 year 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 year 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 supply of and demand for primary care services.

B. Calculating Primary Care Provider Supply

Since the family physician is the most sought after type of primary care provider, we'll conduct a sample demand-based needs assessment using a family physician example. We define demand for primary care at the local level as patient office visits made to a primary care provider.

According to the American Medical Association (AMA) Socioeconomic Characteristics of Medical Practice 1997, family practice physicians spend an average of 48.8 hours a week in direct patient care (Note, 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.

To determine your 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, if a semi-retired doctor only sees patients in his office 16-20 hours per week, he 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 uncomfortably high number for 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 midlevels 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/GP = family physician or general physician*

<i>Patient Visits Per Year</i>	x	<i>Number of FPs/GPs</i>	=	<i>Total Potential FP/GP Office Supply</i>
4,800		_____		_____

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

<i>Patient Visits Per Year</i>	x	<i>Number of PAs/NPs</i>	=	<i>Total Potential PA/NP Office Supply</i>
3,000		_____		_____

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

The operative word here is “potential.” Your 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

1998 national statistics show an individual visits the doctor an average of 3.1 times a year. 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 22.

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 23.

Age/Sex Utilization Worksheet - LOW RANGE

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	Population	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	Population	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 Advance Data “National Ambulatory Medical Care Survey: 1998 Summary” published July 19, 2000, *Table 3: Number, percent distribution, and annual rate of office visits, by patient’s age, sex, and race-United States, 1998*. The data is downloadable from a website for the National Center for Health Statistics - <http://www.cdc.gov/nchs/products/pubs/pubd/ad/ad.htm>.

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

For example, if your low range estimate was 5,000 visits and 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 let’s 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 20 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 its 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.

Estimating Hospital Utilization

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, we can conclude 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 24 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 also will 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 “true” 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 with a new patient with a Level 2 care. A CPT code list with an estimate fee range for the Northwest 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. And the higher the complexity, 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. In either case, the physician is failing to maximize on patient reimbursement due to him or her. 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 in 1992. Visits are now termed “Evaluation and Management Services.” Actual code numbers and descriptions also changed. The list on the following page presents the most recent CPT codes and their corresponding levels of care (1999). The fee range provided is an estimated range for the Northwest based on data obtained in 1995.

CPT CODES: OFFICE OR OTHER OUTPATIENT VISIT

CPT Code Level	Fee Range
----------------	-----------

New Patient Codes

99201	\$45-55
99202	\$54-69
99203	\$81-100
99204	\$111-136
99205	\$169-210

Established Patient Codes

99211	\$20-26
99212	\$35-44
99213	\$46-56
99214	\$68-85
99215	\$118-155

CPT CODES: HOSPITAL CARE

CPT Code Level	Fee Range
----------------	-----------

Initial Hospital Care Codes

99221	\$114-141
99222	\$153-195
99223	\$198-260

Subsequent Hospital Care Codes

99231	\$53-65
99232	\$74-91
99233	\$113-140

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 29:

1. On the "CPT Office Revenue Worksheet," insert your Total Unmet Primary Care Demand number from Page 24 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 25, 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.

Did you know.....

- A primary care physician will generate 133.6 hospital inpatient admissions per year.
- A primary care physician will generate an average of \$535,836 in annual inpatient revenue for hospital.
- Each primary care patient will generate an average of \$5,035 for a hospital.

Source: Ernst and Young 1990 Physician Revenue Survey

CPT Office Revenue Worksheet

CPT Code	Office Visit Demand	Percent Times Used	Times Used	Fee per CPT Code	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 Code
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 by 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 with an estimate for the Percent Times Used, for new patients take 12.7% of the individual CPT percentages and for existing use either 86.4% for office or 81.2% for hospital CPTs.

Step 2. Gaining Support for the Recruitment Effort

The first stops on the support rally must be with the 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. It never fails, if four of the five primary care providers practicing in a community support the recruitment effort, the prospective candidate always seems to contact 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, at least, the majority of the medical staff.

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 discussed in the last section comes in handy. Physicians and midlevels 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 adequate *unmet* demand exists to support another provider. Some may need to be convinced a new provider won't need *their* 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 something more than what the existing family physicians earn, you will 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 cost you the loss of a valued existing provider.

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

Once you gain the medical staff's support, go a step farther 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 these providers have much riding on the recruitment effort. Ask the medical staff to elect one member to be an active participant of the team (not just a passive observer as is often the case when a provider is on 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 well apprised of the recruitment effort and of leading candidates.

You will then meet with other players 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.

Beyond health care providers and for reasons other than their health, many other members of your community have a stake in the success of the local health care system as well. Your job is to identify these “stakeholders,” make them aware of the importance of the primary care provider to the health care system and to the community’s economy, and gain their support for the recruitment effort.

For example, the local banker is a stakeholder who certainly understands the economic value of the hospital’s payroll to his bank. If he can be shown the importance of the primary care provider to the viability of the hospital, he may help secure start-up capital for the new provider’s practice. The school principal is another stakeholder. He or she understands that healthy kids make better students. But does the principal understand the primary care provider is the principal member of a child’s health management team. If you have the principal’s support, he or she could help you address candidate’s questions about the local education system by talking with the candidate and spouse, sending the candidate information and/or providing 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.

In addition, these stakeholders may make great players on your local recruitment team.

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 community’s 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 now leave the community of a new local provider alternative.

Step 3. Forming a Recruitment 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 perhaps 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 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. So provide ample opportunities for the candidate and the community to get to know one another during the recruitment process. For the candidates 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. We use the title “recruitment team” rather 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. Team also implies action.

Many members of your community will be interested in your recruitment effort, and some will be eager to help. We want people who are both eager and appropriate for certain tasks at certain points during the recruitment process. Like a baseball team wants a fleet-footed player for the center field and a sure handed fielder for short stop, we want the right people for the right positions. We 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
- Citizens who match characteristics of candidate (and spouse) you seek
- Media
- Civic minded citizens

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

Building a Recruitment Team

There should be no doubt or misconceptions about the work ahead for the Recruitment Team. When recruiting team members you need to be straight with them 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 make decisions or completing assignments by "committee."

When complaints arise about not involving the community in the recruitment process, it is usually because the recruitment coordinator does not know how to use the community. The coordinator has a group of well-meaning individuals who really don't 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 coordinator 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 *core group* (or primary roles) of the Recruitment Team consists of the Coordinator, Contact Person, Clerk, Interviewer(s), Spouse Recruiter, Reference and Credential Reviewer(s), and 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 Coordinator, 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

COORDINATOR: This is the team captain. This position is responsible for making assignments and seeing they are completed. The coordinator 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 Coordinator'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, for it is usually one of these organizations that first recognizes the need to recruit and has the most to gain or lose by recruiting a primary care provider. But the typical administrator has many complex and time-consuming responsibilities running the hospital or clinic. These primary responsibilities often prevent them from giving the recruitment effort the time it needs. Simply because medical staff development is part of the administrator's job description, it does not mean the

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 a team and cause
- Recognize and thank volunteers often

For more information on recruiting and managing volunteers, including efforts beyond recruitment, contact Idaho Rural Health Education Center (208) 336-5533 ext. 235

administrator needs to be or should be the actual recruiter. In addition, some administrators may lack the interpersonal skills it takes to coordinate the effort.

Whether it be for lack of time or personality, the administrator may want to apply professional sport's general manager approach to running the team: find a coach. This approach allows the administrator to keep the overall responsibility for team success but leaves the recruiting, coaching the team and coordinating the day-to-day recruitment activities to someone else.

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

Because the Contact Person is the point person for candidates interested in your opportunity (and is empowered to represent it), the Contact Person is often the same person as the Coordinator. In most cases, he or she is also one of the Candidate Interviewers. The primary responsibilities of this position include: *promptly* responding to candidate's inquiries by phone, mail or in person, be available on evening or weekends when candidates often contact opportunity sites, and learning all aspects of the practice opportunity and community.

CLERK: This position is mainly one of information traffic director. The clerk sends your opportunity packets to interested candidates, sends candidate information to the candidate screening team and medical staff, and keeps track of where each candidate is in the recruitment process, i.e., opportunity packet stage, interview stage, reference check, site visit, follow up, etc. The Clerk warns the Coordinator when too much time (7-10 days) passes between dates of contact with each candidate.

CANDIDATE INTERVIEWERS: 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. They are 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. They are also key to increasing eligible candidates' interest in the opportunity. Indeed, 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. Persistency is also a valuable trait for an

Interviewer, for 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, Interviewers should be knowledgeable of what candidates look for in opportunities and be prepared to answer their questions about your opportunity. The section called “Questions Commonly asked by Physicians and Their Spouses” of this manual can provide them insight into this (refer to Page 80). In many successful cases, one of the Interviewers has been one of the contact persons. 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're 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 a person or persons on your team whose sole responsibility involves 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 professional or career needs, and 6) providing the Recruitment Coordinator and Recruitment Team 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's spouse (if recruiting a physician or midlevel spouse if recruiting a midlevel) 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 area. 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, likability 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 not be afraid of asking tough questions. They will interview candidates' references using a tool developed by the Recruitment Team to determine how well the candidate matches the community from a third-party 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 what amounts to a *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 Coordinator, will work with the Support Members to help them complete their tasks.

PROMOTION DEVELOPERS: This is a group position, and this group has fun. 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 marketing plan (so to speak) 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 when they come to the community for a site visit. It is critical to the matching process that the site visit team include members who the candidates consider their professional, age, social and interest area peers. 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 the candidate and family's interests. Team members should have a good understanding of the practice opportunity and the community as well.

SITE VISIT HOSTS: From the site visit team, one or two members are the assigned "hosts." 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, for 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. The site visit will be discussed in more detail later. Refer to page 87.

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 talk to and establish a rapport with the candidate. The negotiation session is not the best place to start building trust.

Step 4. Defining Your Opportunity

Before you can identify who you want, you need to understand who you are by fully defining your opportunity.

There are three parts to any practice opportunity: the practice setting, community and compensation. Yet while all opportunities include these parts, its how you define each part that will set your opportunity apart from other opportunities. Once defined and combined, these separate parts 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.

We begin defining our opportunity by developing a profile for each part of the opportunity package.

Practice Setting Profile

The practice profile is one part of the professional proposition of your opportunity. The other part is the compensation package. When defining the practice part of your opportunity, profile 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? How about residency trained? Do you want experience or will a new graduate be satisfactory? Will you consider a foreign medical graduate? For midlevels, 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 – Solo, group, satellite, or hospital-based.

Clinic Facilities – Describe the size (dimensions and number of exam rooms will do), layout, age and condition of the physical plant. Describe the technology located in the clinic. Describe the administrative and clinic 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?

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

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. 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 in our community, including visiting specialists and physicians and midlevels who are not on the hospital medical staff. List 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 combinations of size and form. 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 to candidates today: a simple fee for service offer with \$175,000 per year gross earnings potential or a \$100,000 annual income guarantee plus benefits? Most new providers will opt for the second offer because 1) its “guaranteed: and 2) benefits and expenses must still be deducted from the gross earnings of the first offer, which will dramatically reduce the take-home amount.

You should exercise caution when developing hospital sponsored recruitment packages and always seek legal counsel. Non compliance 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 they refer patients for the hospital or specialized physician services.

Salary arrangements are more common for nurse practitioners and physician assistants than physicians, although a growing number of integrated health care systems are hiring physicians. On the plus side, the salary arrangement allows the organization, especially hospitals, 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, for example, between a hospital and a physician, the physician usually is an independent contractor. The hospital simply guarantees the physician a predetermined annual income in exchange for certain responsibilities or services. As opposed to a salary, 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.

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 \$120,000 per year or \$10,000 per month. Each month when the physician's clinic patient revenues exceed this amount guaranteed, this 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. For an incentive, then, the physician is awarded all or a percentage of the surplus revenues remaining in the pool at the end of the year. 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 income guarantees and incentives are the most fertile ground for legal problems.

Fee for Service – In rural recruitment, this compensation arrangement is going the way of the dinosaur. 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 they develop 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.

In the January 8, 2001 *Medical Economics* there are several tables displaying compensation by specialty and starting salary ranges. The following is taken from a table of 1999 Compensation by Specialty:

- Family physicians: \$128,490 to \$141,560
- Internists: \$127,090 to \$145,375
- General surgeons: \$184,950 to \$243,362
- Ob/gyns: \$191,270 to \$223,584
- Pediatricians: \$133,750 to \$142,770

The following table is data on starting salaries (from a national recruitment firm based on 1,901 assignments from April 1, 1999 to March 31, 2000).

Specialty	Low	Average	High
Family Physicians	\$105,000	\$135,000	\$200,000
Internists	\$100,000	\$139,000	\$170,000
General Surgeons	\$145,000	\$189,000	\$300,000
Ob/gyns	\$150,000	\$225,000	\$300,000
Pediatricians	\$100,000	\$130,000	\$160,000

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 include the following:

Benefits	Cash Value
Paid malpractice insurance	
Paid family health insurance	
Paid relocation expenses	
4 weeks per year vacation/CME leave	

Competitive benefits packages also include the following:

Disability insurance	
Family dental insurance	
Retirement plan	
Paid professional dues	
Education loan repayment assistance	
Signing bonus (<i>usually 5% of annual</i>)	
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 behind 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 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 below perks 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 (preceptorships)
- Established patient base
- Visiting specialists
- Office located close to hospital
- Remarkable hospital or clinic technology
- Medical staff of similar age and interest of 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

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 that of practice opportunities in surrounding rural communities. This means the candidate’s decision on 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 the community. What would you want and need to know? Chances are your list of important information would include the following:

Demographics: A description of the population in terms of size, age groups, values, ethnic and religious diversity, educational and socioeconomic backgrounds of the residents, and so on. Some insight as to why people like to live in the community would be helpful as well.

Location: 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 know locations and recreation areas, and to other remarkable areas of interest. A description of the land features of the area and the climate is also important.

Economy: A description of the current and forecasted economic health of the area. A list that shows the major economic contributors in the area, major employers, employment rates and employment by sector, average income and so on. A description of the housing market in terms of availability, types and prices of housing is also important.

Local Organizations: A description of the professional, social and civic organizations in the community in terms of who comprise their membership and the level of participation and support enjoyed by each group.

Shopping: A description of 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: A description of the preschool through high school education system in terms of grades, public and/or private, academic performance, class sizes and student-teacher ratios, education facilities (computers, etc.), and extracurricular activities (music, art, academic, civic, athletic, etc.). A description of the 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, a description of 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: A description of the history of the area and its people. A list of the social activities, churches, media, museum, 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: A description of what residents do in your area for fun and play and where they do it terms of miles and minutes from your community. Outdoor recreation along with scenery and small population are strong Contract Negotiator selling points, so a written and pictorial description of your area's outdoor attributes in terms of recreation and scenery is a must.

Employment Opportunities: A list of potential employment 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" for insights into what candidates will be looking for.

Packaging Your Opportunity

Now that you have fully defined your opportunity, you're ready to package that information. This step involves translating the three parts of your opportunity into promotional materials. While some communities have developed videos to describe 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. The cover letter 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, the letter should be signed by all appropriate stakeholders, including the recruitment team coordinator and contact person, clinic and hospital administrators, and chief of the medical staff.

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. The letter should be signed by all members of the medical staff.

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 element in two pages or less:

- Attractive graphics or photos
- Attractive typeface
- Attractive lay out
- Use of bullet 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.

Cherrie Johnson (husband, Steve is general practitioner in Malad): 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 in Wendell): 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.

Gary Thompson (wife, Joan, is a family practitioner in Grangeville): 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.

Ann Haller (husband, Fred, is an internist in Kellogg): 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 organization, and state economic development agencies usually have many different kinds of promotional pieces describing your community or region. Maps, brochures, flyers, posters, and yes, even videos. The more colorful, 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 show it! And as a team, they will have fun doing it while feeling a part of an important cause.

Step 5. Defining 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 it 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 doesn’t stay long in the community. Communities generally fishing for an FP or GP, MD or DO, BE or BC, to do OB and cover ER will usually end up with an FWB – first warm body!

A little recruitment team and community input can help you avoid FWBs, focus your recruitment effort on recruiting the right person, involve a large portion of your community in the recruitment effort, and actually begin building anticipation among residents for the new provider – which will aid patient base development.

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 backgrounds are highly compatible

with the needs and wants 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; working style with: physicians, midlevel providers, nursing staff, hospital and clinic administration; career goals; and professional credentials and record.
 - b) The professional attributes least desired.
 - 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; age*; religion*; gender*; physical health.

**indicates criteria that cannot be used to disqualify candidates.*

- 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; places of past residences; 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 their 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 on 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.
7. Once all the dots are placed (and votes cast), count them up by each characteristic. You now have a prioritized list of characteristics and attributes of the candidate who will make the “ideal” provider for your community – and a list of the least desirable traits.

You probably won't be surprised by the group's final prioritized list of characteristics. Indeed, you and maybe one or two others might have developed a similar list. But, the objective of the ideal candidate identification process was not to just 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. The graphic on the next page depicts the process used to develop your “ideal” candidate.

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, for 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 for your community 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 promotion effort to appeal to this type of individual. By understanding the ideal candidates 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?

In the first place, let's define what we mean by "complete" physician. In general use of the term, a complete, fully trained physician has taken the prescribed amount of pre-medical training, graduated from an undergraduate college, and received four years of training in a medical school. The young physician then takes a year's internship in a hospital with an approved intern training program. If he or she elects to enter any one of a number of medical specialties, the doctor engages in a further two- to six-year residency program. Whether one becomes a D.O. or M.D., the route of complete medical training is basically the same. The difference is that the osteopathic physician receives additional training in what osteopathic profession believes to be a most significant factor in comprehensive health care [the relationship between body structure and organic functioning].

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., 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.

In 1969, there were five colleges of osteopathic medicine; today there are fifteen, six of which are state-legislated.

*After graduation from a college of osteopathic medicine, a D.O. serves in one of more than 159 internships in hospitals with intern training programs. Currently 159 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 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.

The Doctor of Osteopathy, D.O., is a fully trained physician who prescribes drugs, performs surgery and selectively utilizes all accepted scientific modalities to maintain and restore health.

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 55 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. Physician assistants, for example, are commonly being recruited at annual salaries between \$45,000 and \$75,000.

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. Physician assistants are also commonly used in rural hospital emergency rooms and nurse practitioners are important health caregivers in district health departments.

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 appears 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;
- 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. In 38 states, PA’s can write prescriptions.

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. PA education is approximately two-thirds that of a medical student, and PA students take some of the same courses as medical students. 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. For instance, in Idaho these rules are jointly promulgated by the State Board of Medicine and implemented by the State Board of Nursing. Idaho code defines a nurse practitioner as a licensed professional nurse having specialized skill, knowledge and experience and who is authorized by these jointly promulgated rules to perform designated acts of medical diagnosis.

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.
- Possess a signed agreement providing for a supervising physician registered pursuant to the rules of the State Board of Medicine, and a copy of the agreement providing for an alternate supervising physician in the absence of the supervising physician.* (Idaho Rules)

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 incurring 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. \$

Total Materials: \$ _____

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

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

Total Advertising: \$ _____

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

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

Total Recruitment Professional Assistance: \$ _____

4. Direct Marketing

- a. Mailing lists \$
- b. Postage \$
- c. \$
- d. \$

Total Direct Marketing: \$ _____

5. Person-to-person Recruitment

- a. Residency program visits (include travel) \$
- b. Conference recruitment displays (include travel) \$
- c. \$
- d. \$

Total Person-to-Person Recruitment: \$ _____

6. Other Promotion/Publicity

- a. Rewards \$
- b. 800 number \$
- c. Freebies (pens, calendars, etc.)\$
- d. \$

Total Other Promotion: \$ _____

TOTAL PROMOTION AND PUBLICITY EXPENSES \$ _____

B. CANDIDATE SCREENING EXPENSES

1. Phone Interviews (20-30 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. \$

Total Phone Interviews: \$ _____

2. Credentials Checks

- a. National Practitioner Data Bank \$
- b. Credential Verification (5-10 minutes/call) \$
- c. \$

Total Credentials Checks: \$ _____

3. Reference Checks

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

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 \$
- e. \$

Total Out-of-State Candidates/Spouses: \$ _____

2. In-state candidates and spouses

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

Total In-State Candidates/Spouses: \$ _____

3. Site visit social gathering

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

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. \$

Total Current Personnel: \$ _____

2. Temporary Personnel

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

Total Current Personnel: \$ _____

TOTAL PERSONNEL EXPENSES \$ _____

E. OTHER COSTS

- 1. \$
- 2. \$

TOTAL OTHER EXPENSES \$ _____

TOTAL RECRUITMENT BUDGETS \$ _____

Potential Barriers to Recruitment and Retention

Once you have completed the preparation portion of your recruitment effort and before you begin searching for candidates, you will want to take an objective look at your opportunity. What are the real strengths of our opportunity? Are they clearly promoted? What are the weaknesses of our 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. If you would like assistance in developing such strategies, contact the Idaho Rural Health Education Center (208) 336-5533 ext. 235.

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

Most Common Barriers

- | | |
|--|---|
| <input type="checkbox"/> Excessive call and coverage schedule | <input type="checkbox"/> No or low compensation guarantee |
| <input type="checkbox"/> Few professional opportunities for spouse | <input type="checkbox"/> Few benefits |

Part Two

Searching for Candidates

Step 7. Generating Candidates

Announcing your opportunity locally is the first step in the candidate search. You 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 tip you on 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 likely local sources of candidates. For example, local physicians and midlevels may know of an old colleague who may be interested. Local residents may have a friend or a relative who is a primary care provider interested in practicing near friends and family.

On the state level, contact your medical association or association of family physicians, hospital association, State Office of Rural Health, Area Health Education Center, medical schools, residency programs, nurse practitioner and physician assistant programs. These organizations could help in promoting your opportunity and/or generating candidates:

On the regional level, contact your regional United States Public Health Service Regional Office, area medical schools and residency programs, area nurse practitioner or physician assistant programs.

Another excellent resource for recruitment of primary care providers is the National Rural Recruitment and Retention Network (3RNET). This not-for-profit organization assists health professionals in locating practices throughout rural America. They have a website that can be accessed at: <http://www.3rnet.org>. Depending on your location, you can log onto this site and find who to contact in your state for recruitment assistance. The 3RNET is comprised of other not-for-profit organizations that include State Offices of Rural Health, AHECs, Cooperative Agreement Agencies and State Primary Care Associations. These organizations have information on rural practice sites in their states and can utilize the 3RNET website to post vacancies. In some states, the participating organization may assess fees for assistance. For information about the 3RNET contact Fred Moskol at 1-800-787-2512; FAX 1-608-265-4400; or email: info@3rnet.org.

The last section in this manual contains a listing of resources (refer to Page 111).

Classified Advertising

Classified ads are the most commonly used form of advertising for promoting practice opportunities around the country. They are usually placed in regional or national medical and professional journals. Using newspapers classifieds to promote your opportunity is not wise. The cost to reach large areas is excessive, and, frankly, physicians and midlevels generally do not peruse the classifieds seeking work.

To improve 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.

We have placed both display classified ads and simple classified ads in journals and have noticed no real appreciable difference in the number of candidates generated. Yet display advertisements are much more expensive. For the typical recruitment budget, we, therefore, recommend you stick to simple classified ads – concisely and creatively written, of course!

Your classified ad should pique the reader's interest and help them determine whether or not your community might fit them. Avoid writing ads of this nature, 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...”

Such an ad may save you a few dollars when being charged by the word, but think of potential candidates lost because of the ad lacked any exciting information about the opportunity. Pull out your opportunity description information and promote a couple of the real positive and unique attributes of your opportunity in your ad.

Tips for writing a good classified ad

1. Use a short, catchy headline.
2. Write the ad as if you were speaking about your opportunity to your ideal candidate face to face.
3. Remove words like “a” or “the” if they do not seem necessary.

4. Use only commonly accepted abbreviations.
5. 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.
6. Once your ad is written, compare it to the AIDA model. Does it work?
7. 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.
8. Place your ad in journals or newsletters targeted at the specific primary care provider type you seek. For example, the journal for the American Academy of Family Physicians is the *American Family Physician* or *AFP*. By comparison, *JAMA* and *New England Journal of Medicine* are highly regarded and widely read by medical professionals as well. However, they are read by many different types of physician specialists and medical providers you do not need to reach. Yet you pay for this reach, nonetheless.

Direct Mail

Direct mail is an effective method of directly reaching specific 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: I.M. Young, M.D., Youngstown, Ohio.

Direct mail lists containing physician names and addresses can be purchased through direct mail houses which have contracts with the American Medical Association. The AMA will provide you with a list of licensed contractors upon request. Some specialty academics 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. From experience, we urge you to shop around before purchasing a list from vendor. Prices 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. Direct mail house representatives can help you translate these characteristics into

a targeted mailing list. The direct mail house tracks candidates using a variety of demographics. Try to get as specific as possible when matching your ideal candidate characteristics with the demographics used by the direct mail house. 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 single page cover letter, an attractive one to two-page opportunity description and, maybe, a colorful post card is all you need. Remember to clearly show your contact information! If you would like them to send a CV, include a self addressed and stamped envelope in the mailer. There is an old rule of thumb in direct mail, the closer you get to actually dropping the response in the mailbox for the recipient, the more likely they will respond.

By the way, 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.

Other Sources of Candidates

Organizations participating in the 3RNET are usually a very inexpensive way to receive detailed information on candidates and their spouses who are interested in rural opportunities. 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.

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. Before contracting with a recruitment firm:

1. Ask other rural communities about the firm.
2. Ask the firm about the retention record of its candidates.
3. Ask how dutifully it helped recruit a second provider in instances where the first provider left prematurely – get references.
4. Use contingency firms versus retainer firms whenever possible – Contingency firms only charge a fee when a placement is made. Retainer firms require a fee up front, regardless of placement.

5. Consider using the money you will have to pay a recruitment firm for a placement for hiring a local resident to coordinate the recruitment process, instead. Why not keep the money in the community? Health professional recruitment is not rocket science, it is personality, persistency and some basic knowledge of recruitment. Plenty of free education materials on the subject exist. The Idaho Rural Health Education Center offers a “Community Recruiter” education program designed to train local recruiters in all aspects of primary care provider recruitment and retention.
6. Understand the motives and incentives for recruitment firms. The placement fee and not necessarily your satisfaction or the retention of your provider is the main objective for a recruitment firm. Keep in mind many recruiters are only paid by commission. If you are going to use a recruiter, simply understand your professional relationship and make sure your best interests are the recruiter’s as well.

When using a recruitment firm:

- Carefully screen all candidates – Some argue if you have to carefully screen candidates supposedly screened by the recruitment firm, why use a recruitment firm? Good question!
- 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 find out what is 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.
- Finally, if you do use a recruitment firm, consider including provisions in your service contract with the firm’s candidate that require the candidate to repay you for all or part of the recruitment firm’s fee.

Are You For Rural?

America is in another cycle of rural rediscovery. Record numbers of physicians are headed for rural areas. Good news? Maybe. But we know not everyone is cut for rural life, especially rural life Idaho style – which is vastly different than rural life California or Iowa style. Even fewer are cut out to be primary care providers in rural communities. Yet visions of “A River Runs Through It” or dreams of a slower pace of life and hopes of getting back to the basics attract many to rural areas every year, but few actually stay. Some candidates who are not cut out for rural life and rural medicine are very sincere when sharing their desire, their dream to practice and live in a rural community. But when they do come, they don’t or can’t stay.

How can you as a recruiter interested in not just attracting a provider but keeping the provider as well tell the difference between a bona fide rural provider and a “thought I could be” rural practitioner. 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 might 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 long hours 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 positives and negatives 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.
- I don’t mind long hours.

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 not to let 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 candidates progress is by using a chart like this one below. The chart can tell you at a glance where each candidate is in the recruitment process, the last time contact was made with the candidate, and source of the candidate.

TRACKING LOG			
Candidate Name	Greg Walker	Mary Smith	John Doe
Specialty	FP	IM	FP
First Contact	8/5/00	9/15/00	9/30/00
Source	AFP Ad	3RNET	AMA
Packet Mailed	8/6/00	9/16/00	10/1/00
Second Contact	8/13/00	9/23/00	10/13/00
Initial Interview	N/A	10/1/00	10/20/00
Second Interview		10/25/00	NA
Spouse Interview		11/1/00	
Reference/Credential Check		11/15/00	
Site Visit		12/4/00	
Follow-up to Site Visit		12/8/00	
Contract		12/15/00	
Disposition	Not really interested	Signed	Does not meet our requirements
Start Date	NA	2/1/01	NA

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

1. Call the candidate to acknowledge receipt of their inquiry if they respond by mail or FAX.
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, on paper, matches your needs and wants.
4. If you decide to pursue the candidate, conduct a credential check to verify the candidate's qualifications and authenticity.
5. Conduct phone interview with the candidate, and request references if not already provided.
6. Interview the spouse to determine his or her awareness about your opportunity and level of interest.
7. Interview references.
8. Conduct a site visit, and make offer (give contract or letter of intent) to desirable candidates.
9. Send follow-up letter to candidate after site visit.
10. Conduct follow up interview or site visit.
11. Finalize contract.

What Motivates Candidates?

You can improve your recruitment skills by better understanding what motivates candidates' practice location choices. Prepared with such insight, you can better evaluate your chances with various candidates and touch the points of your opportunity that matters 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. Interviewing 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 candidate matches your ideal provider. 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?
- Experience and exposure to procedures and patients common to your area.
- Professional goals and aspirations.
- Professional strengths they bring to your community
- Weakness or limitations.
- Location of other opportunities they are considering
- Compensation arrangement, amount, and benefits most desired.
- 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 to 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 “Questions Commonly Asked by Candidates and Spouses” on Page 76 will come in handy 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 community.

The candidate phone interview will follow these steps:

1. Call the candidate within one week after sending them 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 average initial interview lasts about 30-45 minutes.
3. Ask the candidate if they had an opportunity to review the opportunity packet or information sent to them, and answer any questions they have.
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 are worth noting.
6. Answer any questions posed by the candidate. Be prepared: see “Questions Commonly Asked by Candidates and Spouses”
7. Avoid talking about specific income amounts until you are certain the candidate meets your standards – and not vice versa. 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 then you are prepared to offer. Refer to Page 43 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 begin building expectations about your opportunity. By giving a candidate an impression that the dollar figure quoted in your written materials or during the interview is cast in stone, you may be unwittingly losing candidates who may agree to sign for just a few thousand dollars more than what you are promoting.

8. Request a list of references if not already provided and gain permission to contact these references.
9. Arrange a time for a spouse interview.
10. Thank them 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, based on what the candidate told you, will appeal to the candidate.

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 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 is the most significant limitation that you have realized about your working style and what have you learned from it?

What aspects of our 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 different questions that simply 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 a few 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?

Questions Related to the Practice

1. What geographic area is served by the practice?
 - a. How many patients are anticipated?
 - b. What is the payer 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 lab and x-ray facilities?
5. How far away is the nearest hospital?
 - a. What facilities and 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?
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. Is 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. _____ there for my spouse to obtain additional education or training?
4. _____ g 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.
 - 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. _____ schools' test scores rank against state and national averages?
 - g. What is the core curriculum and elective courses at the schools?
 - h. How far to the nearest college or university?
 - i. _____ s or colleges offer outreach courses in your community?
6. What churches are in the area?
7. _____ I, entertainment and cultural activities and opportunities in the area?
8. _____ ity offer?
 - a. What are the values of the community?
 - b. _____ protection, emergency services, public utilities, water and sewer, and local government?
9.
 - a. _____ clothing, restaurants, pharmacy, general merchandise, banking, automotive repair, plumber, electrician and so on?
 - b. _____ large city, its size and shopping and consumer amenities?
 - c. How far to a major airport?
 - d. What type of media serve the area?

Step 9. Conducting a Credential Check

The objective of the credential check is to confirm whether or not the professional and educational (and, sometimes, personal) background claims made by the candidate in his or her CV and correspondences are true. The credential check can be conducted before or after the interview. However, by conducting the check after the interview, you have the opportunity to check out 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.

Credential checks should be conducted by a medical expert on your recruitment committee.

Your first credential check stop should be the Board of Medicine in your state. The Board of Medicine can provide instructions on contacting licensing boards in states where your candidates claim to be licensed and on accessing detailed information on candidates 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.

One common reason for rejection of a provider applying for licensure, according to the Idaho State Board of Medicine, are license revocation in another state, crime, and repeated occurrence of a 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 find out from the Board the candidate is unqualified to practice in that state. In these instances, local recruiters sometimes perceive the Board of Medicine as the spoiler. However, if these recruiters would have contacted the Board early on in the candidate screening process, they probably would not have wasted their time or money 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 be considered not good enough for your community. The Board of Medicine should be an ally in your recruitment effort. The Board is an experienced third party that can help you ensure quality; use them as a sounding board whenever there is a question regarding a candidate's credentials.

Hospitals, when hiring or granting health care privileges to a health care provider, 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 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 much credentialing information on candidates that can be accessed for a low fee. The Data Bank, however, is only accessible to hospitals, physicians for their own records, and medical boards.

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 candidates 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: attendance at the institution(s), dates of attendance, graduation date, and academic record of history.

Internship

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 program's 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 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 administration fees if necessary.

Credit

Sources of Information:

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

Step 10. Interviewing the Spouse

Most recruitment efforts hinge on the candidate's spouse, for 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, reduce the risk of the spouse "spoiling" the match, and improve the provider and spouse-community match.

Spouse recruiting begins with gathering information about the spouse. Ask the candidate for their 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. We often talk with candidates who say they are "very" interested in Idaho, only to find out later that their spouses were not even aware "they" were considering Idaho – or even considering relocating at all!

If 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 something in common with the spouse.

The commonality could be age, gender, education or professional background, or recreation or cultural interests. Your interview with the candidate should provide you enough insight into the spouse to identify a suitable spouse interviewer. Several communities have successfully used spouses of their physicians or midlevel providers to act as either spouse interviewers or the spouse recruiters.

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 kids
- Environmental conditions
- Schools and curriculum for their children
- Employment opportunities for themselves
- 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

The objective of your spouse interview is to determine how closely the spouse matches the characteristics of your ideal candidate's spouse defined earlier. Therefore, 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: recreation, social, cultural and hobbies
- ❖ Personality traits
- ❖ Socioeconomic background, including rural living background
- ❖ Housing preferences
- ❖ Expectations from the community
- ❖ Their ideal community
- ❖ Family profile: ages, interests/needs of children
- ❖ Family needs: education, religion, 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 them

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 they said and how they said 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 of 1990).
5. Listen – allow them ample time to contemplate a response. Silence is not a bad thing. Avoid answering questions for them, finishing their

statements, or making editorial comments (good or bad) on their responses.

6. Paraphrase responses to ensure you understood the candidate's answer, and if you did not understand the response, ask them to rephrase it until you do.
7. Strive for a conversational tone. Relax, and let the interview flow. A relaxed candidate, spouse or reference 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.
8. Answer all questions posed by the candidate or spouse honestly and if you don't know the answer, tell the candidate you will get the answer to them shortly after the interview.
9. Check your notes immediately after the interview is completed and fill in and clarify any incomplete notes, notes or abbreviations that within a few days could lose all meaning to you.
10. Send a thank you letter to the candidate or spouse, including any additional information they requested.

Step 11. Checking References

Because of the perceived legal ramifications, many references refuse to provide information of any depth or substance, and, often, people in charge of 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. In reference checks also remember what is *not* said or how something is said is often quite telling about the candidate.

Legal Reference Checking

References, long a basic part of employee selection at all levels, are harder to get and much scarier 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. The "doctrine of qualified privilege" provides some immunity from liability when responding to reference requests. Concern about the high cost of defending lawsuits has made many employers adopt a

say-nothing reference policy. However, failing to disclose negative job-related information about a past employee or exercising reasonable care when hiring employees can leave employers liable for “negligent referral or hiring” 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, if incompetent or impaired, might pose a risk of injury to the public or fellow employees by means of his or her employment. 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 final interviews to obtain additional information on the top one or two finalists.

If contacting former employers by telephone, it is helpful to use a checklist form. The items on the list should bring out the job elements you have already determined crucial for success on the job [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

The above section was taken directly from a publication called “Conducting the Lawful Employment Interview” by the Idaho Department of Employment, an outstanding resource for any one involved in screening employees and candidates.

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 them for their time but stating 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. Only invite 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 in using (and trusting) 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, and/or continue checking the candidate’s credentials until you can answer “yes” to all the statements or until you reject the candidate.

Step 12. Conducting a Site Visit

Roll out the welcome mat, but keep the welcome wagon in the garage. While it is important to show your enthusiasm for the candidate and spouse, remember, you are still *screening* or checking out the candidate. And the candidate is certainly still checking you out!

There are two goals for the site visit. One is to confirm whether or not the candidate and spouse approximate your ideal candidate enough to make them an offer. The other is to provide the candidate and spouse every opportunity to determine how well the community matches their needs and expectations and to decide whether to accept an offer if it were tendered. Communities most often fall short on the second goal.

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's and spouse's interests and preferences. Of course, this can only be achieved when you have become familiar enough with the candidate and spouse to know what they need and want to know about your opportunity and community.

Site visits should last, at least, a day and half to two days. Shorter site visits should be avoided, for it is too difficult to show all aspects of your community and opportunity. Short site visits usually create a wrong impression and result in candidates making decisions based upon partial information or misconceptions. Site visits are typically conducted on weekends, usually because of convenience rather than practicality. The ideal situation is two-day site visit that includes at least one business day. This gives the candidate and spouse a better feel for daily life in the community and in the practice setting.

You should 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 site visits may save each community on the tour some money, you will find the candidate and spouse far from being a captive audience. Idaho is particularly attractive for (and vulnerable to) multiple community site visits. Because of the scenic appeal of Idaho, we have many candidates who arrange and simply use the multiple community site visit as an expense-paid tour of our state, only partially interested in actually practicing in rural Idaho. If the candidate is sincerely interested in your opportunity, they will find time to make the special trip to your community, especially if you pay for the trip. The site visit is too important to risk "sharing" the candidate's and spouse's attention with what amounts to "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 good and the "less than good" of your community.
2. Tour the clinic location of the practice.

3. Meet and visit with each physician 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 recruitment coordinator, contract negotiator, and the candidate.
10. Have a separate itinerary for the spouse escorted by the spouse recruiter when the candidate is involved in itinerary stops of professional concern – after the spouse is no longer needed or interested in that stop.

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 Sites 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 Idaho, 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 spouse's at one of spouse's homes.

If spouse was following 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 mornings 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's 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 points of interest and places of interest 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 their 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 newcomers – 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 days 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 tour guide only on what will amount to as a “tour of homes” that match 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 <i>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</i>
1:00 p.m.	Self-guided Tour of Community Providing the candidate and spouse a vehicle
3:00 p.m.	Business Interview Administrator of organization recruiting the candidate and candidate meet to discuss the opportunity and, if appropriate the details of the offer. Present the candidate a Letter of Intent or draft contract if the candidate interests you, expressing the number of days you will allow them 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 suggested Itinerary Venues

Personal Venues

- An airplane tour of your area
- An opportunity to experience a popular activity in your area that is of an 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 (spouse of residents of Family Practice Residency Program of Idaho, Spring 1994):

- ❑ Avoid busy itinerary's 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;
- ❑ Be themselves and show the good points but also be open about the community's problems or bad points; and
- ❑ Expose the spouse to daily life in the community for 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

A typical occurrence on site visits is hosting a site visit by mob. 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 community into a van. At most, two or three individuals from the recruitment teams should act as hosts with one host specifically assigned to the spouse. Ideally, these hosts should include the candidate and spouse interviewers, for they have already developed a rapport with the candidate and spouse. The third host then could be the recruitment coordinator or administrator from the agency who will sign the provider – if he or she is not an interviewer. Regardless of who are the hosts, hosts need to be personable and possess knowledge about (and enthusiasm) your opportunity and community.

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. Airfare is the issue when it comes to family site visits. 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.

When children do accompany the candidate and spouse, you should make arrangements for a babysitter and/or involve the children in local activities that will interest them – apart from their parents. This will allow the candidate and spouse to concentrate on the site visit. Often, candidates and spouses who are accompanied by their children the entire visit, especially young become distracted and miss important points during the visit. They also can become annoyed or impatient after hours of controlling bored children while keeping pace with a busy site visit itinerary. When this occurs the site visit will probably leave a negative impression on the candidate and spouse -- and you!

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 (albeit soft-sell!) 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 concerns or reservations about your opportunity. Sales people call this identifying objections to making a purchase. 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 try to get 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 some issue that could have been easily addressed had the community known it was a concern in the first place. 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?” Either way, you are going to get some important insights on 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 for when to make a decision on your offer, he or she usually will delay their decision until lured away by another community – a community that did, as they say in sales, “lock” the buyer in.

To make an offer during the visit:

1. Prepare a contract or letter of intent before the site 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, if possible, the compensation amount and arrangement during the business interview; and
5. Give the candidate a week to ten days to decide, asking them if they decide against the offer to please list reasons why they reject the offer.

On the following page you will find a sample letter of intent.

Sample Letter of Intent

Dear Dr. R.U. Willing,

On behalf of M.I. Tyred, M.D., and the administration and medical staff of Rural Hospital, we are pleased about your interest in helping patients in the Rural, Idaho, 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 \$120,000
2. Three weeks' vacation and one weeks for CME
3. Reimbursement for approved CME sources (including travel expenses) up to \$2,000
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. Tyred 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, possibly 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 will also 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 February 20, 2000.

On behalf of Dr. Tyred and everyone at Rural Hospital, we are looking forward to working with you. We eagerly await your reply.

Sincerely,

Ida Hoan, Coordinator
Rural Idaho, 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 4

Follow Up and Follow Through

Step 13. Follow-up Letter

A thank you letter containing any additional information requested by the candidate or spouse should be sent to them 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 decision period (usually seven to ten days). 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 send 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 which fail to modify their opportunity or adjust their recruitment process are those still recruiting today. One simple question should beg the answers you need to improve your recruitment effort each time you are rejected: “Why didn’t we get this candidate?” Surprisingly, too many communities skip this self assessment – or blame it all on the spouse!

If you have been recruiting for some time and have not assessed your opportunity or recruitment process recently, ask yourself (and answer!) “Why can’t we recruit a physician (or midlevel)?” For every reason you identify, develop a strategy that will address or minimize the problem or reason. For example, many rural communities lose candidates because the spouses perceive small towns as lacking professional opportunities to 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 to the spouse. Income in many cases will not be a major concern to

spouses, thus the spouses may be quite open to other avenues for utilizing his or her skills and knowledge, if they know such avenues exist.

Regardless of whether the barrier to recruiting a provider is the spouse or the condition of the store fronts on main street, the point is to identify and deal with these barriers:

1. Identify reasons why the offer was rejected.
2. Determine whether the reasons for rejection are issues that can be rectified before continuing the recruitment process.
3. Find ways such as “trade offs” to minimize the impact of barriers or problems that cannot be completely addressed. 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 the candidate to sign the contract as soon as possible and 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 98.
2. Facilitate Relocation – To make the provider’s (and family’s) move and integration into your community as smooth as possible, assist the provider 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 also 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 Retention Plan

If you recruited a primary care provider using the Recruiting for Retention approach or similar process, paying particular attention to matching the candidate's characteristics (ideal candidate) to attributes and needs of your community (opportunity development), you have already done a considerable amount of retention building work. In fact, by ensuring a good match between the provider and community, you have build a solid foundation for retention. Without such a foundation, all retention building activities occurring after the provider is in your community will have little impact on retaining a provider who does not fit your community.

The closer the practitioner's (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:

- ❑ Make their relocation to your community as hassle free as possible.
- ❑ Assist in starting and building up the provider's practice.
- ❑ 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 which 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 largely depend 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. To recruit the new practitioner, you were a very attentive suitor. Do not end the courtship at the wedding. 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 (more than annual!) social gatherings of the medical staff, their spouses and families
- Assigning someone specific to orient the new provider to the medical community 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 – 1 out of every four days or less if possible
- Providing the provider and spouse career and personal development opportunities

The Spouses perspective ...

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

Ann Haller (husband, Fred, is an Internist in Kellogg): 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".

Cherrie Johnson (husband, Steve, is general practitioner in Malad): My family – parents, brothers live in Malad, and a little farm. That's why I am here.

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 in Wendell): 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!

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

- 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 other valued health professionals. You should always be aware of how satisfied or dissatisfied a provider or spouse is with the practice or the community.

If you are unsure how they feel, then it is time to ask them.

When a medical provider does leave 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.

From the loss of a provider, you should first of all learn that very few practitioners remain in one community or practice location for their entire career. Like American society in general, primary care providers are becoming more transient. And primary care providers, being in such high demand today, are especially apt to be lured away from rural areas with promises of less work and more pay. Therefore, your recruitment and retention efforts need to be ongoing. Always keep your line in the water! Too many communities are surprised by a loss of one of their primary care providers and are not prepared to quickly replace him or her. Delays in recruiting a new provider causes a deterioration in access to care for residents and places 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 also be on the look out for permanent practice opportunities; and
- ◆ 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 aspect of health care delivery. Over a course of time, these sometimes opposing roles can create tension between the administrator and clinician, thus inhibiting the administrator's and provider's ability to openly communicate with one another, and open communication is essential to retention.

The community approach can help diffuse such potential difficulties and bring new ideas and personalities to the table. The committee does not have to be large, but should include a medical staff member, hospital and clinic administrators, and a few key community members, including someone who is assigned to provider spouse/family retention.

To lay a retention development foundation, the committee should complete the Barriers to Recruitment and Retention Checklist on Page 63 and develop strategies to address or minimize each identified barrier in your community. You may also want to review the retention research finding on Pages 109 and 110 for

Spouses on Improving Spouse Recruitment and Retention

Kitty Spencer (Kitty and her husband, Mark, a family physician, have been in Wendell 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 Silver Valley 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 Emmett 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.

additional insight. Then, the committee should conduct a quick retention assessment, by asking the following:

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

During the first two years in practice, someone from the committee, preferably a physician member, should meet with the new provider on a monthly basis to 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 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.

Like recruitment, retention should not be trusted to fate. The stakes are too high. Keeping a consistent cadre 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 \$20,000 to \$50,000 each time they recruit a physician. Compared to what is at stake, the ante needed to keep 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.

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
- Lack of 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/evaluation of progress

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

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 either a health care provider or facility administrator or someone in charge of recruitment and retention, should be asking 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 honestly respond to questions posed by prospective applicants. To 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, it should be 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. The following questionnaire should be used as an initial attempt to establish a basis for discussion of the retention policies which exist in your organization or community. Using this questionnaire as a foundation, tailor the questions to all medical staff and follow up with one-on-one or group dialogue. If problems are present or impending, deal with them constructively and soon! Even the preliminary diagnosis of the health of your retention efforts is a step in the right direction. Use the information gathered to set up a proactive place for keeping all your providers as well as to increase your 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, regardless if you are now receiving them?

Practice Issues

1. How much input do you have into decision-making and policies which affect your position? How much do you want?
2. What is your perception of your responsibilities and work load?
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, 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 facilitate 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 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, MEd, 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 is 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.

Part 5

Resources

Recruitment Resources Statewide and Regional

Idaho Resources

Idaho Rural Health Education Center, Boise, 208-336-5533 ext. 235 or 265
<http://www.mtnstatesgroup.org>; email: lpowell@mtstatesgroup.org

Family Practice Residency of Idaho, Boise, 208-367-6042

Family Practice Residency Program, Pocatello, 208-282-2978

Idaho Academy of Family Physicians, Neva Allen Santos, 208-323-1156

Idaho Department of Health and Welfare,
<http://www.state.id.us/dhw/hwgd> [www/home.html](http://www.state.id.us/dhw/home.html)

State Office of Rural Health, Andrea Fletcher, 208-332-7212

State Primary Care Officer, Division of Health, Laura Rowen, 208-332-7212

State Health Districts, <http://www.oneplan.state.id.us/cooperators/health.htm>

Idaho Hospital Association, 208-338-5100, <http://www.teamiha.org>

Idaho Medical Association, 208-344-7888

Idaho Primary Care Association, Bill Foxcroft, 208-345-2335,
<http://www.nwrpca.org/>

Idaho Rural Health Association, 208-887-2035

Institute of Rural Health, 208-282-4705, <http://clinic.isu.edu/IRHS/IRHS.html>

Physician Assistant Program, Idaho State University, 208-282-4705

Internet Resources

Idaho Regional Information Online

Idaho Attractions

http://www.idoc.state.id.us/pub/Idaho_File/Idaho_Attractions.html

Idaho State Home Page

<http://www.state.id.us>

The Internet Public Library

<http://ipl.org/youth/stateknow/id1.html>

The Official Idaho Travel Guide

<http://www.visitid.org/>

Online Highways – Travel Guide to Idaho

<http://www.ohwy.com/id/homepage.htm>

Regional Maps

<http://www.visitid.org/regions/index.html>

Idaho Community Economic Profiles

The Idaho Association of Realtors

<http://www.idahorealtors.com>

Idaho Department of Labor

<http://www.labor.state.id.us/lmi/id-lmi.htm>

Regional

Area Health Education Center at WSU, Spokane

http://www.spokane.wsu.edu/community/community_service.html

Montana Office of Rural Health

<http://ahec.msu.montana.edu>

SPARX Program

<http://www.dom.washington.edu/SPARX>

Northwest Regional Primary Care Association

<http://www.nwrpca.org>

WWAMI Regional Medical Program

<http://www.washington.edu/medical/>

National

National Rural Recruitment and Retention Network, Fred Moskol, 1-800-787-2512; FAX: 1-608-265-4400; email: info@3rnet.org
<http://www.3rnet.org>

National Health Service Corps, 1-800-221-9393
<http://www.bphc.hrsa.dhhs.gov/nhsc>

HPSA Classifications: www.bphc.hrsa.dhhs.gov/databases/hpsa/hpsa.cfm

Bureau of Health Professions Area Resource File (ARF):
<http://www.bhpr.hrs.gov>

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/dn/dn.htm>

Bureau of Labor Statistics Current Population Survey:
<http://stats.bls.gov/proghome.htm>

Bureau of Labor Statistics Employment Projections:
<http://stats.bls.gov/proghome.htm>

Bureau of Health Professions US Health Workforce Personnel Factbook:
<http://bhpr.hrsa.gov/healthworkforce/factbook.htm>

Cooperating State Employment Security Administrations have labor market information offices that publish and disseminate ES-202 data for their states:
<http://stats.bls.gov/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 FactFinder: <http://www.census.gov>

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Contents include why a recruitment and retention action plan, a checklist for recruitment readiness, conducting a needs assessment, gaining community support, forming a recruitment team, defining the opportunity, defining the ideal candidate, development a recruitment budget, searching for candidates, screening candidates, conducting a site visits, follow-up activities, and resources.

Disk with Microsoft Word files (*.doc) and ASCII text files (*.txt) with recruitment action plan, recruitment readiness checklist, utilization worksheets, worksheet for assigning benefit values, CPT revenue projection worksheet, budget worksheet, tracking log, sample site itinerary, and sample letter of intent.

Save substantial dollars in consulting fees by utilizing the tools included in this publication.

**Mountain States Group, Inc., private 501(c)3 corporation, is a community resource development organization.
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