Physician Recruitment and Retention in Greater Cincinnati

Printed: March 2008

The Health Foundation of Greater Cincinnati

Copyright © 2008 by The Health Foundation of Greater Cincinnati.

All rights reserved.

To cite this work, please follow this format:
Health Foundation of Greater Cincinnati, The. (2008). Physician recruitment and retention in Greater Cincinnati. Cincinnati, OH: Author.

Permission is granted to reproduce this publication provided that these reproductions are not used for a commercial purpose, that you do not collect any fees for the reproductions, that our materials are faithfully reproduced (without addition, alteration, or abbreviation), and that they include any copyright notice, attribution, or disclaimer appearing on the original. Free copies of our publications are available; see our web site at www.healthfoundation.org/publications.html.

Contents

About this Report ..... **iii**
- Acknowledgements iii
- About The Health Foundation of Greater Cincinnati iii
- About The Doctors Foundation iii

Overview of the 5-County Region **1**
- Demographics 1
  - Aging of the Region 2
- Health Status 2
  - Infant Mortality 2
  - Physical Health Conditions 3
  - Health Insurance Status 5

Physician:Population Ratios in the Region **7**
- Health Professional Shortage Areas 8
- Future Population Growth 8
- Physician Age, Gender, and Ethnicity 8
  - Physician Age 9
  - Physician Gender and Ethnicity 10

Physician Payment, Income, and Turnover in the Region **11**
- Regional Physician Turnover 12

Local Perspectives on Physician Shortages, Recruitment, and Retention **13**

Resources for Physician Recruitment and Retention **15**
- First Steps: Evaluate and Prepare 15
- Screening and Hiring Candidates 18
- Negotiating and Closing the Deal 20
- Potential Recruiting Targets 20
  - Residents, Fellows, and Medical Students 20
  - Physicians in Military Service 22
  - Physicians in Government Service 22
  - Academic and Research Physicians 22
  - Missionary Physicians 23
  - Physicians Already in Private Practice 23
  - International Medical Graduates 23

Grantmaking Aimed at Physician Recruitment and Retention **25**
- Activities Sponsored by Local Foundations and Organizations 25
- Activities Sponsored by National and International Foundations and Organizations 26
- Cincinnati MD Resource Center and www.cincinnatiMDjobs.com 27

Appendix: Interviews and Methodology **29**
- Limitations of this Report 29

References **31**

About this Report

The Health Foundation of Greater Cincinnati's mission is to improve the health of the people of the Cincinnati region. We focus on access to care, and part of that is having enough physicians and specialists to provide care for the people of our region. Working with The Doctors' Foundation, a regional foundation also interested in the supply of physicians in our region, we commissioned this paper to learn more about physician recruitment and retention in Greater Cincinnati.

Acknowledgements

The Health Foundation would like to acknowledge contributors from the Center for Global Health Systems, Management, and Policy at the Boonshoft School of Medicine at Wright State University:

- John McAlearney, PhD, Assistant Professor/Health Economist
- Nancy Terwoord, BS, RN, CPHQ, Senior Consultant
- Richard J. Schuster, M.D., M.M.M., F.A.C.P.. Boonshoft Chair and Director

About The Health Foundation of Greater Cincinnati

Since 1997, The Health Foundation of Greater Cincinnati has invested over $76 million to address health needs in the 20-county region surrounding Cincinnati. The majority of our work falls within our four focus areas:

- Community Primary Care
- School-Aged Children's Healthcare
- Substance Use Disorders
- Severe Mental Illness

We help create enduring projects that will improve health, and grantee sustainability is vital to our mission. We help grantees move toward sustainability by offering workshops, staff consultations, and other technical assistance. We also help grantees find other funders who might be interested in their work.

Through our Health Data Improvement Program, we work to improve the local health data available so communities can make data-driven decisions. Results of our health-related surveys, as well as other local, state, and national health data, are available at OASIS, our Online Analysis and Statistical Information System, found at www.oasis.uc.edu. Our data can also be used to make powerful health-related population maps through *Health*Landscape, found at www.healthlandscape.org.

For more information about the Health Foundation and our grantmaking interests, capacity building programs for nonprofits, and local health data, please contact us at 513-458-6600, toll-free at 888-310-4904, or visit our web site at www.healthfoundation.org.

About The Doctors Foundation

The Greater Cincinnati/Northern Kentucky Healthcare Foundation, Inc., commonly known as The Doctors Foundation, was formed in 2006 from the proceeds of a class action lawsuit brought by three

medical societies and individual physicians against various insurance companies regarding physician payment rates. The initial corpus of the Foundation was $2.27million.

The Doctors Foundation is dedicated to promoting high-quality healthcare in the Greater Cincinnati/Northern Kentucky region by facilitating the recruitment and retention of physicians. Currently, The Doctors Foundation supports the MD Resource Center. Additional grantmaking will begin in 2008.

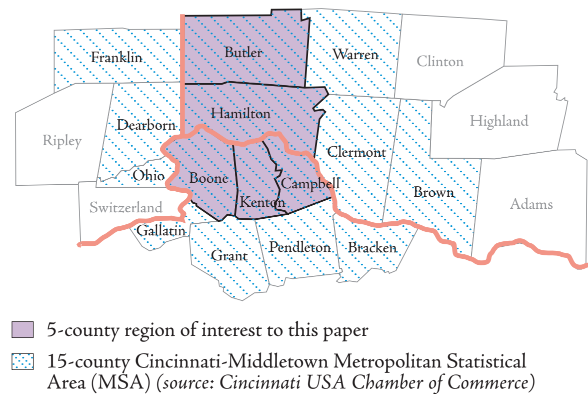
The members of the Foundation are the Academy of Medicine of Cincinnati, the Butler County Medical Society, and the Northern Kentucky Medical Society. These bodies appoint the Board of Directors.

InterAct for Change serves as the grants administrator and staff for The Doctors Foundation. For more information, please contact InterAct for Change at (513) 458-6680 or email info@interactforchange.org.

Overview of the 5-County Region

Earlier research conducted by The Health Foundation of Greater Cincinnati and published in the chart book, *Exploring Primary Care Services and Resources in Greater Cincinnati*, raised concerns about the sufficiency of the regional physician base to address future health care needs (The Health Foundation of Greater Cincinnati, 2006b). To provide an enhanced perspective on this issue, the Health Foundation hired researchers to gather additional background information on the region and investigate the issue of recruitment and retention focusing on five counties within the Greater Cincinnati region (see Map 1).

Map 1. Greater Cincinnati region



Demographics

While the Cincinnati-Middletown Metropolitan Statistical Area (MSA) is home to an estimated 2.1 million people, the 5-county region of interest to this paper is home to over 71% of the MSA's residents, or over 1.5 million people. Specifically, the five counties are:

- Butler, Ohio
- Hamilton, Ohio
- Boone, Kentucky
- Kenton, Kentucky
- Campbell, Kentucky

While the five counties are in close proximity, they are characterized by some fairly strong demographic differences (see Table 1 on the next page):

- The two Ohio counties, Butler and Hamilton, have the largest populations.
- Boone (+28%) , Butler (+7%), and Kenton (+2%) Counties have experienced increases in population, while Hamilton (-3%) and Campbell (-2%) Counties have experienced moderate decreases.
- Boone County has the youngest population with less than 10% of the residents age 65 or older.
- Hamilton County is more racially and ethnically diverse than the other four counties. Just under three-fourths (72%) of Hamilton County's population is white, compared with at least 90% of the population in the other four counties.
- Hamilton County has the most highly educated population.
- Boone County has the highest median household income and lowest percentage of people living below 100% of the federal poverty guidelines (FPG)[1]. Hamilton County, on the other hand, has the lowest household income and highest percentage of people living below 100% FPG.
- Counties with older populations (Hamilton and Campbell) have higher percentages of people with disabilities, while counties with younger populations (Butler and Boone) have lower

[1] *In 2007, 100% of the federal poverty guidelines (FPG) was a household income of $20,650 for a family of 4*

percentages of people with disabilities. The exception is Kenton County, which has the same percentage of residents age 65+ as Butler but has a higher percentage of people with disabilities.

Table 1: Population Demographics

	Butler	Hamilton	Boone	Campbell	Kenton
2006 Population	354,992	822,596	110,080	86,866	154,911
Population, percent change, 2000 to 2006	+6.7%	-2.7%	+28%	-2.0%	+2.3%
Population, percent change, 2000 to 2010	10.5% [a]	-4.5% [a]	12% (all combined)[b]		
Population, percent change, 2000 to 2020	21.4% [a]	-8.7% [a]	12% (all combined)[b]		
Persons 65 years old and over, percent, 2005	10.9%	13.5%	8.4%	12.8%	10.9%
Percent of the population that is white, 2005	90.0%	71.9%	94.5%	96.2%	93.6%
Bachelor's degree or higher, age 25+, percent, 2000	23.5%	29.2%	22.8%	20.5%	22.9%
Median household income, 2004	$49,856	$43,811	$58,749	$44,639	$47,729
Persons below poverty, percent, 2004	9.8%	13.1%	7.7%	10.9%	11.3%
Persons with a disability, age 5+, percent, 2000	14.2%	16.9%	11.5%	18.2%	17.3%

Source: US Census Estimates unless otherwise noted.
[a] Estimates from Office of Strategic Research, Ohio Department of Development.
[b] Estimates from Kentucky State Data Center, University of Louisville

Aging of the Region

The Baby Boom generation, or people born in the U.S. between 1946 and 1965, consists of about 76 million people. As this generation ages, it is predicted that it will cause a huge strain on geriatrics, gerontology, and the healthcare system, especially for mental health and medications. By 2010, there will be over 39 million U.S. citizens ages 65 and over. By 2030, there will be over 69 million U.S. citizens ages 65 and over (The Health Foundation of Greater Cincinnati, 2001). As more people in the region develop chronic conditions associated with aging, require more medications, and use more mental health and other health services, the region may find it does not have enough physicians to handle the need.

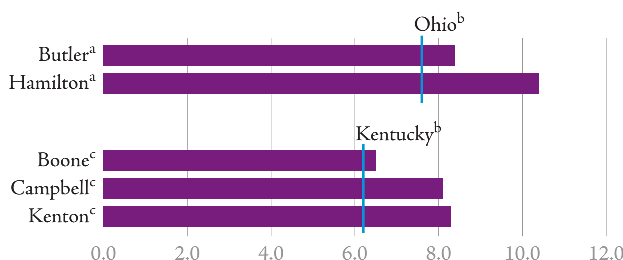
Health Status

We described the health status for the region using a variety of health indicators, including infant mortality, physical health conditions, and health insurance status.

Infant Mortality

The infant mortality rate is a commonly used measure of public health. The infant mortality rate is defined as the number of deaths of children ages 1 year or younger per 1,000 live births. All five counties in the region of interest

Figure 1. Infant mortality rates per1,000 live births



Sources:
[a] Ohio Department of Health County Profile 1999-2001
[b] National Center for Health Statistics, Washington, D.C, 2005 (2003–4 data)
[c] Department for Public Health County Health Profiles, 2002

to this report have worse infant mortality rates than their respective states (see Figure 1 and Table 2). Hamilton County's rate of 10.4 deaths per 1,000 live births would rank it worse than any of the 50 states in the U.S. in 2005.

Table 2: Infant mortality rates per 1,000 live births

	Butler[a]	Hamilton[a]	Ohio[b]	Boone[c]	Campbell[c]	Kenton[c]	Kentucky[b]
Infant Mortality Rate	8.4	10.4	7.6	6.5	8.1	8.3	6.2

[a] *Ohio Department of Health County Profile 1999-2001*
[b] *National Center for Health Statistics, Washington, D.C, 2005 [2003-4 data]*
[c] *Department for Public Health County Health Profiles, 2002*

Physical Health Conditions

The prevalence of a number of physical health conditions—such as diabetes, obesity, smoking rates, and others—can also be used as measures of public health (see Figure 2 and Table 3 on the next page).

- **Diabetes.** The percentage of people who have been told they have diabetes is lower in the Cincinnati-Middletown MSA than in either Ohio or Kentucky as a whole. However, the percentage of people in Hamilton County who have been told they have diabetes is higher than the rest of the MSA and the state of Ohio.
- **Obesity.** The rate of obesity in both the MSA and in Hamilton County appears lower than in either Kentucky or Ohio.
- **Current smokers.** The smoking rate for the MSA is higher than both Ohio and Hamilton County alone, but is lower than the rate for Kentucky.
- **High cholesterol.** The percentage of adults who have been told they have high blood cholesterol is similar among the MSA, Hamilton County, Ohio, and Kentucky.
- **High blood pressure.** The percentage of adults who have been told they have high blood pressure is also similar among the MSA, Hamilton County, Ohio, and Kentucky.
- **Limited activity.** The percentage of people who reported they were limited in their daily activities because of physical, mental, or emotional problems for the MSA is lower than the percentage for Kentucky but is slightly higher than the percentage for Ohio. Hamilton County's percentage is on par with the state of Ohio's percentage.

Figure 2. Prevalence of physical health conditions, percent of adults ages 18+, 2005

2005 BRFSS data

2005 GCCHSS data

(Note: In the GCCHSS, Butler County is grouped with Clinton and Warren Counties, and Boone, Campbell, and Kenton Counties are grouped with Grant County. These data reflect the county grouping, not the individual counties.)

Table 3: Prevalence of physical health conditions, percent of adults ages 18+, 2005

	Diabetes	Obesity	Current smokers	High cholesterol	High blood pressure	Limited activity
Cincinnati-Middletown MSA *(15 counties)*[a]	6.7	22.3	26.1	37.6	27.0	26.1
Greater Cincinnati *(22 counties)*[b]	10.0	27.2	30.0	29.2	32.2	n/a
Hamilton County[b]	9.3	24.7	31.2	25.6	29.8	17.7[a]
Butler County[b]	12.7	26.7	21.9	39.2	34.6	n/a
Boone, Campbell, and Kenton Counties[b]	8.1	26.9	32.1	24.5	30.1	n/a
Ohio[a]	7.7	24.3	22.3	37.2	27.0	17.8
Kentucky[a]	8.9	28.6	28.7	38.1	28.2	22.6

[a] Source: Centers for Disease Control and Prevention, 2005 BRFSS
[b] Source: The Health Foundation of Greater Cincinnati, 2005 GCCHSS *(Note: In the GCCHSS, Butler County is grouped with Clinton and Warren Counties, and Boone, Campbell, and Kenton Counties are grouped with Grant County. These data reflect the county grouping, not the individual counties.)*

Health Insurance Status

According to the Behavioral Risk Factor Surveillance Survey (BRFSS), the percentage of individuals who are uninsured in the Cincinnati-Middletown MSA is lower than the percentages in the states of Ohio and Kentucky (see Figure 3 and Table 4). The BRFSS estimate, however, is lower than the estimate from the 22-county *Greater Cincinnati Community Health Status Survey* (GCCHSS), also completed in 2005. According to the GCCHSS, the uninsured rate for the 22-county region was 13.1% (The Health Foundation of Greater Cincinnati, 2006a).

Figure 3. People without current health insurance, percent of adults ages 18+, 2005

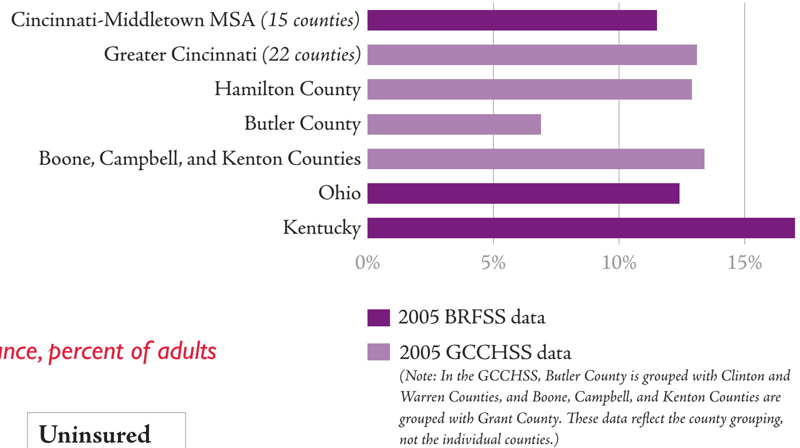


Table 4: People without current health insurance, percent of adults ages 18+, 2005

	Uninsured
Cincinnati-Middletown MSA *(15 counties)*[a]	11.5
Greater Cincinnati *(22 counties)*[b]	13.1
Hamilton County[b]	12.9
Butler County[b]	6.9
Boone, Campbell, and Kenton Counties[b]	13.4
Ohio[a]	12.4
Kentucky[a]	17.0

[a] Source: Centers for Disease Control and Prevention, 2005 BRFSS

[b] Source: The Health Foundation of Greater Cincinnati, 2005 GCCHSS *(Note: In the GCCHSS, Butler County is grouped with Clinton and Warren Counties, and Boone, Campbell, and Kenton Counties are grouped with Grant County. These data reflect the county grouping, not the individual counties.)*

Physician: Population Ratios in the Region

Is there a physician shortage in this five-county region? On the surface, it appears that the five counties have, for the most part, an adequate supply of physicians to meet current demand. Tables 5 and 6 present county-specific counts and physician:population ratios for five speciality areas: primary care, internal medicine, family/general medicine, pediatrics, and obstetrics/gynecology[2] (AMA Physician Masterfile 2006). The counts and physician:population ratios apply to the entire county. Within each county, ratios may differ by neighborhood or census tract.

Table 5: Physician Counts by Specialty

	Butler	**Hamilton**	**Boone**	**Campbell**	**Kenton**
Primary care physicians	199	888	71	48	120
Physicians in internal medicine	66	380	14	14	33
Physicians in family/general medicine	92	255	43	25	58
Pediatricians	41	253	14	9	29
Gynecologists and obstetricians	35	147	7	11	18

Source: AMA Physician Masterfile, 2006.

Table 6: Physician:population ratios by specialty, per 10,000 people

	Butler	Hamilton	Boone	Campbell	Kenton
Primary care physicians	5.7	10.8	7.1	5.4	7.8
Physicians in internal medicine	1.9	4.6	1.4	1.6	2.2
Physicians in family/general medicine	2.6	3.1	4.3	2.8	3.8
Pediatricians	1.2	3.1	1.4	1.0	1.9
Gynecologists and obstetricians	1.0	1.8	0.7	1.2	1.2

Source: AMA Physician Masterfile, 2006

To determine whether the current supply is enough to meet demand in the five counties, researchers compared the above ratios to the estimated full-time equivalent (FTE) demand needed to serve the Midwest (Solucent, 2004). Researchers found that in most cases, the current number of physicians among the five specialty areas is enough to meet the estimated demand, with three exceptions:

- Boone County needs two more obstetricians/gynecologists to have an adequate supply.
- Butler County needs approximately six more family/general medicine physicians.
- Campbell County needs one additional pediatrician.

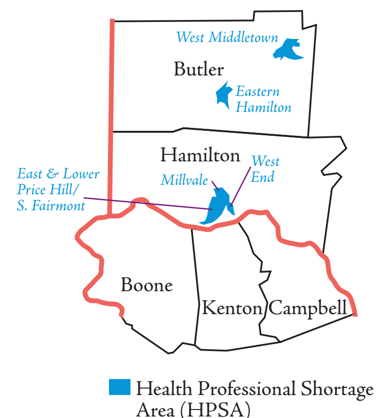
However, this analysis was done on current demand and did not take population distribution, physician location within the county, future population growth, cultural or ethnic backgrounds of physicians, nor the aging of the local physician workforce into account. These factors affect the health care that people receive, both now and in the future.

[2] *"A primary care physician is a generalist physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must be specifically trained to provide primary care services." (AAFP, 2006).*

Health Professional Shortage Areas

Although the five counties as a whole seem to have adequate physicians for current demand, pockets within the counties lack medical professionals. Neighborhoods, census tracts, and demographic groups may not have enough health professionals to serve their needs. The federal Health Resources and Services Administration (HRSA) determines Health Professional Shortage Areas (HPSAs), which are demographic or geographic regions with a shortage of health professionals. HPSAs can be designated for a shortage of primary medical care, dental care, or mental health professionals.

Map 2. HPSAs within the 5-county region, December 2007



As of December 2007, there were five federally designated HPSAs among these five counties, all in Ohio (see Map 2 and Table 7). There are two in Butler County and three in Hamilton County. The three Hamilton County HPSAs are adjacent and appear as one large area when they are really three separate areas.

Table 7: HPSAs within the 5-county region, December 2007

HPSA	Type	Discipline
Butler County		
Eastern Hamilton	Demographic (low-income)	Dental health
West Middletown		
Hamilton County		
East and Lower Price Hill/South Fairmont	Geographic (census tract)	Primary medical care
Millvale		
West End		

Future Population Growth

Areas experiencing rapid population growth without a coinciding increase in medical professionals risk physician shortages in the future. In the five-county region for this report, Boone, Butler, and Kenton Counties are experiencing population growth, according to Census estimates. By 2010, Butler Count could have a shortage of pediatricians and family/general medicine physicians if more do not choose to practice there. Boone County, which is experiencing dramatic growth, could experience a shortage in the number of physicians practicing internal medicine and pediatrics. In contrast, Kenton is growing at a more moderate pace and appears to have an ample supply of physicians among these specialties if the moderate growth continues.

Physician Age, Gender, and Ethnicity

Age, gender, and ethnicity of both physicians and patients can affect how a person gets health care. For example, a county or region with a lot of older physicians may find itself in a crisis when those physicians retire if a younger group are not in place to take over. In communities that have ethnic populations who speak a language other than English, it may not matter how many English-speaking physicians are practicing: the language barrier will prevent people from getting care.

Unfortunately, researchers were not able to find a source which could provide recent county-specific data on physician characteristics such as age, gender, ethnicity, ability to speak other languages, etc. However, researchers did find some regional and national data on demographic characteristics of the physicians.

Physician Age

According to Lisa Adkinson of the Cincinnati MD Resource Center, which collects some data on area physicians, 42% of Greater Cincinnati physicians are over the age of 50. This estimate is virtually the same across counties in the region and mirrors national estimates. According to the AMA physician database, 33% of physicians in Ohio and Kentucky are age 55 or over (American Medical Association, 2007a).

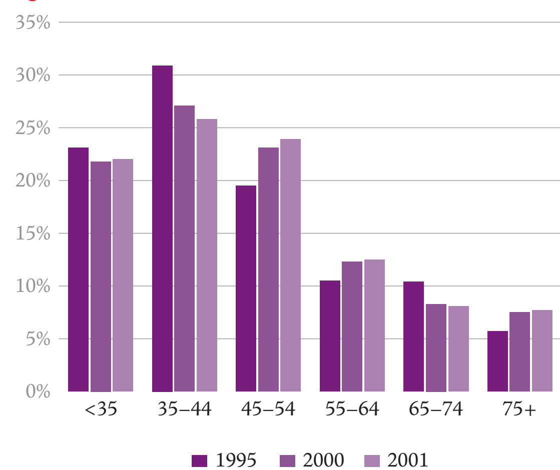
According to HRSA's 2001 Area Resource File (ARF), the most recent researchers had available, 48% of the 5-county area's physicians were 44 years old or younger, while 36% were between 45-64 years old, and 16% were 65 years old or older (see Figure 4 and Table 8). The percentage of physicians ages 65 and older remained relatively constant between 1995 and 2001 at about 16%. However, the percentage of doctors under age 35 decreased from 54% in 1995 to 48% in 2001, while the percentage of doctors ages 35–44 increased from 30% in 1995 to 36% in 2001. If the percentage of younger physicians continues to decrease, the region could run the risk of developing a shortage in the foreseeable future.

Table 8: Physicians in the 5-county region, percent by age, 1995–2001

Age range	1995	2000	2001
<35	23.1	21.8	22.0
35–44	30.9	27.1	25.8
45–54	19.5	23.1	23.9
55–64	10.5	12.3	12.5
65–74	10.4	8.3	8.1
75+	5.7	7.5	7.7

Source: Health Services and Research Administration's 2001 Area Resource File

Figure 4. Physicians in the 5-county region, percent by age, 1995–2001



Source: Health Services and Research Administration's 2001 Area Resource File

Rising medical school debt, coupled with increasing workload for primary care providers and declining real income, has put primary care specialties in jeopardy at a time when growing demand for services is anticipated. An aging of the U.S. population may increase demand for primary care providers, and some workforce reports and publications predict shortages in their numbers. The American Association of Medical Colleges (2007) predicts an impending "crisis" in provider access.

Physician Gender and Ethnicity

Regional data on physician gender and ethnicity were not available. According to the American Medical Association (2007a), 27% of all physicians in the U.S. are female, while 27% of Ohio physicians and 24% of Kentucky physicians are female. Nationwide, 75% of physicians are white, 4% are Black, 5% are Hispanic, and 13% are Asian.

Physician Payment, Income, and Turnover in the Region

Unfortunately, researchers were not able to determine a source that could provide regional- or county-specific data on physician payment or income. The best information found was the *Physician Compensation and Production Survey* conducted by the Medical Group Management Association in 2006. The report summarizes the survey's results for both physician placement (new hire) and employment compensation by regions of the country: West, Midwest (including Ohio), Southern (including Kentucky), and Eastern. This survey had very small sample sizes for Ohio (n=60) and Kentucky (n=27).

Because the Greater Cincinnati region is traditionally considered part of the Midwest, researchers looked at physician compensation for the Midwest as being representative of the five counties of interest in this report. According to the Medical Group Management Association survey, physicians new to the Midwest—or those who have been practicing in the region for less than a year—are paid relatively well among the four regions (see Table 9).

Table 9: Median compensation for new physicians

Specialty	Midwest rank (out of 4 regions)
Family Practice (with obstetrics training)	1st
Internal Medicine	2nd
Orthopedic Surgery: General	1st
Pediatrics	1st (tie)
Surgeon: General	1st
Obstetrician/Gynecologist	1st

Physicians who have been in the Midwest longer than one year, or "existing physicians," are less well compensated than existing physicians in the other three regions (see Table 10). While median physician compensation for the Midwest is ranked highest only in the case of general surgeons, it is never ranked the lowest for any of these specialties.

Table 10: Median compensation for existing physicians

Specialty	Midwest rank (out of 4 regions)
Family Practice (with obstetrics training)	2nd
Internal Medicine	2nd
Orthopedic Surgery: General	3rd
Pediatrics	3rd
Surgeon: General	1st
Obstetrician/Gynecologist	3rd

Regional Physician Turnover

Researchers were unable to locate data for estimates of local physician turnover. Instead, they provided a summary of the results of the most recent and most detailed survey of retention conducted by Cejka Search and the American Medical Group Association (2006). For this survey, the nation was divided into three regions: West, Central, and Eastern (which includes Greater Cincinnati). All percentages represent annual turnover rates.

- Turnover was slightly higher in the Central region (7.0%) compared to the West (6.7%) and Eastern (6.5%) regions of the United States. Thirty-nine (39) percent of responding medical groups felt that their turnover rate was too high.
- By ownership type, the highest turnover rate reported by respondents was among physicians employed in an academic setting (12.4%).
- The rate of turnover among male, full-time physicians was highest in the Eastern region (5.9%) and the rate of turnover among male, part-time physicians was second highest in the Eastern region (15.1%). The rate of turnover for female, full-time physicians was highest in the Eastern region (7.4%) and the rate of turnover among female, part-time physicians was lowest in the Eastern region (5.4%)
- The Eastern region had a higher rate of turnover among experienced physicians (23%) than the West (19%), but lower than the Central (26%).
- Among physicians in the Eastern region who left over the past year, only 11% left because of termination. Seventy-nine percent left voluntarily.
- The most cited reasons for voluntary resignations in the Eastern region:
  - Relocated to be closer to family (46%)
  - Poor cultural fit with practice (43%)
  - Other (32%)
  - Seeking higher compensation (32%)

This survey has important limitations. The survey was distributed in October 2006 to 300 members of the American Medical Group Association (AMGA). Only 92 members responded, giving a 31% response rate. No information is available on turnover rates for members who did not respond. This small sample size also means that results may not be representative of the entire AMGA membership. Also, as Greater Cincinnati is part of the 25-state Eastern region, results for the Eastern region as a whole may not be representative of Greater Cincinnati.

Local Perspectives on Physician Shortages, Recruitment, and Retention

As part of this project, researchers interviewed several Cincinnati and regional professionals expected to have a wide knowledge of physician recruiting and retention issues. These included primary care physicians, recruiters, hospital systems, specialists, and an insurance industry representative. Some general observations were that most everyone researchers talked to did not feel they had a problem with recruiting and retention, at least no more of a problem that any other Midwestern city. "Cincinnati is Cincinnati," one stated. "If [doctors] want access to the ocean, a nice beach, or the mountains, Cincinnati is not for them. But, if they are looking for a Midwest city to raise their family, then we can compete with most anywhere."

Almost everyone researchers spoke with mentioned that a physician's initial connection to Cincinnati could predict most recruitment and retention issues. The vast majority of "viable" candidates have some previous connection to the city or the area, either through a spouse, extended family, or a desire to locate as close as possible to another city or state. Although one interviewee stated that his group routinely does national recruiting and can attract individuals with no previous connections to Cincinnati, a few others reported that they do not even consider a candidate without local ties. Whenever retention becomes an issue, providers said they can almost always trace it back to no connection in the first place.

Payment from insurance companies may also contribute to recruitment and retention problems. The class action lawsuits filed by Cincinnati physicians in the early 2000s were the result of payment issues with insurers. In 2003, Coopers Research conducted the *Greater Cincinnati Physician Practice Survey* for the Academy of Medicine of Cincinnati. In this survey, 67% of the 1,000 physicians that responded stated that low compensation was the primary reason that open positions were difficult to fill.

Although researchers interviewed only 12 individuals for this report[3], many were in medical groups associated with health systems representing as many as 251 physicians. Some of the interviewees believe that lower physician payment levels were responsible for drawing physicians to hospital-based groups or other integrated systems able to negotiate better rates. None of the individuals interviewed indicated that payment was still the primary reason for any open positions, although many indicated that they believe that the perception of low payment levels lingers in the physician community.

Unfortunately due to the proprietary nature of insurance payments, researchers could not locate data that would enable them to analyze whether or not a payment imbalance with other areas still exists. During his interview, Dr. Barry Malinowski of Anthem stated there is currently "no difference" between Dayton, Cincinnati, Cleveland, and Kentucky in primary care payments from Anthem. He stated that there may be a slight difference in specialty fee schedules, but Anthem has made a conscious effort to make all fee schedules equal. He went on to state that the physicians who participate in their quality initiatives have the opportunity to get up to 12% additional over their fee schedule if they meet the criteria. Dr. Malinowski said that 30% of all primary care groups are receiving the additional fees.

[3] *Five of the 12 were physicians, 2 of which were in private practice. See the appendix for details on who was interviewed.*

Separately, the issue of tort reform is still very high on everyone's list of concerns. Many feel that the malpractice rates in Ohio are out of control and this contributes to losing Cincinnati physicians to Indiana, where they appear to be much lower.

Many interviewees commented on lifestyle issues and how these affect recruiting young physicians. Many young physicians of both sexes are requesting part-time positions, job-sharing, specific work hours, guaranteed time off for maternity, and other benefits. They are often unwilling to work long hours, maintain substantial on-call responsibility, or volunteer at hospitals or within the community. Many of the interviewees involved in recruiting functions are having difficulties creating the benefits-compensation packages these new physicians demand. A few interviewees stated that if the recruit is not willing to work as hard as others in the practice, then that recruit is not going to get a job offer. Interviewees whose practices use hospitalists to decrease on-call responsibilities reported that this is an effective recruitment tool since their physicians can have a more regular schedule.

Interestingly, most of the people researchers talked with did not have any formal marketing packages specifically for recruitment. This was true even among the hospitals. Most used informal methods of personal communication; some had preprinted sample contracts available. It appears that talking and showing the recruit around is the most common recruiting technique. No one interviewed felt the need for anything more formal. Similarly, interviewees reported that retention was not much of a problem. They felt that once the organization recruited physicians, they were likely to stay. Retention efforts were almost universally informal, with senior or managing partners being alert for troubles, but there were no structured retention programs.

Resources for Physician Recruitment and Retention

In recent years, physician recruitment has become very competitive across the nation and in Greater Cincinnati. The reason for this is very simple. The population of the United States has grown and individuals are using more health care services per capita, but until recently, the number of new physicians has remained constant. Regions or medical practices looking to grow or replace physicians who leave will search in a highly competitive labor market. Medical groups using the best recruiting practices can not only benefit from more productive searches, but they can also improve retention by employing people who will fit with the group.

There are some local resources for attracting physicians to the region. For example, cincinnatiMDjobs.com, a local resource for physicians looking to move to this area, reported that it had helped place 76 physicians by August 2007, which is almost as many as it helped place throughout 2006 (Richie, 2007).

The recruiting best practices covered in this section are the result of an extensive literature review of medicine, health economics, and health care management. Most of the information gained through this literature search was not region-specific. One particular recruiting literature resource worth noting was *Physician Recruitment & Retention: Practical Techniques for Exceptional Recruiting* by Roger Bonds (2006). This text was especially complete and extremely beneficial.

First Steps: Evaluate and Prepare

Before initiating a search, physician practices can both set themselves apart from other competitors and have a better understanding of their organization's (short and long-term) labor needs if they invest time and resources into planning. The benefits both to recruiting and to the performance of the organization should not be underestimated. Well-prepared reports and analyses can increase organizational support for a new hire. Reports/analyses, such as a Physician Manpower Plan and Practice Opportunity Assessment, can also alleviate potential concern surrounding the personal, organizational and financial impact of a new hire. Management can use materials developed during this planning process to develop secondary reports that they can share with the physician recruits to give them a clear sense of their need within the organization. Providing a candidate with this level of information can alleviate much of the uncertainty surrounding the new position and help them to realize the level of commitment they will be making along with the success they can expect to achieve by coming on board.

- Identify and Quantify Labor Needs
  - A Physician Manpower Committee should exist within the organization to provide input for the development and updating of Physician Manpower Plan (PMP) (Bonds, 2006). It is also up to this committee to foster support for recruiting efforts. The committee should make a case for the organizational benefits of any recruiting efforts. In the development of the PMP Plan, the members need to represent the lifestyle and financial interests of the other practice members. Depending upon the size of the physician group, the committee could benefit from the inclusion of community leaders, administrators, marketing and strategic planning experts, as well as physicians from the group.
  - A Physician Manpower Plan should be prepared, maintained and updated ideally every year and should be considered a vital element of the group's strategic plan (Bonds, 2006; "Due diligence on the internal front," 2004). One of the very first steps in ensuring a successful recruitment

effort is to assess how the organization is structured, positioned, and disciplined. The more specific the PMP, the more confidence current and future stakeholders have in it.

- Prepare for Recruiting
  - Form a Physician Recruitment Committee (PRC). Members of this committee should be "enthusiastic, positive, and personable." They should either be already knowledgeable or be educated on the community and professional benefits of any recruiting effort (Bonds, 2006).
  - Know your competition for recruits -- both local and national (Bonds, 2006).
  - Identify the strengths and weaknesses of your organization and your competitors and know how they compare. With this knowledge readily available, the group can promote its benefits and seek out candidates that will value these.
  - Conduct a Practice Opportunity Assessment to evaluate the strengths and weaknesses of a practice position (Bonds, 2006).
  - A Community Assessment should also be done which assesses the strengths and weaknesses of the community (Bonds, 2006).
  - Given the time and experience demanded for the recruiting process consider hiring a recruiting agency (Bonds, 2006). Remember that most search processes take an average of 9 to 12 months. The services of a recruiting agency can also be purchased on a piecemeal basis to supplement or enhance the capabilities of a medical group practice. Recruiting agencies have:
    - Access to referral networks and in-place resources for identifying candidates quickly and efficiently.
    - Staff trained to employ best practices for recruiting.
    - Experience and an understanding of the present labor market and the level of competition.
  - Develop both a Recruiting Plan and a tracking system to organize recruitment tasks (Bonds, 2006). This system should be set up so that the group can evaluate the recruitment efforts and identify successful elements and problems to assist in improving future efforts.
  - Have ready well-tailored and appropriate marketing materials for your recruits (Bonds, 2006).
  - Based upon the results of the Physician Manpower Plan, the Practice Opportunity Assessment and other strategic planning analyses, construct a practice pro forma that details the practice's financial opportunities for a new physician covering at least the first and second years (Bonds, 2006).
  - The Physician Recruitment Committee should establish selection criteria incorporating required and preferred elements (Bonds, 2006). The following is a list of items to consider when developing selection criteria:
    - Medical schools, residency programs, or fellowship programs to target or avoid.
    - Required level of experience (number of years in practice or teaching, number of procedures performed, recent residency or fellowship program).
    - Medical background and practice interests.
    - Medical/ethical background (Any ethical violations? Do their professional goals coincide with those of the practice?)
    - Preferences for type of doctor or foreign medical graduates.
    - Personality traits (i.e., if they candidate is friendly, outgoing, seems to be a good fit, diverse background, etc.).
    - Spouse's professional goals and personality traits.

  - Hobbies/interests. (This can be problematic if particular interests strongly conflict with others in the group.)
  - Hometown of candidate or spouse. Are there relatives nearby?
- Clearly identify and empower qualified decision-makers who are committed to the recruiting effort. Ultimately, a quick acting committee or single individual should be in charge of extending offers and negotiating contracts. "One member of the decision-making team should be the designated liaison with the recruiter," if a recruiter is hired (Bonds, 2006).
- Design a creative compensation package which can be personalized to a particular recruit (Bonds, 2006). A unique and/or personalized compensation package stands out to candidates compared to those offered by competitors. By personalizing benefits, a recruit will get the impression that the group is trying to recruit them rather than just any physician. So that the candidate can appropriately value your package and compare it with others, be sure to have the financial value of all benefits available. Consider the following:
  - To make the package unique and/or personal, involve others such as bankers who can help you to offer a competitive interest rate or 100% financing for personal or professional use. As a group, consider co-signing for the equivalent of a down payment on a loan.
  - Offer country club and other memberships.
  - Provide call coverage by hiring hospitalists or laborists. Seventy-seven percent (77%) of groups report this as an effective recruiting strategy (Cejka Search and American Medical Group Association, 2006). An alternative is to provide additional compensation for call coverage. Ten percent (10%) of groups report this as being an effective strategy.
  - Contribute funding of college tuition for family members.
  - Offer a shorter than expected workday or make it clear the group will provide the flexibility to choose an alternative work schedule if needed in the future.
  - Offer more vacation time or coverage of CME related expenses.
  - Provide educational assistance for spouse or children.
  - Provide resources for child or elder care for dependents.
  - Explicitly provide for temporary housing in addition to a moving allowance.
  - Cover or provide an expense account to cover professional purchases such as technology, office furnishings, advertising, a mobile phone and pager.
  - Pay for additional training for coding for new graduates that can ultimately be cost-effective to an organization. (Some groups have increased a physician's revenue by at least 25% with coding training alone.) (Giovino, 2002)
  - Consider salary guarantees for two to three years, especially for new graduates. (Giovino, 2002; Weymier, 2003) However, also explain how the group plans to provide assistance so that the new hire can earn more than the guarantee. Sixteen percent (16%) of groups report that increasing the length of the income guarantee is an effective recruiting strategy (Cejka Search and American Medical Group Association, 2006).
  - Consider signing bonuses ("Market watch: Review of 2003 physician recruitment incentives, 2003) Signing bonuses can be between $5,000 to $50,000 or more depending on the specialty. Being ready to provide a signing bonus can help set the group apart -- only 36% of recruiting groups offer signing bonuses.
  - Offers of loan repayment are attractive to new graduates (Giovino, 2002). Practices often offer loan repayment benefits as annual re-signing bonuses ranging from $5,000 to $20,000 per

year. The repayment amount often increases each year that the new partner remains in the practice.

  - Make sure to include health insurance and malpractice coverage since over 90% of groups cover these costs ("Market watch: Review of 2003 physician recruitment incentives, 2003).

- Know What to Expect
  - Recruiting costs can be expensive ranging from $20,000 to $123,000, depending upon the specialty. (Misra-Hebert, Kay, and Stoller, 2004; "Physician recruiting," 2003) However, considering that even on the lower end of the scale the average annual net revenue is $700,000 for a pediatrician, these costs can be recovered quite rapidly by the practice. If one considers all start-up costs related to the hire (including advertising, training, and a period of lower productivity), it usually takes between 18 to 24 months before the practice breaks even (Weiss, 2006).
  - Realize that when recruiting, the group may also have to adjust the compensation of existing staff ("Physician recruiting," 2003). This can be especially true in the case of high-demand specialists. If the group does not adjust compensation then a group's efforts may have unfavorable consequences. The results could be increased turnover as current physicians become resentful and leave the practice. On the other hand, they could stay and sabotage the recruiting process.
  - It continues to be the case that some specialties are extremely difficult to recruit everywhere because of their relatively short supply (Weymier, 2003). These specialties include obstetricians, gynecologists, dermatologists, rheumatologists, neurologists, cardiologists, anesthesiologists, and gastroenterologists. Rural areas and smaller communities often have difficulty recruiting orthopedic surgeons, neurosurgeons, cardiac specialists and vascular surgeons. According to a recent survey, 77% of health care groups report that internists were the most difficult group of physicians to recruit and retain (Cejka Search and American Medical Group Association, 2006).
  - Keep in mind that while insurance payments have generally declined for physicians, salaries have not necessarily followed suit (Terry, 2004). While a group interested in recruiting may think it only has to be competitive regionally, it is important to realize that regional salaries are not isolated from national trends. More specifically, starting salaries for internists have risen nationally with the average between $120,000 and $140,000 in 2004. Salaries for family practitioners and pediatricians have stagnated over the past few years and are about $110,000-$120,000 for family doctors and $100,000-$120,000 for pediatricians. In general, pay is higher where there are fewer doctors. As a result, groups located in smaller, less prestigious cities may have to offer more than those in desirable metropolitan areas.

Screening and Hiring Candidates

A general rule is that physicians prefer to practice where they (or their spouses) have lived before. While it might be easy to gather information on medical school attendance, it is difficult to obtain additional previous residence data. (Private databases available from physician recruiting firms can include this information.) In a large, but dated study on physician location, 51% of physicians practiced in the state in which they completed their graduate medical education (Seifer, Vranizan & Grumbach,1995). However, there was a variation among states of 6 to 71%. The study also reported that generalist physicians were more likely than specialists to remain in their state of graduate medical education.

Aspects of the compensation and benefits package are clearly important when it comes to recruiting. However, when it comes to attracting a talented physician, individuals base 40% of their decision on the quality of the professional opportunity. They base the other 60% of their decision on community and lifestyle. This is a general rule (Bonds, 2006). For young physicians, this ratio might even favor community and lifestyle even more. As a result, it is imperative that the recruiting team members determine what will appeal to the recruit and his or her family on dimensions beyond just the position and its pay.

In many cases, efforts fail because practices only focus on recruiting the physician and do not focus on the entire family and its needs (Giovino, 2002). Does the spouse need a job? Are there special educational needs for the spouse or children? What are the athletic or recreational pursuits that the family members enjoy or might be interested in trying? Are there issues regarding extended family members? Are there friends that live nearby? Are there any hobbies, volunteer interests or religious communities they would like to learn about or that they are involved with presently? It can be very productive to listen to the concerns and interests of all family members and try to modify the package or recruiting efforts (such as the recruiting visit) to address these.

While the goal is to elicit as many of these "hot buttons" as possible as early as possible, the best opportunity to identify the community and lifestyle priorities of the family may be the activities surrounding the recruiting visit. Certainly, the recruiting visit is the best opportunity to show tangible evidence of a connection between those priorities and what the family can expect to find when they relocate. If a screened candidate gets to the place where a visit is the next step, then there is nothing more revealing than looking a candidate in the eye during your discussions and observing them as you show off the community. As a result of the visit's importance, many best practices exist that can be used to further screen the candidate and convince him or her to take the position (Bonds, 2006).

- Details matter and make a strong impression, so plan carefully. Develop an agenda for the candidate, for the spouse/family and for those individuals involved in the visit. The agenda should include time to meet with all significant parties and some potential colleagues. Allow plenty of time to explore and access the community. As a guide, consider applying the 40/60 ratio between professional/family-lifestyle to time spent on the visit. Send the agendas out ahead of time if possible.
- With the itinerary, include biographical data on the people meeting the candidate and his or her family (Bonds, 2006).
- For the individuals involved in the interview process, be sure to include the candidate's CV and a briefing of what the candidate is looking for and his or her interests. If there is some aspect of the position or the community that you want them to cover, let them know explicitly.
- Candidates want an efficient, professional work environment without headaches. Include individuals in the visit who can speak to relevant issues involving equipment, quality and number of procedures performed, medical staff, nursing staff, and local politics (Bonds, 2006). Be honest and cover both negative and positive aspects of these.
- Do not underestimate the spouse's involvement and, certainly, do not make them feel left out. If there are two visits, you should consider including the spouse even in the first visit. According to a survey of health care organizations, one of the best methods of assessing cultural fit was to include the spouse and family in the interview process (Cejka Search and American Medical Group Association, 2006). Contact the spouse and/or send a questionnaire asking them about their interests and what they would like to learn during the visit (Bonds, 2006).

- As part of the visit, be sure to address: the financial practices of the group, the demand for existing specialties, the current and future operational support systems such as the protocol for handling call ("Due diligence on the internal front," 2004).
- Although the visit is perhaps the best time to assess cultural fit, be aware that there is no one right culture (Neuhauser, 2004). The candidate may be a fit professionally, but not a fit culturally with the practice.
- If the visit goes well and there is a fit, take advantage of all the preparation work to prepare a personalized letter of intent and discuss this at the visit's end. This letter doesn't obligate the organization, but gives the candidate some idea of the conditions they can expect in an offer. It is also a good idea to have a sample contract prepared so that the physician can review this as well.

Negotiating and Closing the Deal

Because of the preparation work done originally, the compensation package should be relatively simple to compile. All that is left is to personalize the offer for the candidate which will give them the impression that the practice is intent upon making this professional opportunity right for them. The group should always present a written offer letter and provide a format contract – not simply a handshake or one page hire letter. It is a good idea to encourage recruits to seek a legal review of the contract by an experienced attorney; this process demonstrates that the group is honest and forthright. The group then must be prepared for the recruit's attorney to suggest changes to the contract, so be ready to consider them. This process is more complex, but will generate a more satisfied and informed new colleague.

The decision-making regarding the details of the offer should have already taken place so minor changes do not delay negotiations. After every conversation regarding the offer, the hiring organization should have a plan for the next contact with the candidate (Bonds, 2006). If there was a particularly strong connection between the candidate and a member of the practice during the visit, then the recruitment committee should consider making them the contact person.

Potential Recruiting Targets

Depending upon the needs of the medical group practice, there are different types of recruitable physicians whose experience and training vary by education/work setting. The following section discusses these pools of physician candidates, the issues particular to them and some of the best methods of trying to contact them.

Residents, Fellows, and Medical Students

This group is the most obvious recruitable group because they are entering the workforce post-training and are relatively plentiful. Every year, approximately 25,000 medical students begin residency programs in the United States (American Medical Association, 2007b). There is a large number of residencies in Greater Cincinnati, and an impressive number within a 100 mile radius.

Prior to completing their training, medical groups can reach them through program directors or directly (Bonds, 2006). It is best to recruit them in the next to last year of training or even earlier. According to a 2006 survey of residents, 73% began to start seriously examining practice opportunities a year or more before completion of their training ("Market watch: 2006 survey," 2007). Strong relationships between practice groups and medical schools can assist in identifying students early. In

fostering mentor-student relationships with residents, such as through a position as an attending, practice members can identify quality candidates and begin recruiting early. Some groups offer the incentive of a supplemental residency stipend to help with living expenses during post-graduate study for students willing to commit to working with a particular group after their training (Giovino, 2002; Weymier, 2003; "Benefit of hiring residents," 2004). There are a number of issues that medical groups should remember when considering hiring residents/fellows.

- Today's young physicians are more likely to be female. Currently, 41% of physicians under the age of 35 are women and 48% of medical students are female (Weymier, 2003). Primary care, obstetrics/gynecology, and pediatrics are specialties that have been popular to female physicians in recent years.
- New graduates can be relatively less expensive for a practice to hire and can potentially result in a greater return on investment for the organization. They are less expensive because benefit costs, signing bonuses and relocation expenses are lower and they are more likely to make a lifestyle trade for a lower salary ("Benefit of hiring residents," 2004).
- They come with debt (Giovino, 2002; "Benefit of hiring residents," 2004). For over 75% of residents their debt load is over $150,000. Generation X physicians often are very concerned about the amount of debt they have and maintain a low risk tolerance. This means they are more likely to trade immediate financial stability for future income and partnership opportunities. They also will be attracted to generous loan repayment as part of a compensation package.
- For patients, having a mix of older and younger physicians in a practice can be attractive ("Benefit of hiring residents," 2004).
- Younger physicians are often enthusiastic and can be a source for additional resident hires ("Benefit of hiring residents," 2004).
- Generation X physicians are more concerned about lifestyle than the previous generation of physicians (Giovino, 2002). They often seek specialties that enable them to cover their financial responsibilities, but with fewer hours devoted to work. Young doctors are generally seeking manageable schedules to balance work, family and other priorities. This includes a heightened interest in part-time employment either periodic or long term. To be an attractive group, an organization needs to make it clear that it understands and respects the priorities of young physicians.
- Clearly, young physicians are inexperienced and many do not know how a practice works or how it will feel to be a part of one (Giovino, 2002). Initially their productivity will suffer, and they will be sensitive about their inability to see as many patients in a day compared to their more experienced peers. There may also be a number of training needs. Examples include how to code and how to manage a staff (Cejka Search and American Medical Group Association, 2006). If a group can acknowledge issues like these during the recruiting stage and explains to the candidate how it will address them, this will serve to both alleviate many of the young physician's fears and provide the practice with a recruiting advantage.
- Groups should be aware that it typically takes 18 to 24 months for new graduates to reach the point where they are comfortable and productive (Giovino, 2002).
- New technology can provide significant challenges to a group made up of older physicians; however, young physicians who are technically savvy will be more attracted to groups that have a technological focus. Access to computers and electronic information has been a part of there lives, and they prefer to have access to cutting edge resources for patient care.
- When asked about how they want to be paid, 91% of residents indicated that they preferred a salary with a production bonus ("Market watch: 2006 survey," 2007).

- With regards to group management and organizational culture, Generation X physicians typically dislike structures of hierarchical dominance (Moody, 2002). They often have a skill-based mindset that values experience and knowledge over tenure and protocol. These physicians are loyal, but their loyalty extends to principles, not necessarily to an organization. Rather than experience the continued frustration of office politics and turf battles, Generation X doctors tend to seek conflict resolution.

While younger, newly trained physicians are often the focus of recruiters because they dominate the supply of doctors seeking new positions, older physicians bring many immediate benefits because of their past experience ("Benefit of hiring residents," 2004). Older physicians often know how to set up and operate in a practice, which can result in enhanced patient satisfaction, increased hospital referrals, and a high quality of care. Older physicians sometimes may be receptive to a career and location change, and particularly when the change can accommodate a less stressful lifestyle or partial retirement. While older physicians might not be a long-term hiring solution, a good fit can result in a higher probability of retention since they are more likely to know exactly what they need from a hiring group.

Physicians in Military Service

Every year a significant number of experienced physicians complete their military service and seek civilian employment (Bonds, 2006). To locate these physicians it is best to contact health care facilities on nearby military bases or to post available positions there. The installation commander can provide the names of physicians leaving the military so that contact can be made directly. Military retirees often have a large circle of professional colleagues across the country, and these personal networks can be very effective in recruiting.

Physicians in Government Service

Physicians working for the National Health Service or Indian Health Service may be looking for civilian employment (Bonds, 2006). Either Service can provide a list of names of their physicians for a fee. If a physician has an outstanding commitment for services, a practice may consider a buy-out to enable the physician to take the position.

Academic and Research Physicians

These physicians are generally less interested in private practice; however if particular aspects of the new position are consistent with their current career (research or graduate medical education) they may be more likely to consider a change (Bonds, 2006). Medical groups can find the names of academic physicians easily through a university's web site. Journal publications contain the names of many non-academic, research physicians along with their contact information.

Missionary Physicians

Missionary physicians may have significant financial needs when returning from work in a developing country and they present a non-typical recruiting resource (Bonds, 2006). Contacts can be made through local churches and sponsoring organizations.

Physicians Already in Private Practice

In general, established physicians may be the hardest to recruit because they have the greatest amount invested in their current practice arrangement (Bonds, 2006). However, targeting those who may be dissatisfied either professionally or with their community can be advantageous. Pharmaceutical and medical supply vendors can be a resource in helping to identify physicians locally who might consider leaving to join a new practice. In addition, some physicians may need to move closer to aging parents, or there may have been an economic downturn which has them looking for a new area in need of their services. Recruiters also advise looking for urban physicians who are 10 years from retirement since they might be looking for a lifestyle change (McCartie, 2004).

International Medical Graduates

When recruiting certain specialties, such as gastroenterology and pulmonology, international medical graduates (IMGs) make up over 50% of residents (Bonds, 2006). In addition, IMGs now make up over a quarter of all physicians in the US (American Medical Association, 2007a).

Grantmaking Aimed at Physician Recruitment and Retention

Since regions besides Greater Cincinnati are confronting similar concerns and, in some cases, are experiencing grave problems in recruiting and retention, a portion of this research effort involved a search of how foundation-based support has been used elsewhere to address these issues. As part of this project, researchers looked for other foundations that have funded projects for physician recruitment and retention.

Overall, researchers found surprisingly little grant activity sponsoring either research or initiatives aimed at improving physician recruitment and retention. Unfortunately, they were unable to determine the level of success or failure of these initiatives for this report. Also, it does not appear that there has been much systematic evaluation of these efforts. A possible next step might be to contact the project officers overseeing some of the foundation-funded projects found. The list below includes grant-sponsored activities that could be considered to have either a direct or indirect impact on recruitment or retention.

Activities Sponsored by Local Foundations and Organizations

- The Cincinnati MD Resource Center and its companion web site, cincinnatiMDjobs.com, are projects of the Health Improvement Collaborative of Greater Cincinnati. It includes physician recruitment information and on-line posting of openings. The Health Foundation of Greater Cincinnati (Cincinnati, Ohio)[4] funded the MD Resource Center to recruit minority physicians and nurses. The Doctors' Foundation (Cincinnati, Ohio) recently awarded a 1:1 challenge grant[5] to the MD Resource Center to support their efforts as a regional resource for physician recruitment. *(Note: The specifics of the Center and its web presence will be covered in more detail on page 33.)*
- The Brentwood Foundation (Seven Hills, Ohio), has sponsored a number of grants which could indirectly increase the number of physicians available to the region or make the region more attractive to candidates. Specifically, the foundation awarded $200,000 in 2006 to The Ohio State University College of Osteopathic Medicine toward an integrated learning facility. The Brentwood Foundation also awarded South Pointe Hospital $828,000 for their Center of Excellence and $90,000 for stipends for medical residents to attend educational conferences.
- The Cleveland Foundation (Cleveland, Ohio) recently collaborated with the John A. Hartford Foundation (New York, New York) to fund educational experiences for one or more medical students within a Geriatric Center of Excellence.
- The Good Samaritan Foundation, Inc. (Lexington, Kentucky) awarded 17 "externships" in 1997 to medical students interested in exposure to rural underserved eastern and southeastern Kentucky. Students spent the summer observing and working with local family practice physicians.
- Several foundations have assisted with small grants to facilitate and promote minority recruitment, especially for primary care recruitment in community health centers. Some larger grants have provided salary and start-up expenses to enhance access in targeted underserved areas. Examples

[4] *The city and state in parentheses following a foundation's name indicate the home office location of that foundation. It does not necessarily indicate the region or area in which the funded project's work was carried out.*
[5] *A 1:1 challenge grant means that for every $1 the grantee raises, the foundation will match that with $1.*

include The Cleveland Foundation's grant to a local community health center that provided a physician's start-up salary and a retention bonus.

Activities Sponsored by National and International Foundations and Organizations

- The Commonwealth Fund (New York, New York) awarded the Association for Health Center Affiliated Health Plans approximately $25,000 to study the challenges and best practices of recruiting and retaining specialty physicians in Medicaid managed care.
- The Robert Wood Johnson Foundation (Princeton, New Jersey) sponsored a program-related investment in Idaho to assist recruitment and retention needs in its rural areas. The initiative included hiring local residents to implement aspects of the program. The investment leveraged a $3.5 million bank loan to help improve facilities in underserved areas. Part of the project involved a physician loan repayment program, and 14 communities received assistance in rural health clinic development, community assessments, and strategic planning and implementation. The initiative is credited with having placed 73 providers into rural communities.
- In another large scale program, the Robert Wood Johnson Foundation launched Practice Sights in 1991 to strengthen state efforts to recruit and retain primary care providers (including physicians and mid-level providers) and to develop practice sites in underserved areas. The total award was nearly $3 million which was used to develop new clinics, provide financial and technical assistance to improve practice profitability, and expand the use of mid-level practitioners.
- The Robert Wood Johnson Foundation also created a $32.7 million grant program to challenge medical schools to increase production of generalist physicians. This program was in collaboration with state governments, private insurers, health maintenance organizations, hospitals, and community health centers. In 1994, 14 implementation awards were made to 16 schools to assist them in increasing the number of graduates entering generalist careers. Most schools have implemented interventions throughout the continuum of training: admissions; undergraduate medical education; residency training; and practice entry and support.
- The Robert Wood Johnson Foundation also gives four-year career development awards to outstanding junior faculty in medical school departments/division of family practice, general internal medicine, and general pediatrics. This program is intended to strengthen generalist physician faculty in the nation's medical schools by improving their research capacity while maintaining their clinical and teaching competencies. One hundred and sixty awards were made in the first eleven years of the program (1993-2003). Up to 15 four-year grants of $300,000 were made to sponsoring institutions to help cover the Scholars' salary and research costs. Scholars will be required to spend at least 40% of their time in research and other scholarly pursuits. 2004 was the final year the program accepted new scholars.
- The City of Hamilton, Ontario, Canada, with local foundation funding, created Hamilton Physicians, a community program designed both to recruit family physicians and to retaining existing physicians. In the first year, 12 new family physicians started working in the city. Five were the direct result of the office's recruitment efforts. They developed local recruiting materials, launched a web site (http://www.hamiltonphysicians.ca/), and compiled a detailed database of all family physicians in Hamilton. Their Physician Recruitment Specialist attends medical conferences to meet with prospective physicians, organize candidate visits to the community, show practice opportunities and assist with relocating spouses.
- In Chatham, Ontario, Canada, the Chatham-Kent Physician Recruitment and Retention Committee, the Rotary Club of Wallaceburg, and the Foundation of Chatham-Kent Health

Alliance combined financial resources to support their Physician Recruitment Campaign for Chatham and surrounding areas. The campaign goal of $2.7 million aims to assist in the recruitment of 19 family physicians and nine specialists to the area.

- In 2006, the HMSA Foundation[6] (Honolulu, Hawaii) helped stabilize the Family Medicine Residency Program, which was started in 1992 at the University of Hawai'i John A. Burns School of Medicine in collaboration with Wahiawa General Hospital. Since the first class graduated in 1996, experienced physicians working with the residency program have helped train 59 family practice physicians, and most of them continue to practice in Hawai'i. Another HMSA Foundation grant in 2007 will help expand the program to the Neighbor Islands, with the hope that many of these young physicians will choose to begin their careers providing care to patients in rural communities.
- The UniHealth Foundation (Los Angeles, California) supported a strategy for addressing the shortage of family care physicians in the San Fernando Valley. This project identified key motivating factors for encouraging physicians certified in family medicine to stay in the area and provide primary care for the community.
- The Kansas Health Foundation (Wichita, Kansas) provided primary care students at the University of Kansas Medical School from Kansas City and Wichita with community-based experiences through a summer internship.
- The Meyer Foundation (Washington, DC) has supported the Prince William Health System, which works to fill the needs for more primary care providers serving the uninsured in western Prince William County (Virginia).
- The Claude Worthington Bendum Foundation (Pittsburgh, Pennsylvania) supported a recruitment and retention program for primary health care professionals in underserved areas in 1994–1998. The grant went to the University System of West Virginia.
- The Dakota Medical Foundation (Fargo, North Dakota) has helped continue residency programs for family medicine and has provided medical student "externships" for rural family medicine.
- The Flinn Foundation (Phoenix, Arizona) sponsored a rural primary care residency program in 2000.

Cincinnati MD Resource Center and www.cincinnatiMDjobs.com

The Cincinnati MD Resource Center and its web site (www.cincinnatiMDjobs.com) represent unique local resources for physician recruitment information and on-line position posting. The Resource Center staff conducts local recruiting activities, markets physician opportunities at national conferences, and organizes a monthly series called the "Physician Employer Roundtable," which covers employer issues such as how to perform a background check on a candidate. The staff also focuses its resources on increasing minority recruiting.

On the cincinnatiMDjob.com web site, physicians can locate positions, post their curriculum vitae (CV), express their job interests, get advice on preparing a CV, and find out how to prepare for an interview. They also can find out details about the local health care practice environment. The web site includes an introduction to health systems in the area, candid information on medical malpractice premiums and managed care, and data on the health of the population. To learn about what it is like to live in the Cincinnati region, the site includes information on area attractions, cultural and recreational resources, links to universities and data on school quality, annual events, and religious worship. To

[6] *The HMSA Foundation goes by its initials. It was started by the Hawaii Medical Service Association, but its legal name is HMSA Foundation.*

assist in relocation, the site also offers location guides for communities within the region, access to specialized realtors, and moving discounts.

Medical groups and organizations seeking physicians can not only post positions, but can also access a variety of resources aimed at educating employers on best recruitment practices. Specifically, recruiting groups can access documents to help them:

- create a written practice opportunity,
- develop a detailed job description,
- conduct a medical group needs analysis, and
- interview candidates more effectively.

Local interviewees were familiar with the Cincinnati MD Resource Center and cincinnatiMDjobs.com. The general feedback was that the Center is doing some things very well. However, some groups are still not using their services and others did not know what was available.

Appendix: Interviews and Methodology

As part of this research project, researchers interviewed several Cincinnati and regional professionals. The majority of the interviews were conducted face to face, while a few others were phone-based. The interviews were purposefully informal to create an ease of candid discussion. The researchers asked open-ended questions. The researchers had a list of prepared questions to keep the dialog moving forward, but the formal questions were not solely relied upon which allowed conversations to explore multiple topics and facilitated a more frank dialogue.

To begin, the researchers outlined the basic project and then proceeded with some of the prepared set of questions to gather opinions on recruitment and retention. In practice, this led to other questions, comments and lengthy discussions on related issues. In general the interviewees were very interested in the issues covered.

Interviewees were selected based on the researchers' networks, availability, and convenience, with the intent to assemble people who would have a wide knowledge of physician recruiting and retention issues. These included primary care physicians, recruiters, hospital systems, specialists, and an insurance industry representative.

Interviews were conducted with the following people:

- Lisa Adkinson, Executive Director, Cincinnati MD Resource Center
- Kevin Aukerman, MD, Director of Radiology, Mt. Airy Hospital
- Joseph Bateman, MD, Vice President and Medical Director, Integrated Management Service, Health Alliance
- Dan Cole, COO, Internal Medicine Associates of Northern Kentucky
- Andrew Fellac, MD, Senior Associate Dean-Academic Affairs, University of Cincinnati Medical School
- Paula Hawk, BSN, Director of Medical Staff/Physician Relations, Mercy Health Partners
- Paul Hiltz, President/CEO, Mercy Mt. Airy
- Barry Malinowski, MD, Medical Director, Anthem
- Brian McCartie, Regional Vice President, Cejka Search
- Steve Slutsky, COO, St. Elizabeth Medical Center of Northern Kentucky
- Greg Stevens, MD, Kidney & Hypertension Center
- Brenda Ziegler, Director of Strategic Development, Alliance Primary Care

Limitations of this Report

While the interviewees contributed valuable information and insights, there are a number of perspectives and experiences that were not included. The interviewees were a small, purposeful, convenience sample of informants. Consequently, results cannot be interpreted as representing a complete picture of the issues. In particular, the sample did not include female or minority physicians. It probably overrepresented larger institutions compared to smaller practices, and urban practices compared to suburban or rural practices. Some interviewees were in positions of responsibility for which they might be inclined to believe that recruitment is under control.

A larger sample was not within the scope of planned interviews because of time, expense, and logistical constraints. Future work could be targeted toward physicians who are women, minorities, younger, and older, and toward physicians who practice in non-urban settings. There are significant recruitment and retention issues for each of these groups that merit more in-depth coverage.

References

American Academy of Family Physicians (2006). Primary care. Retrieved on August 30, 2007 from http://www.aafp.org/online/en/home/policy/policies/p/primarycare.html.

American Medical Association (2007a). Physician characteristics and distribution in the U.S. Chicago, IL.

American Medical Association (2007b). National resident matching program – frequently asked questions. Retrieved on August 18, 2007 from http://www.ama-assn.org/ama/pub/category/8231.html.

American Medical Association Physician Masterfile [database]. (2006) Chicago: AMA.

Association of American Medical Colleges (2007). Recent studies and reports on physician shortages in the U.S. Washington: Author.

The benefit of hiring residents. (2004). Recruiting Physicians Today, 12(6), 1-3.

Bonds, R. G. (2006). Physician recruitment and retention: Practical techniques for exceptional results. Rosewell, GA: American Academy of Medical Management.

Cejka Search and American Medical Group Association (2006). 2006 physician retention survey. Retrieved on June 15, 2007 from http://www.cejkasearch.com/retentionsurvey/2006PhysicianRetentionSurvey.html

Cooper Research. (2003). Greater Cincinnati physician practice survey. Cincinnati, OH.

Due diligence on the internal front enhances recruiting success. (2004). Recruiting Physicians Today, 12(1), 1-2.

Giovino, J. M. (2002). How to recruit new residency graduates. Family Practice Management. 9(3), 33-36.

Health Foundation of Greater Cincinnati, The (2006a). 2005 Greater Cincinnati community health status survey. Cincinnati, OH: Author.

Health Foundation of Greater Cincinnati, The (2006b). Exploring primary care services and resources in Greater Cincinnati: A chart book of the issues. Cincinnati, OH: Author.

Health Foundation of Greater Cincinnati, The (2001). Meeting the challenges of an aging population in Greater Cincinnati. Cincinnati, OH: Author.

Health Resources and Services Administration. 2001 Area Resource File. Washington, DC: author.

Health Resources and Services Administration. Find HPSAs. Retrieved December 3, 2007, from http://hpsafind.hrsa.gov/HPSASearch.aspx.

Kentucky State Data Center, University of Louisville.(2006). Northern Kentucky profile. Retrieved August 15, 2007 from http://www.thinkkentucky.com/edis/cmnty/Demog.aspx?cw=049.

Market watch: 2006 Survey of Final-Year Medical Residents Highlights. (2007). Recruiting Physicians Today. 15(2), 3.

Market watch: Review of 2003 physician recruitment incentives. (2003). Recruiting Physicians Today, 1 (5), 3.

Medical Group Management Association (2006). Physician compensation and production survey. Englewood, CO.

Misra-Hebert, A., Kay, R., & Stoller, J. K. (2004). A review of physician turnover: Rates, causes, and consequences. American Journal of Medical Quality, 19(2), 56-66.

Moody, J. (2002). Recruiting generation x physicians. Recruiting Physicians Today, 10(1). Retrieved on June 15 from http://www.nejmjobs.org/rpt/recruiting-gen-x-physicians.aspx

Neuhauser, P. C. (2004). Building a high-retention culture in healthcare: Fifteen ways to get good people to stay. Clinical Leadership & Management Review, 18 (5), 259-266.

Office of Strategic Research, Ohio Department of Development. (2005). Ohio county profiles. Retrieved August 15, 2007 from http://www.odod.state.oh.us/research/files/s0.htm.

Physician recruiting: costs and rewards. (2003). Recruiting Physicians Today, 11(4), 1-2, 4.

Richie, J (2007, August 17). Health Care Resource center finds lots of new doctors want to stay in area. Business Courier of Cincinnati.

Solucent, LLC. (2004). Physician community requirements in the 21st century: The 2003 physicians to population ratios. Evanston, IL: Author.

Seifer, S. D., Vranizan, K., & Grumbach, K. (1995). Graduate medical education and physician practice location: Implications for physician workforce policy. Journal of the American Medical Association, 274(9), 685-691.

Terry, K. (2004). Jobs 2004: Primary care outlook. Medical Economics, 81(10), 84-87.

US Census Bureau (2007). State and county quickfacts. Retrieved August 15, 2007 from http://quickfacts.census.gov/qfd/states/.

Weymier, R. E. (2003). Recruiting genX physicians. Physician Executive, 29(6), 24-27.

Weiss, G. G. (2006). Group practice: How to keep the new guy. Medical Economics, 83(24), 36-40.

Rookwood Tower
3805 Edwards Road, Suite 500
Cincinnati, OH 45209-1948
513.458.6600 [TF] 888.310.4904
www.healthfoundation.org