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INSTRUCTIONS

Health Center Provider Retention and Recruitment Plan

**Provider Retention and Recruitment Plan Template Instructions**

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**Provider Recruitment and Retention Plan Template**

# Introduction

The STAR² Center is a project of the Association of Clinicians for the Underserved (ACU). In July 2014, ACU received a national cooperative agreement to develop a clinician workforce center for recruitment and retention at community health centers. In partnership with the federal Bureau of Primary Health Care, ACU created the STAR² Center (pronounced Star Center) to provide free resources, training, and technical assistance to health centers facing high workforce need. John Snow, Inc. has subcontracted with ACU to assist in research, training, and designing resources and tools to support the STAR² Center. This Provider Retention and Recruitment (R&R) Plan Template is one of these tools. The R&R Plan is meant to be a working, living document that can be easily modified to adjust to changing conditions within a health center and the changing health care environment.

# How to Use the Recruitment and Retention Template and the Action Plan Documents

The purpose of the Recruitment and Retention Plan Template is to provide a structure and thought process for improving retention and recruitment practices in your practice. The template is formatted in Microsoft Word to make it easier for health centers to customize it to meet their own needs. If parts of the template do not apply to your practice, just skip them. The template is comprehensive. Some parts, such as the assessment and the retention sections, might be most easily completed by clinical administrative staff, while the recruitment team might choose to complete the recruitment section using the information gleaned from the assessment and retention sections. An Excel document, Candidate Tracking Sheet, is available separately to provide a convenient system for tracking provider applicants through the initial application through each interview, visit and final result of the recruitment process.

In addition to the instructions, there is a companion Recruitment and Retention Action Plan worksheet. Each major item in the template is included in the Action Plan. The Action Plan is for documenting identified gaps or barriers, opportunities and strategies for addressing unmet needs. The Action Plan is a tool to assist in quality improvement efforts for recruitment and retention.

If you have questions about using these tools or would like to access our other resources or services for health centers, please contact the STAR² Center at <http://www.chcworkforce.org/contact-us> or 1-844-ACU-HIRE (1-844-228-4473).

# Assessment

The first step in any planning process is to make an assessment of your current situation and identify opportunities, barriers and unmet needs. There are simple tools built into this template to assist you with this assessment, however, the STAR2 Center has developed two other tools that are an ideal starting point for your center’s planning process.

The first is the *Self-Assessment Tool*. The Self-Assessment Tool’s primary purpose is to help you identify strategies that may improve your success with provider recruitment and retention. Using your responses, the Self-Assessment Tool provides brief recommendations on those topics you might want to pursue. Many topics covered in the tool have corresponding resources in the STAR² Center resource center. Also, the tool can inform technical assistance provided to your health center. The report generated from this tool can be used with the individual health center recruitment and retention profile to paint a comprehensive picture of workforce challenges at an organization and next steps to address those challenges. This comprehensive tool is located at <http://www.chcworkforce.org/acu-self-assessment-tool>.

The second tool is a *Financial Impact Tool*. The Financial Impact Tool is available to help you calculate the estimated cost of provider vacancies and recruitment. This tool was created in Excel and can be downloaded for your center’s use. If you do not have all of the input data easily available to you the tool provides national estimates to assist you. It is important to note that the financial impact is only part of the impact on practices losing a provider. Other negative impacts can include 1) quality, 2) continuity of care, 3) pressure on remaining staff from being short-staffed, 4) loss of patients, 5) increased family pressure if more time is spent working or covering call, and 6) changes in referral patterns.[[1]](#footnote-1) The Financial Impact Tool is available for download at <http://chcworkforce.org/star2-center-financial-assessment-tool>**.**

# Recruitment and Retention Plan

Review and update the Recruitment and Retention plan periodically along with general health center strategic planning. Optimally, an annual review is recommended. Include the last date of review in the plan and expected next date of review.

|  |  |
| --- | --- |
| **Recruitment and Retention Plan**  **Last Date of Review** |  |
| **Anticipated Next Date of Review** |  |
|  |  |

## Practice Assessment

Any planning process should be built on a firm understanding of the practice. The best way to do this is to conduct a practice assessment. Without a comprehensive assessment of operations, it is difficult to determine the true recruitment needs. What appears to be a need for more providers may actually be less than efficient practices, low productivity or shortages of other types of staff. An assessment may also point to areas in need of improvement that, with a quality improvement process, may result in greater provider retention. Using the findings of the assessment, the health center can make an improvement plan to fill gaps and make corrections. Also, the health center may consider different recruitment and retention strategies depending on the findings of the assessment.

### Provider Capacity and Demand

Both high and low provider production and demand can result in provider dissatisfaction. A provider in a low demand situation may become bored and/or feel unfulfilled. A provider experiencing too much demand may become overworked and burn out. While patient care is moving toward models that are not primarily based on patient visits, this transition is still underway. Patient visits are still predominantly the main measure of provider productivity.

Table 1 provides a mechanism for a gross assessment of individual provider productivity. Complete the information for each provider, giving each a line of the table. Since the benchmarks, or comparison measures, for this information is from the Uniform Data System Report, please use UDS definitions for the measures. These definitions by calendar year are available in the UDS manuals on the Health Services Resources Administration (HRSA) website at

[*http://www.bphc.hrsa.gov/datareporting/reporting/index.html*](http://www.bphc.hrsa.gov/datareporting/reporting/index.html)*.*

Comparing the individual provider productivity to UDS data provides a snapshot of how providers compare to national data for their specialty. If your health center is large enough, it is also useful to roll up the individual providers by specialty in addition to by individual provider. If you have more than one clinic site, you should also do this analysis by individual provider by site. It is important to note that this comparison does not explain any variation in productivity for an individual provider or site. It is a measure that should be reviewed in the context of your health center’s retention and recruitment needs.

To complete Table 1:

1. Complete the first five columns in Table 1 – Provider Name, Provider Type, Provider Specialty, FTE, and Health Center Visits. Make sure the full time equivalency (FTE) reported accurately reflects the clinical time of each provider. Extend the table by adding more lines if necessary.
2. Normalize the visits by dividing the Health Center Visits for each provider by the FTE for that provider. This will give you the Health Center Visits per 1.0 FTE for each provider.
3. Look up the UDS Mean in Attachment X. UDS Mean Visits: Productivity Benchmarks for each provider type and specialty and document for each provider.
4. Calculate the percent difference from the UDS Mean by dividing the individual provider Health Center Visits per 1.0 FTE by the UDS Mean. Subtract this number from 1.0 and convert to a percentage.

**Table 1. Provider Productivity**

Measurement Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Dates included in measure/12 month period)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Name | Provider Type\* | Provider Specialty\*\* | FTE | Health Center Visits | Health Center Visits per 1.0 FTE | UDS Mean# Visits per 1.0 FTE | % Difference from Mean |
|
| (Last, First) | **(Degree or Licensure)** | **(Areas of Expertise)** |  |  | **(Visits/FTE)** | **(Fill in from Attachment 1)** | **(1.0 - [HC Visits/FTE ÷ UDS Mean]]** |
|  |  |  |  |  |  |  |  |
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\*Provider Type - MD, DO, NP, PA, resident, CNM, DDS, etc.

\*\*Provider Specialty - Family Practice, Internal Medicine, Pediatrics, Ob/Gyn, Dental, etc.

# See Attachment 1 UDS Mean Visits: Productivity Benchmarks

#### Productivity Analysis

Review any provider productivity that is significantly different from the UDS Mean (found in Attachment 1. UDS Mean Visits: Productivity Benchmarks) for each provider type and specialty. Very small FTEs (i.e. 0.10) may result in large differences due to the small number of clinic hours. You may want to focus on providers with an FTE of 0.4 or greater for meaningful differences. Differences of more than 10% in either the positive or negative direction should be noted and reasons for the difference should be explored. Document the analysis in Table 2. Possible causes and consequences of productivity extremes are listed below in Figure A. These are not exhaustive.

**Table 2. Analysis of Productivity Differences**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider Name | Provider Type\* | Provider Specialty\*\* | % Difference from Mean | Possible Reasons for Differences |
| (Last, First) | **(Degree or Licensure)** | **(Areas of Expertise)** | **(1.0 - [HC Visits/FTE ÷ UDS Mean]]** |  |
|  |  |  |  |  |
|  |  |  |  |  |
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**Figure A. Productivity Extremes; Causes and Consequences**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Possible Causes** | **Possible Consequences** |
| **Productivity** | **Low** | * Provider 1st year of practice or 1st year practicing in the health center * Lost clinic time due to travel between clinic sites * Differences in on-call coverage distribution among providers * Scheduling issues (addressed in scheduling section) * Staffing issues (addressed in staffing section) * Inefficient use of space * Slow pace * Low patient demand * Excess capacity | * Reduced patient access * Unfair labor distribution for higher producing providers * Provider boredom or dissatisfaction * Possible reduced revenue * Less efficient use of resources |
| **High** | * Experienced provider * Extended clinic hours * Differences in on-call coverage distribution among providers * Scheduling issues (addressed in scheduling section) * Fast pace * High patient demand * Capacity shortage | * Overworked provider * Unfair labor distribution for higher producing providers * Provider burnout * Staff stress * Provider vacancy |

### Appointment Access

Patient demand on providers can also be measured through appointment access measures. This measure can help to round out the productivity picture for providers. A health center with productive providers and long patient waits for appointments are at the high end for needing to recruit new providers. They are also at greater risk for losing their current providers due to overwork and increased stress. Patient appointment access should be measured using the “Third Next Available Appointment Method.” A sample tool for collecting Third Next Available Appointment access data is included below. More information on the definition and collection of data using this method are available through the Institute for Healthcare Improvement (IHI) at:

<http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx>.

IHI defines the Third Next Available Appointment as the “Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.”[[2]](#footnote-2) This method also aligns with NCQA PCMH 2014 Standard 1. Patient-Centered Access, Element A. Patient-Centered Appointment Access, Factor 4. Availability of Appointments.[[3]](#footnote-3)

A sample appointment access data collection table is included as Table 3. Many Electronic Health Records also have automated reports for Third Next Available Appointment. If your Electronic Health Record has reports that will generate Third Next Available Appointment, validate once by calculating the data by hand and comparing to the reports. Make sure the reports are set up with the same definition for Third Next Available Appointment.

In the sample, appointment access for three main types of appointments - sick visits, routine follow up visits, and preventive visits (i.e. physicals, well child checks) – are measured for each provider and also separately for each provider team. The measures are compared to practice policy based on clinical norms and set by the clinical practice. The policy sets norms for access that may be as simple as defining the range for various appointment types; i.e., sick patients have access within 0-1 day, routine follow up appointments within 1 week, and physicals within 2-3 weeks. The access measures should only include those appointments available to the person scheduling appointments. Appointment slots requiring triage or requests to the provider should not be included as available.

**Table 3. Weekly Appointment Access Report Today's Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Provider** | **Provider** | **Appointment** | **3rd next appointment** | | | **Meets Written Policy** | **If No** |
| **Speciality** | **Name** | **Type** | **Type** | **Date** | **# Days Provider** | **# Days Team** | **(Y/N)** | **Reason/Corrective Plan** |
| **Family** |  |  | Sick Visit |  |  |  |  |  |
| **Practice** |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 1 | MD | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 2 | DO | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 3 | NP | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
| **Internal** |  |  | Sick Visit |  |  |  |  |  |
| **Medicine** |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 4 | MD | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 5 | PA | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
| **Pediatrics** |  |  | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 6 | MD | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |
|  | Provider 7 | PA | Sick Visit |  |  |  |  |  |
|  |  |  | Follow Up |  |  |  |  |  |
|  |  |  | Preventive Visit (Physical) |  |  |  |  |  |

\*If the third next available appointment is the same day, report as “0”

Appointment timeframes that consistently fall outside of policy guidelines need to be examined to assess if the long waits are temporary (such as a provider on vacation), are trending better or worse, and to determine potential causes. Long waits may not necessarily indicate a need to recruit, but may instead point to issues with provider schedules or appointment scheduling. Document appointment access issues and productivity by provider and team (or service) in Table 4. Review whether the issues are due to capacity or other non-capacity related issues. See Figure B for a summary of the Relationship of Provider Productivity and Patient Appointment Access.

**Table 4. Analysis of Appointment Access and Productivity**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provider Name | Team | Access within Policy Limits | Productivity | Identified Capacity Gap | Other Non-Capacity Gap |
| (Last, First) | **(or Service)** | **Y/N** | **Low (>10% Below Ave), Average, High (>10% Above Ave)** |  |  |
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Figure B shows the relationship between provider productivity and demand and suggests how you might use this information in making recruitment decisions for your health center. If a provider has high productivity and long waits for a patient to get an appointment, this indicates that there may not be enough capacity to meet patient demand. A provider with high productivity and short waits for an appointment would indicate an efficient provider who is meeting demand. If this provider communicates any stress, minor schedule changes may relieve the workload while still meeting patient demand. A provider with low productivity and long waits for an appointment is likely one that could benefit from an analysis of appointment scheduling, available office hours, staff efficiency, adequate exam room space, etc. This provider has enough patients to increase productivity, but some factor or set of factors is decreasing provider capacity. In this case, these issues should be identified and resolved prior to initiating a recruitment effort. It is possible that additional providers are not needed to expand capacity if this provider is able to become more productive. A provider with low productivity and short waits for appointments is likely a provider with a small patient panel. This could be a new provider or an unpopular one. If this situation is occurring in an otherwise busy practice, it should also be reviewed to determine cause and resolved prior to initiating recruitment efforts.

**Figure B. Relationship of Provider Productivity and Patient Appointment Access**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | **Productivity** | |
| **Low** | **High** |
| **Appointment Access** | **Low** (long wait for apt) | **UNLIKELY NEED TO RECRUIT**  **Situation:** Provider with available capacity but unable to meet demand.  **Action:** Identify capacity issues and resolve prior to recruitment decision. | **NEED TO RECRUIT**  **Situation:** Efficient provider with high patient demand.  **Action:** More capacity needed to meet patient demand. May need to recruit or review team-based care structure. |
| **High** (short wait for apt) | **UNLIKELY NEED TO RECRUIT**  **Situation:** Low provider demand.  **Action:** Review low demand causes. If new provider, market practice; if established provider in an otherwise busy practice, identify and resolve issues prior to recruitment decision. If neither, there is unlikely a need to recruit. | **PLAN FOR FUTURE RECRUITING**  **Situation:** Efficient provider meeting patient demand.  **Action:** If provider is experiencing stress, review schedule to lengthen wait for appointment within clinic standards. Should review recruitment long term plan if demand is likely to increase. |

### Care Teams and Provider Mix

Inter-professional care teams support a strong health center care model. Care teams also help promote provider retention and recruitment[[4]](#footnote-4) [[5]](#footnote-5) and are fundamental to Patient Centered Medical Homes.[[6]](#footnote-6)

A review of provider mix, the ratio of physicians to non-physician providers, can provide insight into potential problems and solutions relative to recruitment and retention. Non-physician providers, such as nurse practitioners, physician assistants, and certified nurse midwives, play a critical role in meeting patient demand and providing high quality care in health centers. If your plan is to recruit a physician, you should do this review to compare your health center with common practices at other health centers and other types of practices. You may benefit from considering recruiting a non-physician provider instead of a physician. Document the ratio of non-physician providers to physicians in Table 5. Non-physician providers are defined as nurse practitioners, physician assistants, and certified nurse midwives. Do not include registered nurses or ancillary staff in the ratio. Include a line per team or service or site for more detailed information to better guide your recruitment strategies.

**Table 5. Ratio of Non-Physician Providers to Physicians**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **UDS Table 5 Line #** | **Staffing Ratios** | **Your Health Center** | **UDS 2014 National Rollup** | **2015 MGMA Mean per Physician FTE**  **(Based on 2014 Data)** | | |
| **Per Provider FTE** | **FP** | **IM** | **Ped** |
| 8/10a | Ratio Non Physician Providers to Physicians |  | 0.81 | 1.01 | 0.49 | 0.41 |

### Support Staff

Both maintaining a reasonable “support staff to provider ratio” and using well-trained support staff appropriately will help to retain providers and support staff. If there are not enough support staff, providers will not be as efficient, may have to take on additional work, and may be dissatisfied with their positions. Overworked support staff are also unlikely to remain at the health center. Conversely, too many support staff may be an inefficient use of health center resources that may be better used for other purposes.

Table 6 provides a simple way to compare your current staffing ratios to other benchmarks from the 2014 UDS and 2015 Medical Group Management Association (MGMA) Survey (based on 2014 Data). Comparison should be made by provider specialty to provide the most accurate review of staffing levels. While staffing levels are unlikely to fall on the exact mean, these ratios provide some context for comparison to assess if your staffing is well under or over other FQHCs and other types of primary care practices. Adjustments in staffing ratios may increase productivity and quality of care. If these adjustments are necessary, you may want to put them in place to assess the impact prior to recruiting new providers.

**Table 6. Staffing Ratio Comparison to UDS 2014 National Rollup and 2015 MGMA Means (2014 Data) by Specialty**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **UDS Table 5 Line #** | **Staffing Ratios** | **Your Health Center** | **UDS 2014 National Rollup** | **2015 MGMA Mean per Provider FTE**  **(Based on 2014 Data)** | | |
| **Per Provider FTE** | **FP** | **IM** | **Ped** |
| 11 | Nurses |  | 0.71 | 0.87 | 1.08 | 0.91 |
| 12 | Other Medical Personnel (Med Asst, Nurses' Aides) |  | 1.15 | 0.89 | 0.69 | 1.03 |
| 32 | Patient Support Staff  (Front Desk/Appt Staff) |  | 1.40 | 0.87 | 1.11 | 0.80 |

### Patient Schedules

Provider patient schedules are comprised of several dimensions. The most basic is the overall schedule of which type and how many providers are covering office hours on specific days and times. The second dimension is the time of clinical session start and end, including lunch breaks and administrative responsibilities. The third is the detail of the number and type of patients who are seen at any particular time during a clinical session.

Provider schedules are determined by many factors. These include: the days and times the office is open; support staff availability to support providers; exam room availability; provider specialty; patient panel demographics (i.e. older patients may take more time); and provider preference.

#### Office Schedule

The following graph (Figure C) of a health center office schedule shows the number of providers seeing patients by time and day of week. In this schedule, the range in providers working on any given session (morning or afternoon) varies from 1 provider to 18 providers. Even the peak times of each session have a variation of 8 providers to 18 providers. This graph also shows that providers rarely work through an entire session, with peaks occurring at 9:30 AM in the morning and 1:20 PM in the afternoon and tapering off after those times. In this real example, 1) support staff FTEs are relatively constant throughout the week, 2) the number of exam rooms is constant, and 3) patient demand is often unmet on Fridays. This type of a schedule can result in enormous stress on the practice system with support staff and room availability stretched beyond capacity during the busy sessions and provider satisfaction plummeting. In addition, productivity is reduced during peak times because patients cannot be roomed efficiently and have longer waits for support staff attention. The sessions with lower numbers of providers can result in too few appointments to meet demand and potentially inefficient use of support staff.

Table 7 is a tool to record and track the number of providers, support staff and exam rooms for a one week period. While you may do this every week, it may also be used as a tool to spot-check the schedule on a quarterly basis. Even in small health centers, there can be minor schedule changes or drift in schedule times that can disrupt patient flow and provider/staff satisfaction as well as present a false picture of recruitment needs.

**Table 7. Weekly Asset Matching – Providers, Support, Exam Rooms**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Team A** | | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| AM | Providers |  |  |  |  |  |
|  | Support |  |  |  |  |  |
|  | Rooms |  |  |  |  |  |
| PM | Providers |  |  |  |  |  |
|  | Support |  |  |  |  |  |
|  | Rooms |  |  |  |  |  |

#### On-call Schedule

On-call coverage, particularly for small or rural health centers, can be a major issue in both retention and recruitment. If call coverage is an issue for your health center, consider exploring the following strategies.

* Contract with a local practice to share call
* Contract with the local hospital for coverage
* Expand non-physician providers to include 1st tier call coverage with physician back-up
* Expand office hours during times with high call volumes, typically 7 – 9 PM, to alleviate stress on the covering provider

Be sure to accurately communicate the call coverage requirements in your health center to provider candidates.

**Current On-Call Ratio and Description of Call Rotation**

**Number of days on call per month**: \_\_\_\_\_\_\_\_\_\_\_\_

**Description of call rotation:** (i.e.1 weekday per week and 1 weekend per month; or one week 24/7 per month; or non-physician clinician coverage until 10 PM each day, then physician coverage 1:7 after 10 PM)

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### Provider Satisfaction

Keeping tabs on provider satisfaction can help avoid retention issues before they occur. By knowing what is working well and where improvements need to be made, your health center can respond to provider concerns before providers make a decision to leave. In addition, asking providers about issues that are important to them shows your desire to work collaboratively to make improvements. The following is a list of issues that have been identified as adversely impacting provider satisfaction. Each of these issues is a potential barrier for recruitment and retention.

Issues impacting provider satisfaction [[7]](#footnote-7)

* Staffing: most commonly mentioned factor; includes lack of training, especially for medical assistants, and lack of partnership between support staff and providers
* Work load: often exacerbated by staffing issues
* Management: need for better “facility flow” and infrastructure, lack of power to make improvements, not heard by management
* Financial considerations: salaries not competitive
* Scheduling/vacation: inflexible schedules, lack of work/life balance

None of these issues is insurmountable. While each is addressed in this template, the following strategies are generally recommended for improving provider satisfaction.

* Hold regular professional progress evaluation meetings with the provider to discuss morale and professional satisfaction concerns and issues.
* Sponsoring periodic social gatherings of the provider staff, their partners and families.

#### Provider Surveys

* **Provider Satisfaction Survey conducted**

(Circle One)

Yes No Not in the past year Unknown

Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Provider Satisfaction Survey Conducted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

* **Regular professional progress evaluation meetings held with individual providers to discuss morale and professional satisfaction concerns and issues**

(Circle One)

Yes No Not in the past year Unknown

Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Meeting Held \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

* **Sponsor periodic social gatherings of the provider staff, their partners and families**

(Circle One)

Yes No Not in the past year Unknown

Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Social Gathering Held \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

For a sample provider satisfaction survey, see <http://www.chcworkforce.org/resources>.

#### Exit Interviews

Another key opportunity to identify potential issues impacting retention is when a provider is leaving. An exit interview provides a chance to gain insight and feedback on issues that may not be otherwise identified, may be too sensitive for someone remaining in the practice to feel comfortable discussing, or if already identified, the information may help to prioritize issues.

* **Exit Interviews conducted for all providers leaving (regardless of reason)**

(Circle One)

Yes No Unknown

For sample exit interview questions, see <http://www.chcworkforce.org/resources>.

## Strategic Planning

### Provider Succession Planning

Even with a well-staffed health center and satisfied providers, planning for future changes is essential to maintaining a stable provider staff. Keep in mind relative provider age, general physical health, and aspirations. That said, it is important to discuss future plans with providers on a periodic basis. Reaching the age of 65 is not necessarily indicative of retirement; many providers retire both before and well after age 65 depending on their professional and personal needs. Retirement is not the only concern. Family changes that result in maternity or paternity leave or decreases in FTE due to family changes or slowing down closer to retirement can often be planned for by working closely with providers through strategic planning.

Making these discussions a routine part of strategic planning may help providers think about these issues and encourage more advance planning. The process also makes the discussion less judgmental and more focused on the long term plans for the health center rather than on the individual. Record strategic planning processes and discussions with providers in the recruitment and retention plan and update periodically, Table 8.

**Table 8 Strategic Planning for Retirement, Extended Leave, and Changes in FTE**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider** | **Provider Age Range** | | | **Over Age 50** | | **All Ages** | |
| **< 50** | **51 - 60** | **61+** | **Discussed Retirement? (Y/N)** | **Planned Age for Retirement** | **Major Leave Plans** | **Expected Changes in FTE** |
| Provider 1 |  |  |  |  |  |  |  |
| Provider 2 |  |  |  |  |  |  |  |
| Provider 3 |  |  |  |  |  |  |  |

# Retention

While one typically thinks of provider recruitment prior to provider retention, this template is organized in a way to focus first on provider retention prior to recruitment. The best strategy to minimize recruitment problems is to retain providers in the long term. Even if it is not possible to retain a current provider, or if your health center is expanding and adding additional providers, it is worthwhile to look at retention issues prior to undergoing a recruitment effort. If any issues are identified, these may be resolved or, at the least, recognized prior to recruitment. Understanding retention issues can help your health center focus recruitment on candidates who might best fit into your health center culture and environment.

## Mission

A critical factor for provider retention is alignment of a center’s organization mission with provider beliefs and values.[[8]](#footnote-8) If your health center does not have a mission, developing one is a primary step in any strategic planning effort. The retention and recruitment plan is a part of the strategic planning process. Even if you do have a mission, it is worthwhile to revisit it periodically to ensure it is still relevant for your health center.

The health center mission is:

|  |
| --- |
|  |

The mission statement was last updated on \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date). The next date of review is planned for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

Staff members contributing to the original Mission or most recent update (if it has been updated) are listed in Table 9 below.

**Table 9. Provider and Non-Provider Staff Members Contributing to Health Center Mission**

|  |  |
| --- | --- |
| Name | Position |
|  |  |
|  |  |
|  |  |
|  |  |

The mission is prominently displayed on (check all that apply):

* Website
* Letterhead
* Waiting Room
* Break/Lunch Room
* Conference Room
* Facebook Page
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The mission is discussed as part of the interview process with

* Physicians
* Nurse Practitioners
* Physician Assistants
* Administrators
* Nurses
* Medical Assistants
* Administrative Support
* Other Clinical Support
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* None

For mission-driven strategy ideas beyond aligning missions, see <http://www.chcworkforce.org/kansas-health-institute-rural-kansas-hospital-focuses-%E2%80%98mission-driven%E2%80%99-medicine-recruit-doctors>.

## Compensation

Review provider compensation to ensure the health center’s overall compensation package is competitive in your local market. If you have a Provider Compensation Plan, include it as part of your recruitment plan. If you do not have a Provider Compensation Plan, it might be a good time to review your compensation policies and strategies to be sure they optimize provider retention. Also, be sure the provider compensation plan is reflected appropriately in provider contracts.

**Provider Salary Review Conducted on \_\_\_\_\_\_ (date).**

**Provider Salary Review Results**

**Example:**

**Date:** October 2015

**Findings:** Providers salaries reviewed by provider type (MD, NP, PA) and compared to MGMA survey by region, NACHC survey by state, and locally during the Fall of 2015. Salaries for physicians are competitive. NP and PA salaries are about 25% below local salaries.

**Action plan:** Effective January 2016, increase NP and PA salaries by 15% per year for 2 consecutive years and reassess October 2017.

**Provider Salary Review:**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Findings:**

**Action Plan:**

Next Provider Salary Review Scheduled for \_\_\_\_\_\_ (date).

**Provider Incentives**

Consider offering incentives as a part of the health center’s compensation package to make the overall compensation package more appealing and also to encourage provider behaviors through compensation rewards. Be sure to involve providers in the compensation planning process and to get their buy-in before making large changes to the compensation model. Create compensation policies in advance of making any changes with very specific formulas and definitions to make the changes clear to all participants. Test and assess changes by conducting a “shadow” model in advance of actual implementation by running a mock compensation change for a 3-6 month period to fully understand the impact of any compensation model revisions. Get feedback and adjust the model as needed prior to full implementation.

**Select the components of the health center’s incentive-based provider compensation and note the % of the total salary compensation attributed to each component.**

**Complete % of total compensation:**

* Base Salary

Incentives based on:

* Production (revenue, visits or RVU based)
* Quality
* Patient Satisfaction
* Internal Administrative Task Completion
* End of year bonus
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Benefits

Similar to the Provider Compensation Review, conduct a Benefit Review. Consider offering improved educational benefits to encourage retention and to promote quality improvement initiatives in the health center. Review each of the following benefits to determine competitiveness in the market place. The first line “Vacation” is completed as an example in the following, Table 10.

**Table 10. Benefit Review**

|  |  |  |  |
| --- | --- | --- | --- |
| Benefit | Details | Review Results | Action Plan |
| Vacation | 3 weeks, 4 weeks after 5 years, 5 weeks after 10 years | Competitive | None |
| Holidays |  |  |  |
| Sick |  |  |  |
| Educational Leave |  |  |  |
| Educational Travel |  |  |  |
| Educational Conference |  |  |  |
| Health Insurance |  |  |  |
| Dental Insurance |  |  |  |
| Life Insurance |  |  |  |
| Disability Insurance |  |  |  |
| Retirement Plan |  |  |  |
| Loan Repayment |  |  |  |
| Other (specify) |  |  |  |

## Work Schedules

A no or low cost strategy for provider retention and recruitment is work schedule innovation. Adequate clinical coverage and on-call coverage is the highest priority for health centers, but this is not always best achieved with traditional full-time schedules. There are many advantages to part-time or flexible schedules. For example, rather than hire a full-time provider, consider hiring two providers for 3 days per week each. This type of schedule can be attractive to young parents or older providers beginning to ramp down their schedules. It can also provide benefits to the health center by allowing two providers to overlap during busy times, such as Monday mornings, or stretch the clinic schedule to 6 days per week. This type of scheduling can also provide built in vacation coverage through job sharing arrangements. Flexible full-time schedules can accommodate time for providers to cover evenings and have other time off during the week. Longer days could allow providers to have more days off during the week and at the same time extend the health center hours. Evening hours could be combined with on-call coverage to make more “free” time available to providers. Be careful to assess the patient and support staff schedules with any provider work schedule innovations to preserve patient access and adequate support staff and room availability (see Assessment: Patient Schedules).

**Provider Schedule Opportunities**

Indicate the provider schedule opportunities and barriers in Table 11. Be sure to document requests for flexible schedules that might be met as part of the larger recruitment and retention plan.

**Table 11. Provider Schedule Types**

|  |  |  |  |
| --- | --- | --- | --- |
| Schedule Type | Availability | Assessment | Action Plan |
| Part-time | Available | 3 part-time staff | None |
| Job Sharing | Not available | No job sharing partner | Consider for next provider recruited |
| Flexible Schedules |  |  |  |
| School hours |  |  |  |
| Evenings |  |  |  |
| Weekends |  |  |  |
| Long days |  |  |  |

## Career Path

Providers are often more likely to stay with an organization if there is opportunity for professional growth and advancement. Indicate the types of professional growth and advancement currently available in the health center in Table 12. Also document your assessment of each type and action plans to incorporate professional growth and advancement into the practice.

**Table 12. Professional Growth and Development**

|  |  |  |  |
| --- | --- | --- | --- |
| Type | Availability | Assessment | Action Plan |
| Clinical Oversight (Other Providers or Clinical Teams) |  |  |  |
| Administrative Oversight (Programs/Services) |  |  |  |
| Teaching Opportunities |  |  |  |
| Medical Students |  |  |  |
| Medical Residents |  |  |  |
| Advanced Practice Students |  |  |  |
| Advanced Practice Residents |  |  |  |
| Telemedicine Opportunities |  |  |  |
| Other (specify) : |  |  |  |

# Recruitment

## Community Recruitment Plans

Before you begin recruiting, and on an ongoing basis, be aware of other planning initiatives in your region. Talk with local hospitals and other primary care providers about their recruitment plans to assess competition for providers or potential collaboration opportunities.

Our health center has had discussions with:

* Hospitals about their recruitment plans
* Other Providers about their recruitment plans

Opportunities for Collaboration:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once you have conducted the health center recruitment and retention needs assessment and determined that 1) you need to recruit, and 2) you know which type of provider to recruit; set up the recruitment process.

## Recruitment Team

It is important to have the right people involved in the recruitment process both to make sure you have the decision makers at the table and get buy-in internally, but also to present your health center to a candidate in the best light. Establishing the recruitment team in advance of beginning the recruitment process provides structure and organization, allows staff to have input early on, and makes it easier to act quickly when a candidate expresses interest. List your health center recruitment team in the table below. It can vary depending on the position being recruited.

### Recruitment Team Roles and Responsibilities

Establish clear roles and responsibilities for team member, keeping in mind their stake in the recruitment, their availability, and respective skills. For example, you may want to include a clinical support staff member to be part of an interview and provide input, but this may be the limit of this person’s role. Whereas, the Chief Medical Officer or Medical Director may not wish to deal with the administrative responsibilities, but clearly needs to spend one-on-one time with final candidates and potentially be part of the screening process. A sample list of Recruitment Team Members and Responsibilities is detailed below in Table 13a. Complete the blank Table 13 for your health center.

**Table 13a. Typical Recruitment Team Members and Corresponding Responsibilities**

|  |  |
| --- | --- |
| Position | Responsibilities |
| Chief Medical Officer | With CEO define position, Contribute to draft ad, Assist with screening calls, Final interviews, Visit dinner event |
| Administrator/CEO | With CMO define position, Contribute to draft ad, Assist with screening calls, Final interviews, Visit dinner event |
| Recruitment Staff (may not have this title, but need to appoint someone in this role) | Coordinate with recruiting firm (if any), Draft final ad and coordinate with media and social media outlets, Screening calls, Coordinate all parts of visit and interviews, Track candidates, Develop and negotiate contracts, Assist with moving arrangements and community connections (schools, partner employment) |
| Provider Team Members | Input defining position, Contribute to draft ad, Final interviews and visit events as necessary |
| Clinical Support Staff | Part of site tour and informal interviews during visit |
| Administrative Staff | Support Recruitment Staff, Potentially part of site tour and informal interviews during visit |
| Community Member | Potentially part of final interviews, Visit dinner event |
| Provider Team Spouse | Provide assistance and support to candidate partners/families, Lunch with partner |

**Table 13. Recruitment Team Members and Corresponding Responsibilities**

|  |  |
| --- | --- |
| Name | Responsibilities |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

## Recruiting Priorities

Define a “big picture” written set of priorities to provide a map to guide your recruitment plans. Use information gleaned from the Practice Assessment and Strategic Planning process to identify positions to be filled and realistic timelines for completing the recruitment process and document in Table 14. Plan out as far as you have information, at least 3 – 5 years. Dates do not need to be static, so use the best information you have. For example, if you have a physician who has indicated she plans to retire in 5 years, include this information. While her retirement plans could change, including the information in the plan is a reminder to ask her about her plans and refine the information as the dates approach.

When setting priorities, consider the length of time it could take to fill each position to plan adequate time to fill expected vacancies. The Association of Staff Physician Recruiters (ASPR) defines Days to Fill as the “difference between the date a search was initiated and the date a contract was signed.” [[9]](#footnote-9) According to the ASPR In-House Physician Recruitment Benchmarking Report 2015 Executive Summary, the average days to fill a primary care physician was 124 days in 2015 and 95 days for an Advanced Practice position (NP).[[10]](#footnote-10) The days to fill data are from organizations with in-house staff recruiters. The length of time to fill vacancies in FQHCs and rural areas may be significantly higher. Days to fill data also does not include the positions that go unfilled.

**Table 14. Provider Recruitment Priorities**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Position | FTE | Replacing | FTE | New Position | Reason | | | | | Date | |
| Current Vacancy | Planned Vacancy | Retire-  ment | Growth | Other | Anticipated Need | Begin Recruiting Process |
| NP | .75 | Susan Smith, MD | .5 | No | X |  |  |  |  | ASAP | 3/16 |
| FP | 1.0 |  |  | X |  |  |  | X |  | 6/17 | 6/16 |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

## Recruitment Budget

Plan for a realistic recruiting budget to ensure you have the resources required to mount a successful recruitment effort. The following worksheet (Table 15) is included to assist with recruitment budget planning.

**Table 15. Recruiting Budget Worksheet**

|  |  |
| --- | --- |
| **Staff Costs (Planning, Recruiting, Onboarding)** | |
| Business Office (Patient Accounts/Billing) Salary and Benefits per Hour |  |
| CEO/Administrator Salary and Benefits per Hour |  |
| Chief Medical Officer Salary and Benefits per Hour |  |
| Human Resources Salary and Benefits per Hour |  |
| IT Hourly Rate plus Benefits |  |
| Nurse/MA Hourly Rate plus Benefits |  |
| Other Providers Average Hourly Rate plus Benefits |  |
| Support Staff Salary and Benefits per Hour |  |
| **Total Salaries/Benefits** |  |
| **Outside Recruiting Expenses** | |
| Recruiting Service |  |
| Advertising Costs (2 national journal print ads, 1 national online service x 3 months) |  |
| **Total Outside Recruiting Expenses** |  |
| **Interview Expenses** | |
| Number of In-Person Interviews |  |
| Hotel Expense per Night per Interview |  |
| Travel Expense per Interview |  |
| All Staff Breakfast with Candidate per Interview |  |
| CMO Lunch with Candidate per Interview (incl. candidate and guest) |  |
| Number of People Included in Interview Dinner per Interview |  |
| Interview Dinner Cost per Person per Interview,(incl. tax and gratuity) |  |
| Cost of Other Interview Items (such as gift baskets, babysitting service) |  |
| *Total Cost Per Interview* |  |
| **Total Interview Expenses (# of Interviews X Total Cost per Interview)** |  |
| **Hiring Expenses** | |
| Relocation Costs |  |
| Signing Bonus |  |
| Publicity Costs |  |
| Other Costs, i.e. cell phone, lab coat |  |
| **Total Hiring Expenses** |  |
| **Total Recruitment Budget** |  |

## Recruiting Firm

If you use a recruiting firm, list the name and contact information below as well as pricing for budget purposes, Table 16. Keep rating information in your recruitment plan for future reference as to the quality of your health center’s experience with the recruiting firm. Keep notes about the experience for possible improvement over the span of the recruitment process or for the next recruitment process.

If you plan to use a firm, contact those who may offer discounts based on your non-profit status.[[11]](#footnote-11) If you have a standing relationship with a firm, request a discount based on your non-profit status.

**Recruiting Firm:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Table 16. Recruiting Firm Contact Information and Notes**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Contact Name | Phone | Email | Address | Fees | References | Date Last Used | Position Filled | Rating  1-5 |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Track other activities and expenses below.**

## Advertising

Plan and track all advertising, either done directly by your health center or by a recruiter, if you use one. Record any differences from your plan so that future recruitment efforts will begin with the more accurate information. Utilize sources that are familiar with health center recruiting issues and working with mission driven organizations and providers looking for a mission driven organization. Post positions with state, regional, and national agencies including Primary Care Organizations (PCOs) and Primary Care Associations (PCAs).[[12]](#footnote-12) Use Table 17 to document your advertising efforts.

**Table 17. Media Outlet Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Media Outlets | Contact Name | Phone | Email | Timing | Frequency (Ongoing?) | Fees | Rating 1-5 |
| National Journal Print Ads |  |  |  |  |  |  |  |
| Journal 1 |  |  |  |  |  |  |  |
| Journal 2 |  |  |  |  |  |  |  |
| Journal 3 |  |  |  |  |  |  |  |
| Primary Care Organization (PCO) |  |  |  |  |  |  |  |
| Primary Care Association (PCA) |  |  |  |  |  |  |  |
| NHSC Job Center |  |  |  |  |  |  |  |
| Regional Advertising (specify) |  |  |  |  |  |  |  |
| Online Recruitment Site Service |  |  |  |  |  |  |  |
| Health Center Website |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

### Ad Text

Keep a copy of your ads in or attached to the recruitment plan so you don’t have to reinvent the wheel. Review the ad to make sure it is meeting your health center’s needs. For providers who respond to the ad, ask them for their opinion as to why it attracted them and what other information they would have liked to see covered in the ad.

Draft ad text in advance to minimize turnaround time for placing ads or posting in social media. Include the ad text in the recruitment and retention plan to avoid having to “reinvent the wheel” each time there is a position open. In particular, there should be standard text describing the mission and region.

**Ad Template**

|  |  |
| --- | --- |
| **Title** |  |
| **Body**   * + Type of organization recruiting   + Location   + Statement of position type, FT or PT   + Promote mission driven health center environment   + Brief description of the positive aspects of the region     - i.e. If urban, cultural opportunities; if rural, outdoor/nature experiences   + Promote any positives, such as flexible schedules, teaching opportunities   + Include any recognition, such as PCMH   + Include possible incentives, such as professional development benefits, bonuses, relocation expenses |  |
| **Contact Person and Information** |  |

## Strategies for Use of Social Media[[13]](#footnote-13)

Make optimal use of social media to get the word out. Younger candidates, such as residents, frequently use social media for information. Make sure your health center is connected to potential recruits with an Internet presence that goes beyond your website. Social media sites provide forums to get very detailed information about your health center for recruitment purposes, but can also be helpful for patients, for example, posting flu clinics on Facebook. The New England Journal of Medicine Career Center[[14]](#footnote-14) suggests several ways to improve your use of social media.

* Set up LinkedIn Company Profile and establish broad provider connections
  + Post jobs, join groups, or purchase “In Mail” credits to send messages to prospective candidates outside of their extended network
  + To reach Twitter fans, consider following these accounts: @physicians, @doctorslounge, @doc2doc (reaching physicians around the globe), @psychiatrists, @radiologists, @internists, @surgeons, and so forth. Smart use of a search engine like Twubs will produce other hashtag (#) and @ Twitter sites worth considering.
* Establish and maintain an updated Facebook Page for the health center
  + Post Jobs and highlight the benefits of working in health center
  + Post provider testimonials
* Use YouTube Videos to introduce your facility to potential candidates
  + Create videos highlighting your health center, also use any existing videos that highlight your region and community
* Consider starting a Blog connected to your other social media outlets
  + See Top 50 Blogs by Physicians for ideas (<http://bestmastersinhealthcare.com/2010/top-50-blogs-by-physicians/>)
* Ensure your health center website has essential community links
  + Providers interested in your health center will browse your website and can gain a greater perspective of the community through links to highlights you want to emphasize in your region

**Table 18. Use of Social Media**

|  |  |  |  |
| --- | --- | --- | --- |
| Social Media | Use (Y/N) | Assessment | Action Plan |
| Website |  |  |  |
| Use for Job Posting |  |  |  |
| Highlights of HC |  |  |  |
| Community Links |  |  |  |
| Linked-In Company Profile |  |  |  |
| Twitter (see instructions) |  |  |  |
| HC Facebook Page |  |  |  |
| Use for Job Posting |  |  |  |
| Highlights of HC |  |  |  |
| Community Links |  |  |  |
| YouTube Videos |  |  |  |
| HC Highlights |  |  |  |
| Regional Highlights |  |  |  |
| Blogs |  |  |  |

## Screening Process

Once you begin to attract candidates, be sure to carefully track the results. It is critical to respond quickly, communicate often, and ensure rapid turnaround of questions, interviews and site visits. The Excel document, Candidate Tracking Sheet, a separate component of the Recruitment and Retention Plan is a tool for tracking applicants through the recruitment process.

### Telephone Interview Content[[15]](#footnote-15)

The Medical Director or Chief Medical Officer should contact the candidate within five business days for a brief telephone interview.[[16]](#footnote-16) This expresses interest and is important to make sure you do not lose a potential candidate.

Develop the content for the telephone interview in advance. Use a set of predetermined questions to guarantee you are not forgetting any essential question. The telephone interview can go beyond the key questions, but should collect basic information to help the health center determine the next steps for each candidate. Sample telephone interview content and next steps are shown below.

Adopt or edit the following interview content and next steps.

**Telephone Interview Content:**

* Describe the position
* Describe the health center, the town/region, and approximate salary
* Ask:
* How did you hear about the position?
* Why are you interested in this position?
* Do you have any special clinical interests?
* Are there clinical procedures or types of patients/conditions you are not comfortable with?
* Is there anyone you need to take into consideration during your search (spouse/partner)?
* Do you have any malpractice history?
* Is there any reason you wouldn't be able to get credentialed?
* Do you have any employment gaps?
* Did you change training programs and/or specialty?
* Do you have any inactive licenses?
* Field questions from the candidate.
* Discuss the health center recruitment process and next steps.

**Next Steps:**

* Record the interaction for later review by the Recruitment Team.
* Review the candidate’s CV and make sure he/she is board eligible.
* Present results to the Recruitment Team
* If the Recruitment Team thinks the candidate is a good fit, check references, and then arrange a visit.
* If there are further questions, arrange a second telephone interview with the appropriate person.

## Visit

If the telephone interview is successful, the Recruitment Team needs to arrange a visit as soon as possible. Often there are two visits involved in a normal recruitment cycle, one for the candidate and then another for the candidate and partner/spouse and family. Do not delay in scheduling the visit(s); lag times can lead to lost candidates due to either perceived lack of interest from the health center or very competitive environments. Table 19, Visit Details Worksheet, lists the common elements of a candidate visit. To ensure a smooth visit, pick the candidate up at the airport. Assign a key staff person to guide the candidate through the itinerary and another person to assist the partner/spouse.[[17]](#footnote-17) [[18]](#footnote-18) [[19]](#footnote-19)

**Table 19. Visit Details Worksheet**

|  |  |  |  |
| --- | --- | --- | --- |
| Item | Details | Responsible or Lead Person | Date Finalized |
| Arrange Logistics 2-3 days |  |  |  |
| Travel – flights, ground transportation |  |  |  |
| Reserve hotel |  |  |  |
| Gift Baskets – if children are coming, include age appropriate toys |  |  |  |
| If children attend: Babysitting service |  |  |  |
| Create & distribute itinerary |  |  |  |
| Provide directions & maps |  |  |  |
| Visit |  |  |  |
| Pick up at Airport |  |  |  |
| Provider Itinerary |  |  |  |
| Breakfast with Staff (support staff included) |  |  |  |
| Tour of Site(s) |  |  |  |
| Visit Hospital/Hospital Administration |  |  |  |
| Meet with Providers, Provider Team |  |  |  |
| Meeting with CEO |  |  |  |
| Review of Contract/Benefits/etc. |  |  |  |
| Lunch/meeting with CMO |  |  |  |
| Partner Itinerary |  |  |  |
| Schools |  |  |  |
| Child Care Providers |  |  |  |
| Banks |  |  |  |
| Realtors |  |  |  |
| Lunch with community member(s) |  |  |  |
| Local recreational facilities & sights |  |  |  |
| Meetings with Potential Partner Employers |  |  |  |
| Joint Itinerary |  |  |  |
| Dinner with key providers, administration and partners/spouses |  |  |  |
| Attend cultural performances |  |  |  |

## Follow up with Candidates

It can be easy, especially in a health center without dedicated recruiting staff, to delay in following up with candidates when juggling many different health center priorities. For this reason, it is important to set expectations and timeline goals for timely follow up with candidates at each stage of the recruitment process. Table 20a is a sample of a completed follow up plan. A blank table is provided in Table 20.

**Table 20a. Sample Candidate Follow Up Plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Stage (F/U after each event) | Frequency | Timeline | Type of Contact | Responsible Person |
| Application Received | Min. of up to 5 attempts | Within 5 work days | Email, telephone | Administrative Assistant |
| 1st Telephone Interview | Min. of up to 5 attempts | Within 5 work days | Email, telephone, mail | CMO |
| 2nd Telephone Interview (if applicable) | Min. of up to 5 attempts | Within 5 work days | Email, telephone | Provider conducting 2nd interview |
| 1st Visit | Min. of up to 10 attempts | Within 5 work days | Email, telephone, mail | CMO |
| 2nd Visit (if applicable) | Min. of up to 5 attempts | Within 5 work days | Email, telephone, mail | Recruiting Staff or HR |
| Offer | Min. of up to 10 attempts | Within 10 work days | Email/  Telephone **and** mail | CEO |

**Table 20. Candidate Follow Up Plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Stage | Frequency | Timeline | Type of Contact | Responsible Person |
| Application Received |  |  |  |  |
| 1st Telephone Interview |  |  |  |  |
| 2nd Telephone Interview (if applicable) |  |  |  |  |
| 1st Visit |  |  |  |  |
| 2nd Visit (if applicable) |  |  |  |  |
| Offer |  |  |  |  |

## Contract Development and Negotiation

Ideally, a provider contract needs to be developed prior to the first telephone interview. In addition to specifying the work expectations, compensation and benefits, the contract should include provisions for moving expenses, signing bonus (if applicable), and professional development time and expenses. Attach a boilerplate version of the health center provider contract to the Recruitment and Retention Plan. Update the contract as necessary. Be prepared to discuss the general terms of the contract during the telephone interview and very specific details during the candidate visit.

**Check the following Contract Terms that are included in the health center boilerplate contract:**

* Work Expectations
  + Clinical office hours
  + Administrative responsibilities
  + Call schedule
  + Office sites
* Compensation
  + Details of Incentive Compensation (if applicable)
    - Base Salary
    - Incentives for production (revenue, visits or RVU based) including goals
    - Incentives for quality, including metrics
    - Incentives for patient satisfaction, including goals
    - Incentives for internal administrative task completion, including expectations
    - End of year bonus
* Benefits
  + Vacation
  + Holidays
  + Sick
  + Health Insurance
  + Dental Insurance
  + Life Insurance
  + Disability Insurance
  + Retirement Plan
* Professional Development
  + Educational Leave
  + Educational Travel
  + Educational Conference or Other Required Educational Expenses
* Moving Expenses
* Signing Bonus
* Other benefits such as sabbatical leave

**Boilerplate Contract is Included as Attachment \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Date Contract Reviewed/Updated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Onboarding

Provider recruitment does not end when an offer is extended and accepted. One of the most important parts of recruiting is onboarding. A comprehensive plan for onboarding providers is key to beginning a relationship to promote provider retention. Provider onboarding is the process of integrating a provider into the practice. Onboarding activities include: credentialing and billing set up; orientation to the facility, office staff, computer system, electronic medical record, and operational systems and procedures; building relationships with administration, the CMO, provider staff and the care team; understanding the organizational culture; and integration into the community. The process begins just before or as soon as an agreement is in place and before the provider actually starts working at the practice and continues through the first six months to a year of employment. Comprehensive onboarding improves provider retention rates through greater communication and provider satisfaction. Common onboarding tips and activities are listed below. [[20]](#footnote-20) [[21]](#footnote-21) Develop an onboarding plan or checklist to ensure you are maximizing the retention of new providers and maximizing the understanding of the practice and communication among all parties. For a comprehensive list of onboarding best practices developed by the New Hampshire Vermont Recruitment Center of the Bi-State Primary Care Association go to the STAR2 resources page at <http://www.chcworkforce.org/resources>.

**Tips for successful onboarding:**

* Assign a mentor to orient the new provider and help integrate him or her into the medical community.
* Assign a person and realistic timeline to each onboarding activity to ensure accountability.
* Set expectations for the new provider regarding getting out into the community and meeting other members of the group and medical staff.
* Conduct weekly check-in calls prior to provider beginning practice.
* Conduct weekly check-in meetings as soon as the provider begins at the practice, to be tapered off to bi-monthly and monthly over the first few months.
* Provide opportunities for peer interaction outside the community.
* Develop telecommunication links to practitioners in other communities and to medical education and support resources.

**Common Onboarding Activities:**

* Licensing
* Credentialing
* Hospital medical staff privileges
* Third party insurance enrollment
* Appointment scheduling set up
* IT issues and training on systems
* Human Resources
* Training on how to obtain needed clinical consults, tests, and support for patient care
* Defining expectations for productivity, quality, and work effort
* Organizational orientation/Introduction to culture
* Marketing
* Community orientation
* Policies/Procedures
* Ancillary departments
* QI/Clinical review

# Other Topics

## Patient Centered Medical Home and Team-Based Care

Many providers are attracted to organizations that have a Patient Centered Medical Home (PCMH) model.[[22]](#footnote-22) Patient Centered Medical Homes encourage Team-Based Care, another attractive component of PCMH. If the health center is recognized as a PCMH, include this information in recruiting advertising and materials and discuss it with candidates.

**Health Center Patient Centered Medical Home Recognition Status**

* Recognized at Level \_\_\_\_ on \_\_\_\_\_\_\_\_(date) by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (recognition organization such as NCQA)
* Not recognized but application is in process and expected on or about \_\_\_\_\_\_\_ (date)
* Not recognized and application not in process
* Unknown

## National Health Service Corps

The National Health Services Corps (NHSC) offers financial and other support to primary care providers and sites in underserved communities.[[23]](#footnote-23) The following information is excerpted from the NHSC website. The NHSC has programs for loan repayment and scholarships. Health centers can recruit candidates eligible for loan repayment or in the scholarship programs through the NHSC. For more information, see http://www.nhsc.hrsa.gov. Community Health Centers, Federally Qualified Health Center (FQHC) Look-Alikes, Indian Health Service Facilities, Tribally-Operated 638 Health Programs, Urban Indian Health Programs, Federal Prisons, and Immigration and Customs Enforcement (ICE) Health Service Corps sites are auto-approved and do not need to submit an application during the site application period. Contact the Bureau of Health Workforce’s Division of Regional Operations to begin for more information about the auto-approval process at <http://nhsc.hrsa.gov/sites/helpfullcontacts/drocontactlist.pdf>.

Health centers can use the status as an NHSC-approved site to recruit new providers and help retain current staff.

* Notify your current staff that they may be eligible to apply for loan repayment assistance. Priority consideration is given to eligible applicants whose NHSC-approved site has a HPSA score of 26 to 14, in descending order. Eligible applicants may receive up to $50,000 in loan repayment for an initial service commitment until funding is exhausted.
* Inform primary care providers when you interview them for positions that your site is NHSC-approved and therefore they may be eligible to apply for loan repayment if they accept your open position.
* Post job openings on the NHSC Recruitment Site [Job Center] to alert prospective and current Corps members to your needs.

#### Loan Repayment

Licensed health care providers may earn up to $50,000 toward student loans in exchange for a two-year commitment at an NHSC-approved site through the [NHSC Loan Repayment Program (NHSC LRP)](http://nhsc.hrsa.gov/loanrepayment/loanrepaymentprogram.html).

#### Scholarship Program

Medical students (MD or DO) may earn up to $120,000 in their final year of school through the [Students to Service Loan Repayment Program](http://www.nhsc.hrsa.gov/loanrepayment/studentstoserviceprogram/index.html) (S2S LRP). Students must commit to serving either 3 years full-time or 6 years part-time at an NHSC-approved site with a Health Professional Shortage Area (HPSA) score of 14 or higher.

### State Loan Program Participation

Through the NHSC, states and territories may offer a [State Loan Repayment Program](http://www.nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/index.html) (SLRP) program for health professionals that provide primary care in Health Professional Shortage Areas within their state. Not all states offer an SLRP.

#### Other State Loan Repayment Programs

Review and document any other loan repayment programs that might be available in your state. Information for these programs should be available through your state’s Primary Care Association (PCA) or health department website.

**Complete the following.**

The health center is:

* NHSC approved site
  + Current providers were notified of this status
  + Recruiting materials include information about the NHSC status
  + Job openings are posted on the NHSC Recruitment Site (NHSC Job Center)
* In the process of becoming NHSC approved site
* Not NHSC approved site
* Unknown

The health center state:

* Has a state loan repayment program, the contact information follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does not have a state loan repayment program
* Unknown

## Medical Education Connections through Residency Programs

Hosting residents through an accredited Medical or Nurse Practitioner Residency Program can offer unique recruiting opportunities. If your health center is already connected to a residency program, maximize your probability of hiring within the residency pool.

The health center is:

* Connected to a residency program
  + The health center optimizing resident recruitment through the following actions:
    - Identify residents who fit with the health center culture and mission
    - Meet with residents during their entire tenure to build a positive relationship
    - Whenever possible, include residents in provider teams
    - Hold social events between current providers and residents
    - Approach residents early to assess their interest in working long term at the health center
    - Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The health center is not connected but is in the process of connecting to a residency program.
* The health center is not connected to a residency program.

## Attachment 1. UDS Mean Visits: Productivity Benchmarks

Health Center Data Reported in the Uniform Data System (UDS) 2014

|  |  |
| --- | --- |
| PERSONNEL BY MAJOR SERVICE CATEGORY | Mean Patient Visits per 1.0 FTE |
| Family Physicians | 3238 |
| General Practitioners | 3427 |
| Internists | 3059 |
| Obstetrician/Gynecologists | 2968 |
| Pediatricians | 3451 |
| Other Specialty Physicians | 3452 |
| Average All Physicians | **3241** |
| Nurse Practitioners | 2639 |
| Physician Assistants | 2937 |
| Average All NP and PA | **2730** |
| Certified Nurse Midwives | 2335 |
| Dentists | 2637 |
| Dental Hygienists | 1237 |
| Psychiatrists | 2571 |
| Licensed Clinical Psychologists | 1059 |
| Licensed Clinical Social Workers | 943 |
| Other Licensed Mental Health Providers | 996 |
| Ophthalmologist | 2906 |
| Optometrist | 2605 |

1. Robinson, J. The Cost of a Physician Vacancy. Merritt Hawkins. An AMN Healthcare Company. Accessed at http://www.merritthawkins.com/Clients/BlogPostDetail.aspx?PostId=39321 [↑](#footnote-ref-1)
2. Institute for Healthcare Improvement. Third Next Available Appointment accessed at [*http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx on January 6*](http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx%20on%20January%206)*, 2016.* [↑](#footnote-ref-2)
3. National Committee on Quality Assurance (NQCA). PMCH 2014 Standards and Guidelines. Available at www.ncqa.org. [↑](#footnote-ref-3)
4. Recruitment and Retention of Primary Care Physicians at Community Health Centers: A Survey of Massachusetts Physicians. January 2010. MassAHEC Network. University of Massachusetts Medical School. Accessed at http://www.umassmed.edu/uploadedFiles/CWM\_CHPR/About\_Us/RecruitmentRetentionPCPs\_CHCs\_January2010.pdf on1/27/14. [↑](#footnote-ref-4)
5. Auerbach DI, Chen PG, Friedberg MW, Reid R, Lau C, Buerhaus PI, & Mehrotra A. (2013). Nurse-managed health centers and patient-centered medical homes could mitigate expected primary care physician shortage. *Health Affairs, 32(11),* 1933-1941. [↑](#footnote-ref-5)
6. 2014 PCMH Standard 2. Committee on Quality Assurance (NQCA). PMCH 2014 Standards and Guidelines. Available at www.ncqa.org. [↑](#footnote-ref-6)
7. Primary Care Bureau, Community Health Administration, DC Department of Health, Government of the District of Columbia. (2013). *Assessment of Provider Retention Opportunities in the District of Columbia: Keeping Health Care Providers in DC’s Communities of Need.* [↑](#footnote-ref-7)
8. Recruitment and Retention of Primary Care Physicians at Community Health Centers: A Survey of Massachusetts Physicians. January 2010. MassAHEC Network. University of Massachusetts Medical School. Accessed at http://www.umassmed.edu/uploadedFiles/CWM\_CHPR/About\_Us/RecruitmentRetentionPCPs\_CHCs\_January2010.pdf on1/27/14. [↑](#footnote-ref-8)
9. ASPR Benchmarking Survey Questions. 2015. Association of Staff Physician Recruiters. *Accessed* at <http://c.ymcdn.com/sites/www.aspr.org/resource/resmgr/Files/2015-Survey-Questions.pdf> on 4/4/16. [↑](#footnote-ref-9)
10. ASPR In-House Physician Recruitment Benchmarking Report 2015 Executive Summary - Fall 2015. Association of Staff Physician Recruiters. Accessed at http://www.aspr.org/?page=JASPR\_Fall15\_3 [↑](#footnote-ref-10)
11. # Physician Recruitment Plan. Community Health Association of Mountain Plains States. Accessed at <http://champsonline.org/tools-products/rrresources/physician-recruitment-plan> on 4/4/16.

    [↑](#footnote-ref-11)
12. # Physician Recruitment Plan. Community Health Association of Mountain Plains States. Accessed at <http://champsonline.org/tools-products/rrresources/physician-recruitment-plan> on 4/4/16.

    [↑](#footnote-ref-12)
13. Physician Recruitment and Social Media Networking. Recruiting Physicians Today. NEJM Career Center. Accessed at <http://www.nejmcareercenter.org/minisites/rpt/physician-recruitment-and-social-media-networking/> on 2/28/16. [↑](#footnote-ref-13)
14. Physician Recruitment and Social Media Networking. Recruiting Physicians Today. NEJM Career Center. Accessed at <http://www.nejmcareercenter.org/minisites/rpt/physician-recruitment-and-social-media-networking/> on 2/28/16. [↑](#footnote-ref-14)
15. [The Initial Screening Questions You Should Ask Physician Candidates](http://www.mdrsearch.com/blog/the-initial-screening-questions-you-should-be-asking-physician-candidates). MDR Associates. Accessed at

    [http://www.mdrsearch.com/blog/the-initial-screening-questions-you-should-be-asking-physician-candidates on 3/6/16](http://www.mdrsearch.com/blog/the-initial-screening-questions-you-should-be-asking-physician-candidates%20on%203/6/16) [↑](#footnote-ref-15)
16. Vitale, Joe. A Guide to Physician Recruitment. Professional Staff Affairs. Cleveland Clinic. Accessed at <https://my.clevelandclinic.org/ccf/media/files/Alumni/A_Guide_To_Physician_Recruitment.pdf> on 3/6/16 [↑](#footnote-ref-16)
17. Cassling. Physician Recruitment: Tips for Attracting the Right Doctor for Your Community. A Cassling White Paper. Accessed at http://cdn2.hubspot.net/hub/381908/file-1393601328-pdf/PhysicianRecruitment\_WP\_21023120.pdf?t=1438377984624 on March 7, 2016. [↑](#footnote-ref-17)
18. Physician Recruitment Plan. Community Health Association of Mountain Plains States. Accessed at http://champsonline.org/tools-products/rrresources/physician-recruitment-plan on 4/4/16. [↑](#footnote-ref-18)
19. The Whatcom Alliance for Health Advancement (WAHA). Whatcom Alliance for Healthcare Access Physician Recruitment & Retention Program. Copyright 2007. Accessed at http://www.whatcomalliance.org/wp-content/uploads/2011/01/Rec\_Step4b.pdf accessed on April 12, 2016. [↑](#footnote-ref-19)
20. Healthcare Strategy Group. Though Leadership: Articles. Onboarding New Physicians: The Value of a 100-Day Plan. Accessed at http://www.healthcarestrategygroup.com/thought-leadership/articles/onboarding-new-physicians-value-100-day-plan/ on April 14, 2016. [↑](#footnote-ref-20)
21. Byington, Melissa. Keys to Onboarding New Hires at Your Medical Practice. Physicians Practice. May 8, 2013, Accessed at http://www.physicianspractice.com/blog/keys-onboarding-new-hires-your-medical-practice on April 4, 2016. [↑](#footnote-ref-21)
22. Gamble, Molly. 5 Reasons Why Patient-Centered Medical Homes Are a Win-Win Strategy. Becker’s Hospital Review. September 6, 2011. Accessed at http://www.beckershospitalreview.com/hospital-physician-relationships/5-reasons-why-patient-centered-medical-homes-are-a-win-win-strategy.html on April 14, 2016. [↑](#footnote-ref-22)
23. National Health Services Corps. U.S. Department of Health and Human Services. Accessed at http://www.nhsc.hrsa.gov on April 17, 2016. [↑](#footnote-ref-23)