Physician recruitment strategies for a rural hospital. (Fellow Project). James M. Full.
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ORGANIZATIONAL INFORMATION

The organization is a rural healthcare system with inpatient and ambulatory care services. The hospital is the sole hospital provider in a rural county with a population of approximately 27,000. The county has the highest unemployment rate in the state and is located in a "health professional shortage area." The hospital is a not-for-profit, county-owned, stand-alone rural health system now managed by one of the top 100 hospitals and based in a town of 6,500 people. Five rural health clinics are situated throughout the county. The payer mix for the hospital is 70 percent Medicare, Medicaid, and self-pay. The facility is licensed to be a 49-bed hospital and has 30 operating beds, five federally designated rural health clinics, home health care, and wellness programs. In September 1999, the hospital became a critical access hospital with 25 beds. It has an annual budget of $19.5 million. Over 80 percent of the hospital's revenues are from outpatient sources.

BRIEF SUMMARY OF THE PROBLEM

The hospital discussed in this article (1) had a dysfunctional medical staff that was perceived by the community as providers of poor medical care and (2) was experiencing an acute shortage in the number of physicians to meet the healthcare needs of the community. When I was appointed CEO for the hospital, approximately 85 percent of the residents in the county traveled at least 30 miles for their healthcare. The physician shortage had an adverse effect on the hospital's financial status and future survival.

DESCRIPTION OF THE PROBLEM

Rural physicians' recruitment and retainment has traditionally been a challenge for hospitals and rural communities. According to the University of North Carolina Center for Rural Health, although 22.5 percent of the population in the United States reside in nonmetropolitan areas, only 13.2 percent of physicians practice in these areas (Weisfeld 1993). Three reasons have been identified for the unpopularity of rural practices: lifestyle issues, medical practice issues, and competitive issues.

1. Lifestyle Issues. Physicians are concerned about residing in a community that has access to a variety of social activities. Many rural communities are often located a significant distance from larger cities. During their residencies, physicians are usually trained in urban settings and perceive rural areas as lacking cultural outlets, social activities, and accessibility to convenient shopping. Rural school systems are frequently perceived as weaker when compared to their urban counterparts. In addition, employment opportunities for the physician's spouse may be limited.

2. Medical Practice Issues. Physicians in small, rural communities work longer hours than their urban peers (NRHA 1998). Vacation and leisure time is often limited because

of the lack of professional backup. Group practice opportunities are limited. Many times the physician's office may be located a good distance from the hospital. Most physicians are trained in large, tertiary care settings with the latest technology, which may not be available in rural settings. Many physicians are nervous about the prospect of providing medical care without the immediate availability of specialists. In addition, physicians in rural areas receive less reimbursement by Medicare and other payers. The population in rural settings is usually older, poorer, more likely to be uninsured, and in poor overall health.

3. Competitive Issues. Primary care physicians are in heavy demand. Often a rural hospital's major competitor has a residency program and "locks" a physician resident to the organization before the physician is aware of other opportunities. HMOs have a heavy demand for primary care physicians. Finally, competitors of the rural healthcare providers may be better able to offer employment opportunities that a rural hospital cannot offer because of a lack of financial or practice management resources.

I was appointed as CEO for the rural hospital in 1992, and I was the third CEO appointed in a five-year period. Five years before my arrival, most of the physicians had either retired or left for personal reasons. The remaining five primary care physicians in the county of more than 27,000 had independent private practices. Three of these clinicians had poor clinical reputations and their practices were struggling. When I arrived, the county's healthcare had an outmigration rate of 85 percent because of the shortage of quality physicians. Residents traveled over 30 miles for healthcare. Two physicians made 90 percent of all admissions to the hospital. For a number of years the hospital was in financial distress and operated with a negative cash flow. Without the successful recruitment of quality physicians, the hospital's future looked bleak.

ADMINISTRATIVE DECISIONS

My strategy was to successfully recruit a quality medical staff in a four-step process I call "plan, locate, screen, and sell."

1. Plan. I put a great deal of emphasis on the education of the board of trustees, the medical staff, employees, and community leaders about future trends in healthcare. This training was successfully accomplished through strategic planning retreats, discussions at medical staff meetings, and community presentations to service groups.

The first day of the initial strategic planning retreat, the board of trustees participated in extensive brainstorming sessions and discussions regarding the strengths and weaknesses of our medical staff. At this meeting the board of trustees identified the two physicians around which the hospital would build a quality medical staff. The board also determined that seven additional primary care physicians would be required to meet the needs of the community. This number was based on the norm that there should be one physician to every 2,000 to 4,000 members of the population. This goal was incorporated into the five-year strategic plan. The two core physicians were later brought into the process, and they were supportive of the goal.

The hospital's strengths and weaknesses were also assessed at this strategic planning retreat, and a vision for the future was created. This "long-term vision" was initially used

to sell the hospital to physicians. On my arrival, the hospital's environment was dreary and the medical equipment was outdated. Updating the medical equipment took about three to four years because of limited resources. We began by reviving the patient rooms and hallways with fresh paint, new wall coverings, and tile to improve the patients' initial impression of the hospital.

2. Locate. Physician search firms, both retainer and contingency firms, were used extensively to locate potential physician candidates. The retainer firm, which works strictly for the client employer but requires a significant financial deposit, was not successful. The contingent search firm, which only gets paid if one of their recruits is signed to a contract, proved to be more effective. The contingency firm is usually paid $15,000 to $22,000 when a physician and hospital agree to terms.

Our hospital signed agreements with 16 contingency firms, and about seven worked regularly with the hospital. I found that developing a positive relationship with the individuals in the search firms, including responding promptly to phone calls and providing timely feedback, helped us develop a win-win relationship. Once rapport was developed, we screened an abundant number of candidates over the years.

The National Health Service Corps afforded us another opportunity to identify potential candidates. After learning about the potentially valuable benefits associated with being identified as a "health professional shortage area," we requested that the state board of health initiate a study to determine if the county was a shortage area. The state recommended to the federal government that our county be designated as a health professional shortage area because one physician served 3,500 members of the population. Our status became official in a few months. This health professional shortage area designation has many benefits:

* Federal loan waivers are available for physicians who practice in such an area.

* National Health Service Corps physicians, though few in number nationally, are required to practice in an area with such a designation.

* Physicians with visas are allowed to stay in the United States permanently if they provide medical services in a shortage area for a five-year period.

* All primary care physicians receive a 10 percent quarterly bonus in their reimbursement from Medicare for practicing in a shortage area.

* Many physicians review and respond to the government's posting of all health professional shortage area sites that have access to student loan waivers.

3. Screen. Once a potential physician is identified, an initial screening is performed: A National Practitioner Data Bank inquiry is made to investigate the physician's history of malpractice claims, the physician's curriculum vitae is assessed by the CEO and chief of staff, the physician's status as board eligible or board certified is confirmed (this is a requirement of the board of trustees and the medical staff), and we check to see if the candidate has moved frequently (if so, that candidate is ruled out). I then initiate a telephone interview with the candidate to assess communication skills, longevity

potential, community involvement, professional interests, spouse's career needs, academic concerns for their children, and professional requirements (i.e., employment versus private practice). If the interview is positive, materials about our community are mailed to the physician. During the second contact, the physician and his or her family are invited for an on-site visit.

4. Sell. The most important event during the physician recruitment process is the on-site visit. I dedicate 100 percent of my time to the candidate and his or her family during this visit. The visit is structured yet flexible to address the needs of the candidate. All travel arrangements are made by the hospital. Flowers or a fruit basket are ordered for their hotel room. The first face-to-face contact is usually over breakfast. The visit usually includes a tour of the hospital, a drive through the community to look at housing, a meeting with the school superintendent and a visit to the local school, dinner with the physicians and board members, and a tour of the local businesses to meet community leaders. I actively listen to the candidate and his or her spouse to assess their ideal needs. I also reinforce the community's strengths (i.e., low crime, low cost of living, strong sense of community, location, excellent school system, and the hospital's vision).

The hospital has had to make changes and adjustments to meet the needs of candidates. One major change has involved the provision of employment opportunities for physicians. Most candidates that we interview right out of residency prefer to be employed by the hospital. Over the past five years, the hospital has activated five federally designated rural health clinics. These clinics are funded based on cost by Medicare and Medicaid, and the clinics have allowed the hospital to provide employment opportunities for primary care physicians. A base pay with an incentive program is usually proposed to a physician when he or she requests employment. An income guarantee is provided if the physician prefers to be in private practice. This flexibility has been a successful selling point for the hospital.

During on-site interviews, candidates often openly express concerns, which I address immediately. Some candidates are concerned about their student loans, and we discuss the Federal Loan Waiver option. Several physicians have taken advantage of this program. Another candidate who had been a chief resident at his medical school expressed a desire to continue to teach. The state's medical school was contacted and an adjunct faculty appointment was arranged. Job interviews for the wife of another candidate were arranged during their on-site visit to meet her employment needs. One first-year resident was concerned about being in debt when he completed his residency program. A contract was provided whereby the hospital paid him a monthly stipend during his residency, and he made a five-year commitment to practice in our community so he would not have debt when he began his career. Active listening skills, genuine personal contact, creativity, and flexibility have been essential in the successful recruitment of physicians in our rural setting.

RESULTS

The hospital has been extremely successful in the recruitment of a young, quality medical staff of the past six years. As new physicians have moved into our community, the physicians whose performance was questionable left on their own. During this period, the hospital recruited seven family practitioners, one general internist, the area's

first OB/GYN and pediatrician, an anesthesiologist, and an invasive radiologist. With the exception of one, our oldest physician is 46 years old! Five of our physicians are employed by the hospital and provide clinical services at the five rural health clinics. We have also recruited four family nurse practitioners. All of the employed physicians signed five-year contract extensions.

The hospital's financial status has dramatically improved during this period, despite the cash drain that new physicians initially have on the organization. Gross revenues have increased by an average of 19 percent per year. In 1992, the hospital employed 75 people. Today, 230 employees are listed on the payroll. Market share has nearly doubled as well. The hospital received Joint Commission accreditation in 1998 for the first time in 35 years. We have successfully negotiated a merger with a large health system, and they have commented that the quality of our medical staff is just as good, if not better, than theirs. This organization was recently rated as one of the top 100 in the country.

I recently surveyed our medical staff to inquire why they chose to move into our community. The following were their reasons:

* The community's strong need for physicians;

* The supportive and quality-oriented physicians;

* The well-organized on-site interview in which the physician felt valued;

* A hands-on recruitment approach by the CEO;

* The availability of federal loan waivers;

* The hospital's proactive vision for the future;

* The ability to locate spouse employment;

* The friendly community;

* The flexibility of the hospital to support either employment or private practice opportunities;

* The health professional shortage area status; and

* The availability of an academic teaching opportunity.

It is my opinion that the CEO of a small rural hospital must play an active role in all phases of the physician-recruitment process. Active listening skills, creativity, and flexibility were essential in the successful recruitment of our medical staff.

SOURCE MATERIALS

National Rural Health Association. 1998. "An Issue Paper Prepared by the National Rural Health Association." Kansas City, MO: NRHA.

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James Full, FACHE, serves as CEO for St. Vincent Randolph Hospital in Indiana. Mr. Fuller has previously worked for Alliant Management Services in Louisville, Kentucky, and was the executive director for the Greater Randolph Community Health Plan in Winchester, Indiana. In these positions he has coordinated the merging of a rural hospital system with the St. Vincent Hospital System/Ascension Health; is coordinating the planning for construction of a new critical access hospital; and has activated specialty clinics, comprehensive wellness and occupational medical programs, and model rural health clinics and training centers to provide rural exposure for medical residents and students. Prior to these experiences, Mr. Full worked as a CEO for a Charter Medical Corporation Hospital in Lafayette, Indiana, and as administrator for the Veterans Administration in Colorado and Illinois. Mr. Full is a member of the National Association of Social Workers, the Indiana Hospital and Health Association Council on Rural Health, the Indiana Primary Care Association, and the Indiana Rural Health Association. He has received several awards for innovative program development and volunteers his time with Junior Achievement, Boy Scout Medical Explorers, Rotary International, and the Randolph County United Way. He has been a member of the American College of Healthcare Executives since 1985 and achieved Fellow status in 1999. This case study represents a part of his Fellow project and was voted one of the best case studies in 1999.

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