
New England Society for Healthcare Strategy

Physician Recruitment Research Findings & Summary

About Us



New England Society for Healthcare Strategy

As a membership based organization, the New England Society for Health Care (NESHS) seeks to provide career and professional development opportunities to enable practitioners in healthcare strategy, business and network development and physician relations to enhance their competence and effectiveness, thereby contributing to the success of the organizations they serve.

A 17-member Board of Directors representing the diversity within the membership by geography, organization type and position leads the organization.

More information about the Society can be found at www.neshs.org.



The Barlow/McCarthy (B/Mc) team is a market leader in working with hospitals and their medical staffs to create and implement relationship strategies. The team has worked in group practices, hospitals and health systems in a variety of physician relations, recruitment and strategic development roles. Their approach is to utilize observation and assessment – combined with a focused intention on evaluating the strategic results. From there, the Barlow/McCarthy team creates specific, individualized solutions— solutions that are actionable and deliver measurable returns. Their client base represents group practices, hospitals and health systems with diverse missions and market positions from coast to coast, including a strong New England presence.

More information about Barlow/McCarthy can be found at www.barlowmccarthy.com or by calling 866-315-7774.

Introduction

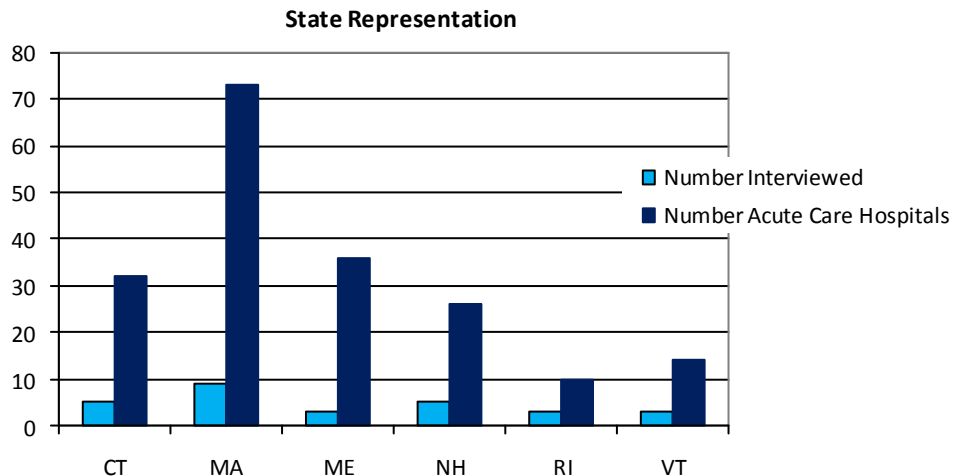
Physician recruitment is a growing concern for hospital leaders. With ever more organizations competing for a shrinking physician pool, there is mounting pressure for them to meet community need and to survive as a hospital enterprise.

According to the HealthLeaders Media Industry Survey of 2009, CEOs cited physician recruitment and retention as a top priority just behind quality/patient safety in their overall rankings.

The strategic implications for the hospital community are significant – since physicians are central to quality improvements, market share growth and financial viability. As a result, the New England Society for Healthcare Strategy (NESHS), in partnership with the consulting firm of Barlow/McCarthy (B/Mc), studied this area in more detail. Their collective goal was to better understand the depth of the issue across New England, learn what individual organizations are doing to address the challenges, uncover unique differences about New England that either softened or exacerbated this national concern, and share insights that could help practitioners in healthcare strategy, business and network development and physician relations.

Research Approach

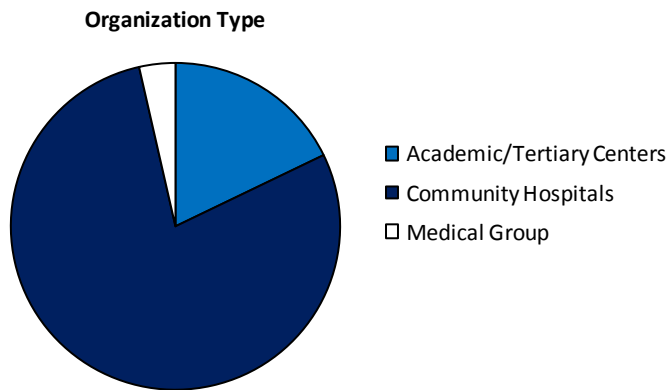
NESHS collaborated with B/Mc to conduct a qualitative research study targeting key hospital executives responsible for physician recruitment. NESHS members were initially approached to ensure diversity in market location and type, along with organizational size and mission. Barlow/McCarthy's network supplemented the participation to ensure the desired representative mix was obtained.



The total number of organizations surveyed equaled 28.

Respondents ranged from hospital CEOs to physician recruiters – based on whom the organization felt had the best “pulse” on the physician recruitment efforts and outcomes. For many facilities, it was determined that dual participation in the interview was needed to provide both the broader strategic insights and operational details of the effort.

Interviews with representatives were conducted from October 2008 through January 2009. Given the depth and breadth of the topic, and desire for interview consistency, a prepared questionnaire was used to facilitate discussions and determine valid observations and conclusions.



Of the 28 organizations represented in the study, there were 22 community hospitals, 5 academic/tertiary hospitals and 1 physician group.

Nearly 80% of the participants represented community-based hospitals. Given the typical academic decentralized approach to physician recruitment, this was a much more challenging organization to interview since responsibility often falls to various department chairs and chiefs. Five academic facilities were interviewed, representing each New England state except Vermont (two were from Massachusetts – one within and one outside Boston proper). At one community hospital, the physician recruitment efforts were assigned to their employed physician group thereby including a single group practice representative in the mix.

Overall Findings

Aware and Concerned

With growing attention on physician recruitment (see HealthLeaders survey findings below), 86% of those surveyed said their organization is adequately (56%), or very prepared (30%) to face this increasing challenge.

	Percent Selected
Quality/Patient Safety	69%
Physician recruitment/retention	35%
Consumer satisfaction	26%
Construction/capital improvements	24%
Reimbursement	23%
Cost reduction	21%
Revenue cycle	20%
Nurse/staff recruitment/retention	14%
Technology system/equipment	13%
New clinical products/services	11%
Physician staff ventures/realignment	10%
Employee satisfaction	8%
Leadership development	7%
Transparency	4%
Other	3%

The 312 HealthLeaders survey respondents were asked to rank their organizations' top three priorities for the next three years. The percent that selected each category are noted.

Those interviewed who believe they are prepared, still see obstacles and difficulties ahead. Some leaders, in other settings, described it as “The Perfect Storm,” and others as the “Silent Killer” as hospitals and health systems see their highest admitters move closer to retirement without a transition plan. Supplement this with studies that show the new generation of physicians is demanding more lifestyle balance – which means investing less of their energy in their careers, their practice and the hospital – and the recruitment/retention pressures increase.

The study's findings suggest the New England region of hospitals and health systems are aware of the physician recruitment challenges but uncertain about the solutions. While some are clearly developing physician practice models that put the ownership and risk on the hospital, another group seeks to do the same but lacks a supportive medical community or the funds for that option. A third group remains committed to the private practice model for the next several years since practice ownership has been attempted in the past without good results.

Cost of Living

In addition to practice models, the high cost of living in New England, combined with lower reimbursement than other parts of the U.S., results in lower physician compensation, which increases the challenge in attracting physicians. In fact, other than in New Hampshire, respondents cited the high cost of living and lower compensation potential as the greatest challenge in getting prospects to consider New England opportunities. As a result, New England hospitals compete for a smaller group of physician prospects that choose to practice in New England for other than financial reasons. In fact, to some extent, the interviewees suggest these physicians actually reject higher financial rewards to practice in New England.

Keeping New England Students

There appears to be opportunity to increase the retention of physicians who go to medical school and/or train in New England given the feedback from survey participants. Those interviewed who recruited a lower percentage of residents/fellows believe financial issues are the main reason they are unsuccessful in recruiting more of that target group. Others believe it goes back to medical school and residency selection – where the goal is solely to attract the best and the brightest to the benefit of the educational program – versus also considering the local health care needs as a factor in selection.

Resource Investment

Finally, there is considerable variability in the resources invested in recruitment across the interviewed organizations. While most organizations have some in-house staff dedicated to the effort, several still rely on external firms to fulfill their recruitment objectives. Within hospitals relying on in-house staff, there is no clear trend to show staffing patterns follow any predictable benchmark, i.e. based on number of searches, size of medical staff, number of beds, etc. And the cost – per physician needed – represents a wide range from about \$10,000 to \$125,000. To achieve any standards in this area would require further study. Some interviewed said they are hopeful the upcoming results from the Association of Staff Physician Recruiters/Medical Group Management Association physician recruitment study will provide valid benchmark data.

Each of these summary areas will be explored in more depth in the remainder of this report. Overall, the results suggest that ongoing efforts to improve reimbursement rates will support the recruitment agenda to the extent it provides a greater financial return to physicians. Until then, the New England hospitals, health systems and group practices will continue to compete for the smaller pool of physicians seeking new opportunities in New England for other personal and professional reasons. As an increasing number of New England health care organizations intensify their recruitment efforts, the demand/supply pressures will likely result in richer recruitment

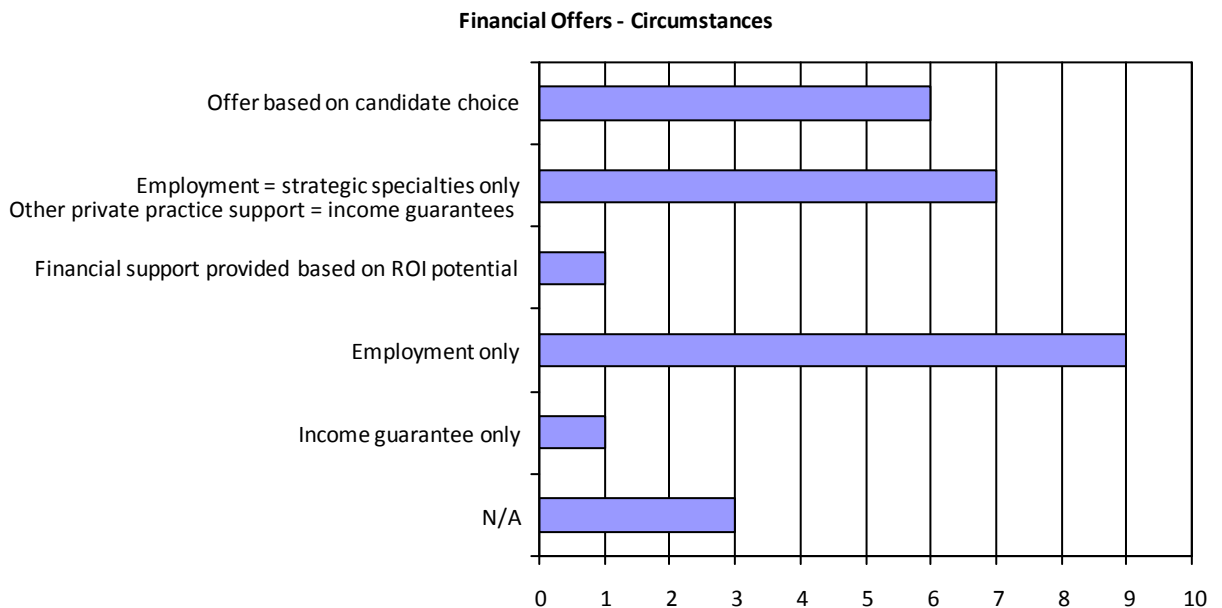
packages for prospects. Additionally, organizations “dabbling” in recruitment without dedicated resources, or effective internal processes, won’t be able to compete with those that already have a structure and strategy. B/Mc’s client experience demonstrates well organized recruitment functions that “fast track” a prospect through the interview process and communicate a “welcome” message in all their interactions – from administration through the medical staff – achieve better closure rates and recruitment results. We believe establishing physician recruitment readiness is a core competence requirement to compete in this market for the foreseeable future.

Increasing Financial Incentives

The days of private practices doing their own recruitment without hospital financial support are nearly over, according to the study findings. In fact, there is a growing trend toward hospital employment within the region.

- Just over one-third of the respondents indicated that the only financial model they provide to physician recruits is hospital employment.
- Another 46% percent offer employment or income guarantee either based on the organization’s strategic priority for that specialty or the preference of the physician candidate.
- Only two respondents cited that financial support was used very sparingly (based on the ROI potential of the situation) or income guarantee arrangements were the only support model being offered.

Note: Three additional organizations chose not to share this information or didn’t have it available at the time of the interview.



The trend toward hospital employment seems to be following the national movement according to research conducted by Phoenix Services. Using the

American Hospital Association's *Hospital Statistics 2008* and the American Medical Association's *Physician Characteristics and Distribution in the U.S., 2008 Edition*, one of seven physicians were being employed by a U.S. Hospital by the end of 2007 – a doubling outcome over the past 25 years. Per Phoenix Services, the largest cohort of hospitals increasing employment is those with over 500 beds. In both 2006 and 2007, these hospitals represented 90% or more of the employment growth.

The *2008 Physician Recruiting Incentives Survey* by Merritt Hawkins Associates, which shows that only 19% of the financial incentives offered during 2007/2008 were income guarantees, validates this. Salary with bonus was the most popular model at 59%, which was an 8% decline from the previous year. This study seems to suggest that straight salary may be on the rise again with a 10% increase in these types of offers from the prior 12-month period.

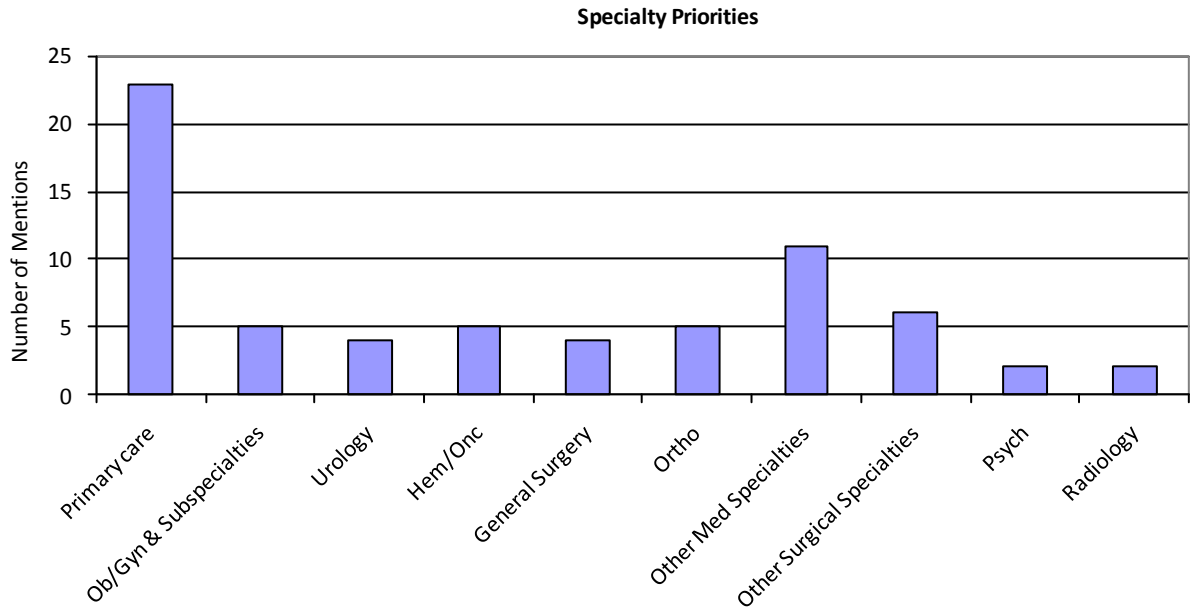
Specialty Priorities

It likely comes as no surprise that primary care is the dominant physician recruitment need within the region. When asked to name the specialties the organization had placed a high priority on recruiting, nearly every respondent mentioned primary care – whether in an urban or rural market or a small community hospital versus a large academic medical center.

While the supply of primary care physicians continues to grow, the demand continues to outpace availability. According to the National Health Policy Forum, between 1995 and 2005, the number of primary care physicians per 100,000 population increased 12%, compared to 5% for other physician specialties. During that same time period, the number of physician assistants, nurse practitioners and others licensed to perform primary care functions almost doubled.

The challenge, according to the study, is that fewer U.S. allopathic medical school graduates are entering primary care residencies. International and osteopathic graduates are the ones filling this rise in primary care providers. While osteopathy graduates are commonly accepted – except in some in academic facilities – it is the lack of acceptance of the international medical graduate that creates the recruitment challenge. B/Mc's client work has revealed that many hospital leaders and physician recruiters recognize that the populaces they serve may not yet be ready to accept a new physician, unless they are American-born and trained. And while physician assistants and nurse practitioners can effectively augment the existing physician practices, B/Mc has seen less confidence in having these professionals successfully lead the launch of a new practice location and expand market share without high level physician presence. This is likely to continue to create a physician recruitment dilemma for many years.

Medical specialties were the next greatest area of recruitment priority. Oncology was mentioned frequently enough that it warranted special recognition in the chart below.



Interviewees were permitted to list several specialties priorities. Thus the results are tabulated based on “Number of Mentions” versus number of responding organizations.

The aging population and the resulting increase in cancer treatments are certainly driving this trend. And, according to the American Society of Clinical Oncologists (ASCO), the number of oncologists is expected to increase by 14% in the next 12 years, but the demand for those physicians will increase 48%.

Beyond that medical specialty, other areas of need included gastroenterology, neurology, cardiology and endocrinology. Not only are these specialties needed to care for an aging community, but B/Mc’s national experience validates that GI, Neuro and Cardiac are seen as necessary medical feeder specialties for their surgical counterparts – for which hospitals rely significantly for higher contribution margin. Just as having a strong primary care presence is needed to build the referral base, these specialties are viewed as the next critical layer to ensure the full clinical throughput is present.

Growing population demand and positive hospital revenue streams also are establishing recruitment priorities in several surgical areas including Orthopedics and Urology. The growing need for General Surgery has another factor at play. According to a study published by the Archives of Surgery, General Surgery is one of the few physician specialties where the absolute

number of surgeons is actually shrinking. Because of increasingly intense schedules, particularly in rural communities, declining reimbursements and the ability to earn more in other surgical subspecialties, the number of General Surgeons per capita has declined by 25% in the past 25 years. Beyond these surgical needs referenced by the survey respondents, a few other less frequent mentions included neurosurgery, vascular surgery and trauma.

Ob/Gyn and its subspecialties (perinatology, gyn oncology, etc.) may also be worth further elaboration. The lifestyle desires of the younger generation of physicians are causing the hospitalist phenomenon to start spreading into this area. In a recent HealthLeaders Media article titled “The Hospitalist of the Future,” managing editor and author Elyas Bakhtiari said that when working on a magazine article about women’s health service lines, executives from six leading hospitals noted they were working with laborists or OB hospitalists in one form or another. And they all expect that model to become even more influential in the industry going forward. If the effect of hospitalists in the recruitment of internal medicine is any indicator, then this will likely intensify the demand/supply dynamics in this specialty as well.

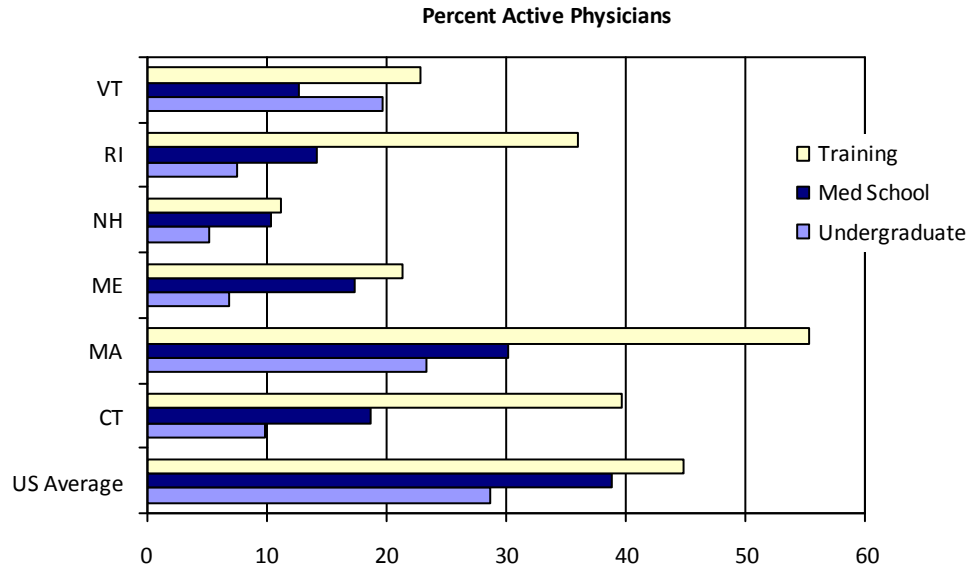
Recruitment: Residents versus Practicing Physicians

Given the number of residency training centers located in the New England region, one might presume the area has a built in “feeder” system for physician recruitment. But the results of this study might suggest otherwise.

- Only about 40 % of the respondents are filling the majority (75% or more) of their openings with residents or fellows.
- Another 20% fill about half of their openings (50-60%) with residents/fellows and the rest are predominantly filling their searches with practicing physicians.

Based on feedback from prospects, there are several reasons for this. One is that the New England cost of living – and lower compensation levels – encourages residents to go outside the region for greater financial rewards. Others suggest training programs have worked hard to recruit medical students from top tier educational programs and these students are then returning back to their “roots” to establish practice.

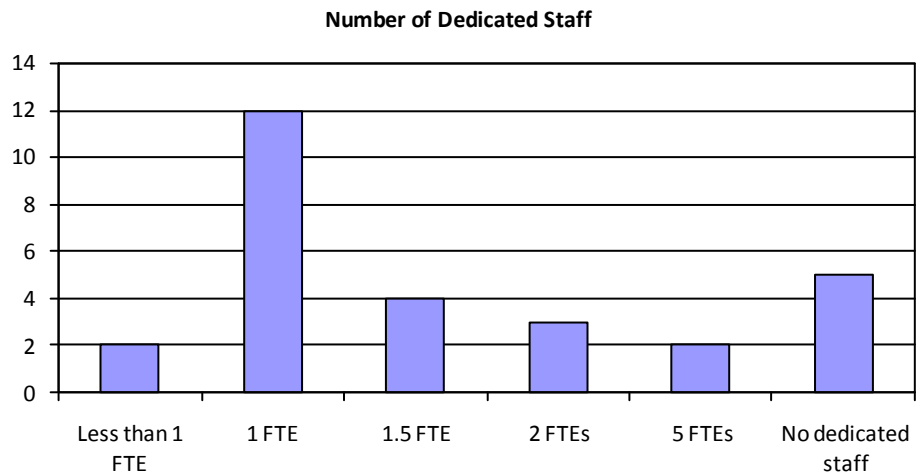
This may be validated by the American Academy of Medical College’s data. In their 2007 State Physician Workforce Report, they noted the New England states were behind the U.S. average in retaining its undergraduates, medical graduates and trainees as active physicians (see below) – except for Massachusetts, which was the only state that retained more of its trainees than the U.S. average. While this study does not indicate how many stay within the New England region, it does suggest that there is significant opportunity to work more aggressively in retaining those that are educated and trained in the region to practice in the region.



This graph shows that all of the New England states are below the U.S. average in retaining active physicians who completed undergraduate or graduate studies in that state. Only Massachusetts was above the national average in retaining those that do residency training in the state.

Managing Recruitment Process

The majority of respondents had one full-time employee responsible for physician recruitment. There was some variation within tertiary centers – many which had multiple staff working on physician recruitment. While a couple of centers had up to five individuals on the recruitment team, the remaining tertiary centers interviewed had no more than two physician recruitment staff. While multiple facility health systems would appear to warrant a higher staffing level, those interviewed were in the one FTE, or less range of staff complement.



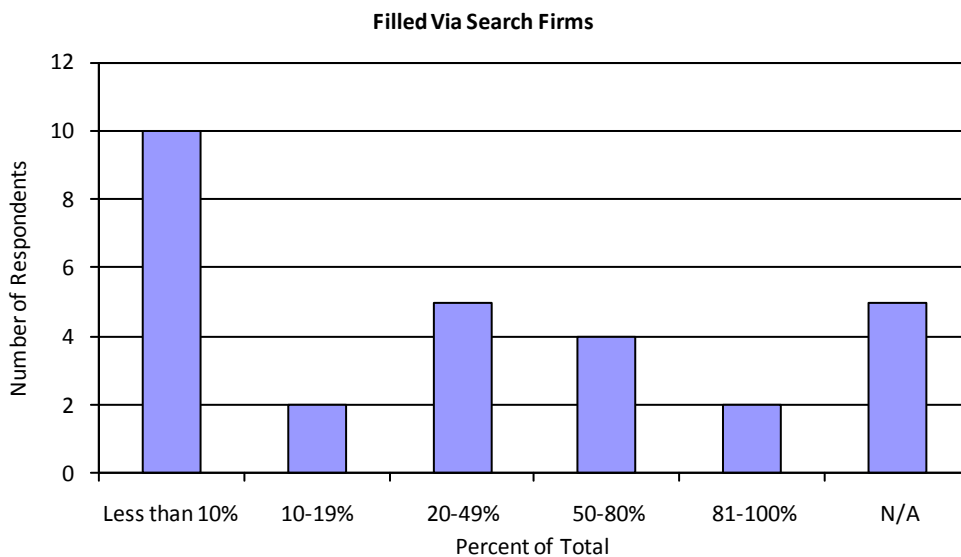
The breakdown of responses based on 28 total organizations surveyed.

External Resources as an In-house Substitute

One surprising finding was the number of organizations still working in this challenging strategic area without any dedicated internal resources. These entities were relying solely on either dedicated consulting resources or external search firms for their recruitment needs. Several of those interviewed, who were managing those external resources, questioned the merits of using the approach for much longer given the increasing recruitment pressures on the organization.

Search Firm Utilization

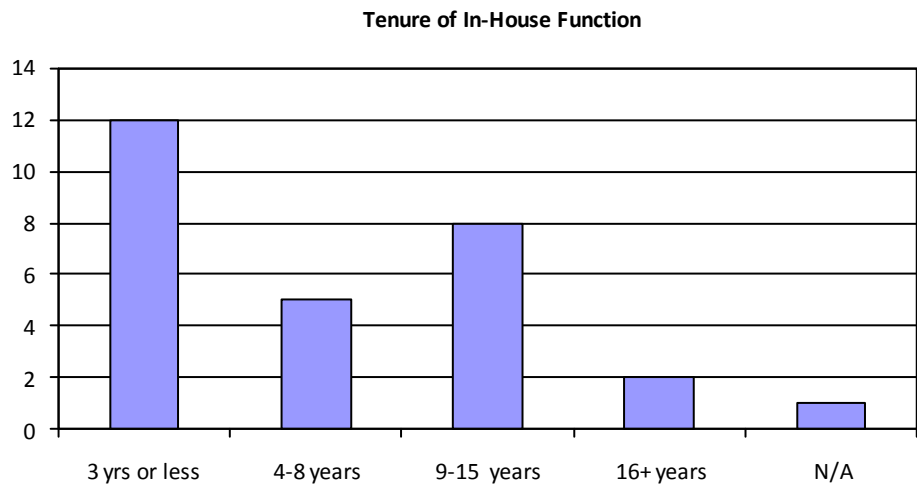
The utilization of external search firms to support physician recruitment is minimal for more than one-third of the respondents. Many of those interviewed in this group cited a concerted effort to limit the use of search firms – believing that their own internal efforts are more cost effective and deliver a stronger candidate pool than what can be achieved through firms. The study findings appear to validate that those organizations with dedicated in-house recruitment resources have less use of search firms. Organizations without dedicated in-house resources must rely on external resources to meet their needs whereas those with internal resources make a strategic decision to use them on specific searches (by specialty or type of position).



The respondents were asked to estimate the number of searches completed each year through the use of search firms.

Function Tenure

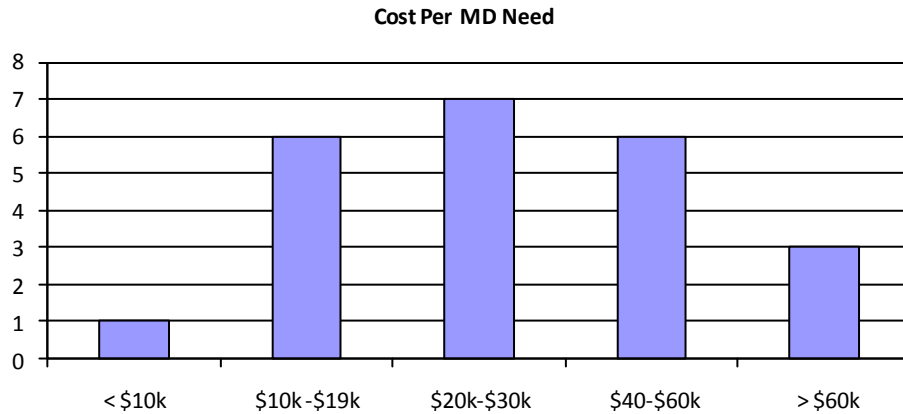
Almost half of the organizations interviewed were fairly new to physician recruitment. In contrast, nearly 30% of these organizations had physician recruitment functions in place for 9 to 15 years. These facilities likely developed in-house capabilities during the 90's – when primary care acquisition/recruitment was a dominant hospital strategy – and then maintained the function as those efforts evolved. Further study would be needed to determine if there is a perceived difference in performance between those organizations with long recruitment function tenure versus those that have younger programs in place. Some argue that physician recruitment needs to be a “core organizational competency” to be successful. Whether that's true or not, B/Mc has observed that seasoned recruitment functions enables the organization to develop solid working relationships with area education/training programs and recruit prospects earlier in physician development (i.e. during medical school or in the early training years). It also helps to keep the medical staff focused on practice transition and replenishment; thus having a direct impact on the organization's ability to manage the medical staff “asset” and ensure community access to medical services.



The breakdown of responses based on 28 total organizations surveyed.

Recruitment Investment

To understand the cost of physician recruitment on these organizations, the interviewees were asked to share their estimated total annual recruitment budget (without physician salaries or any other expenses allocated directly to the physicians). When that was compared to the number of physicians that needed to be recruited (converting their three-year projections into annual estimates), the cost per physician need resulted in the graphic below.



Cost Per MD Need was calculated based on the total annual estimated recruitment budget as compared to an annualized, 3-year estimate of physicians to be recruited.

In an attempt to verify a common belief held by in-house recruiters that having internal resources will improve the cost efficiency of physician recruitment, B/Mc found the “cost per physician need” cannot be answered by staffing structure alone. In B/Mc’s experience, other variables affecting recruitment costs include:

- Specialty and skill sets of those being recruited
- Desirability of geographic location and organization type
- In-house recruitment function experience.

The lack of correlation in the results suggests that individual organizations in individual markets with differing needs are going to have variable costs. Rather than broad benchmark comparisons, individual assessments may be more effective to ensure that the tactical allocation of dollars expended is done so most strategically. B/Mc advocates that tracking and trending experience over time – to learn the organization’s unique return on investment – is likely more beneficial. But this can only take place with a centralized resource that provides the rationale for the allocation of funds and then analyzes the results to understand the outcome and make improvements over time. It is there that the argument of an in-house resource might be best justified.

New England: Both Positive and Negative

Those actively working in physician recruitment know you have to “sell” what is positive and “minimize” the challenges to present a positive description of the practice opportunity.

Studies over time show “geographic location” is one of the first criteria used by physician prospects to conduct a search. With so many opportunities in all specialties in most U.S. locations, they narrow their search based on where they would prefer to locate personally. After that, they begin a search within that specific geographic area.

Everyone interviewed, said successfully positioning the positive attributes of their location was one area key to success. Whether it was an urban or suburban locale in greater Boston or Hartford or a more rural market in Maine or Vermont; the respondents look at lifestyle attributes of their locations to initially position their practice opportunities with some specific nuances:

- Connecticut recruiters note their location – between New York and Boston – provides both suburban living and reasonable access to the metro area’s cultural offerings.
- Rhode Islanders offer the same but combine that with the coastal ambiance available within a good portion of the state.
- Maine, New Hampshire and Vermont offer the attributes of “small town America” along with the active four-season outdoor lifestyles available.

However, the respondents also noted that location alone won’t make the sale. As noted earlier, many cited that the New England location has financial detriments that can deter prospects from available opportunities.

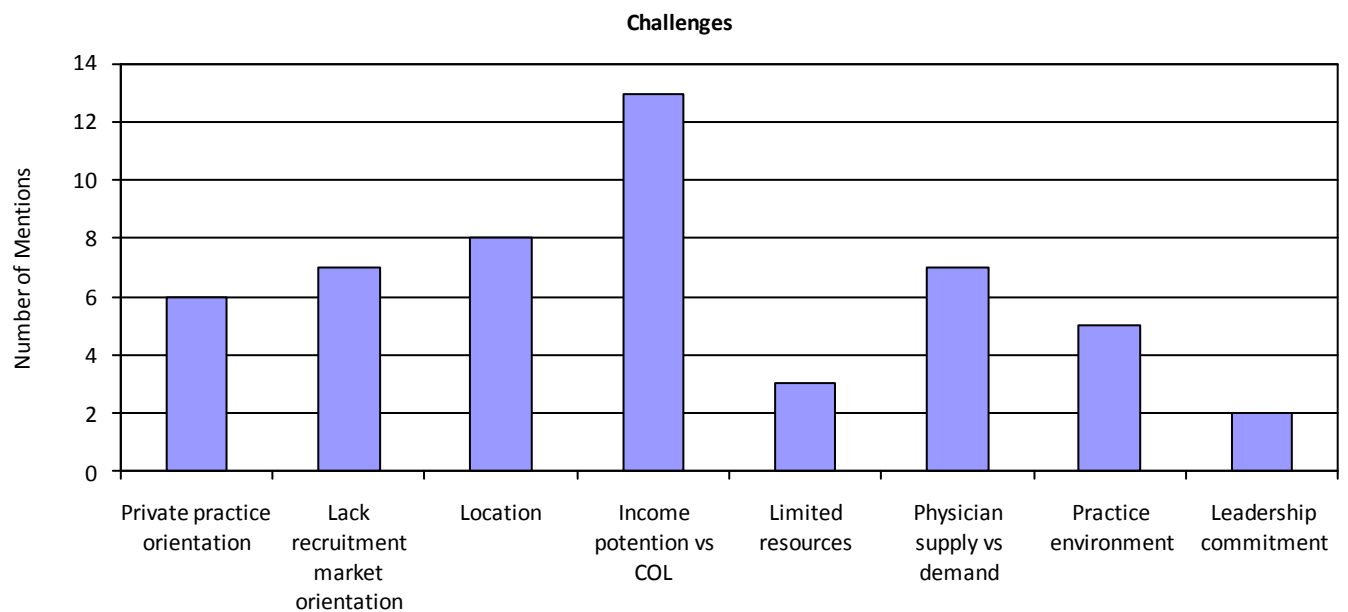
Other than New Hampshire, respondents noted the high cost of living with lower compensation potential as the greatest challenge in getting prospects to consider New England opportunities. The compensation picture is derived directly from reimbursement rates in the state. While New Hampshire enjoys a more lucrative reimbursement environment, the other New England states are particularly challenged by the payers. Rhode Island in particular receives the fifth lowest reimbursement nationally and the lowest in New England (per the Hospital Association of Rhode Island). For the Rhode Island hospitals/groups, if they can get a prospect to consider New England, they often lose them to a Massachusetts or Connecticut opportunity for higher compensation potential – according to the Rhode Island interviewees. There was unanimous opinion by those interviewed that physicians who chose to practice in New England desired to be in New England for personal reasons. And while lifestyle was the draw, many interviewees said this could also be a challenge in terms of physician productivity. For those in Maine, New Hampshire and Vermont in particular, the strong lifestyle desire for time with community, family, outdoor sports, etc., can mean a less practice

“driven” physician population. This means management has to be careful not to create a “bait and switch” perception – to use the lifestyle offering as an advantage for recruitment but then demand high productivity expectations once in practice. This can lead to a significant retention issue for the organization and a continuous medical staff “gap” requiring repeated recruitment to fill the position.

Beyond lifestyle and productivity, lack of diversity in some areas also creates a recruitment challenge. A few study participants noted they are located in areas where there is more uniformity than variety. For them, this creates particularly significant issues with primary care recruitment since foreign medical graduates are becoming the predominant make-up of those practitioners. They recognize that to be successful in these recruitment efforts there must be a long-term effort in working with the broader community at large to be welcoming and supportive of cultural differences. With 42% of the internal medicine residents and 46% of the family medicine residents representing foreign medical graduates, according to the American College of Physicians 2008 report, *The Role of International Medical Graduates in the U.S. Physician Workforce*, this makes recruiting and sustaining this group of new practitioners challenging.

The current national recession and growing unemployment is also having a ripple effect on physician recruitment. In the past, the physician in the household may have made the first “employment” decision, the trend now is for the physician’s spouse to locate a position and then the physician will follow. Several study participants noted that their declining area employment options have hindered their ability to “close the deal.” In those instances, the physician candidates delayed their search until their spouse had successfully locked in their professional opportunity. From B/Mc’s perspective, this will put more pressure on physician recruiters and hospital leadership to be networking and dialoguing closely with other area employers so that recruitment can be done jointly for the full household.

Other Noted Challenges



Interviewees were permitted to list several areas of organizational challenge in physician recruitment. The results are categorized into themes and tabulated based on “Number of Mentions.”

Beyond the income potential/cost of living issue, several other challenges were noted by the study participants including:

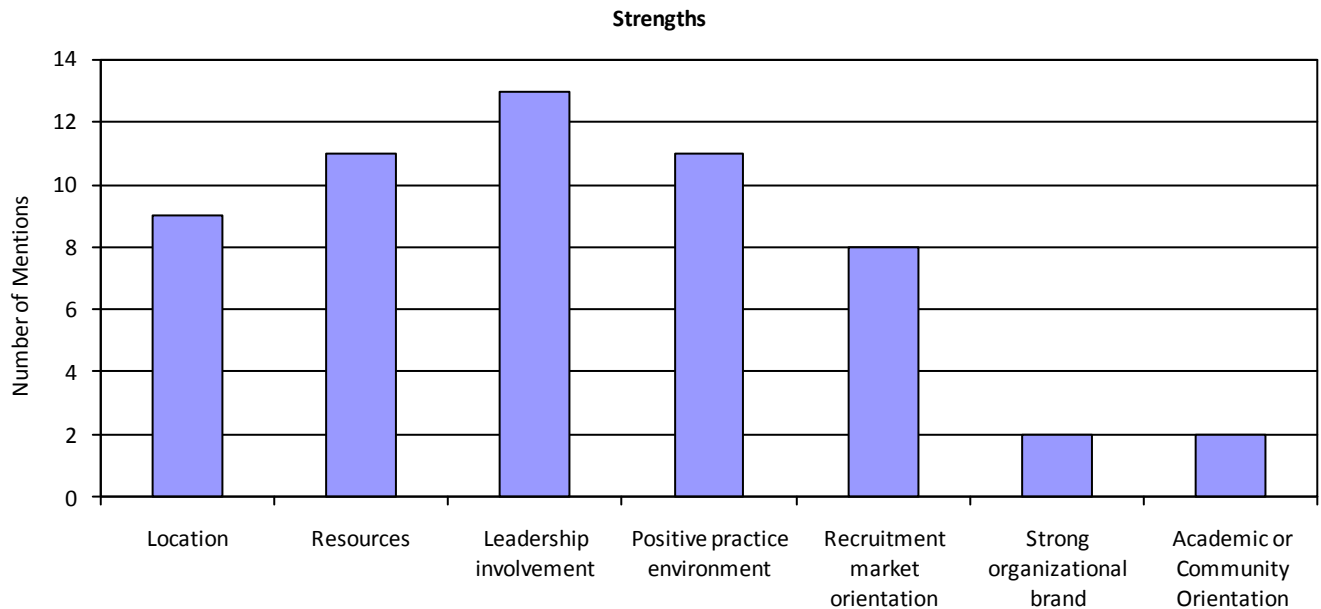
- Location – the specific community of the facility was considered a barrier for some because of its less than desirable patient population/payer mix, rural orientation or the proximity of the facility to others considered more attractive by physician prospects, i.e. academic medical centers.
- Lack of recruitment market orientation – several cited that their organization and/or medical community did not have a good sense of the recruitment marketplace. This was exhibited by offering undesirable compensation packages, passive responsiveness to prospects or a disorganized approach to the effort.
- Physician supply versus demand – in this case the organization understood the marketplace and recognized the number challenges of a growing recruitment demand with an inadequate supply of physicians to fulfill those enlarging number of petitions.
- Private practice orientation – was perceived as an obstacle as the community need for physicians rises but the medical community lacks the motivation or desire to support new providers into their practices and/or into the community. These hospitals are confronted with either continuing to work collaboratively but at a slower pace with the existing medical staff to bring them to the recruitment table or experimenting

with new practice models at the risk of creating a dispute with their medical staff.

- Practice environment – for some it is beyond the issue of the practice models but is more about the culture and behavior of the medical community. In these cases, the interviewees work with a very independent group of physicians who have established more of a competitive than collaborative dynamic. When physician prospects have a choice of this environment versus one that is more supportive and nurturing, they most often choose the latter.
- Limited resources – these organizations lack the staff support or the budgetary allocations to effectively compete in the recruitment marketplace. Their ability to be successful is hampered by the means to make it happen – either in time or dollars.
- Leadership commitment – there was a sense that the recruitment effort just didn't have the strategic priority of the organization that it needed to meet the market challenges.
- Lack phased retirement models – one forward thinking organization was concerned that they could not recruit at the pace fast enough to match the number retiring over time. The vision is to build practice models that would permit "phased" retirement and retain the physicians in practice longer – even if at a lower productivity level. This would then enable the organization to establish more creative recruitment offers, such as part time packages, to provide for the interim need and allow more time to work on the long term need.

Factors Enabling Success

While the situation might appear grim, there are still a significant number of physicians being recruited into New England practice opportunities each year. There is a sizeable prospect pool of physicians still available who have New England roots, past experiences or a desire to relocate to this area, which is still appealing to many. With location as the initial criterion, the organization's job is to "woo" the prospect to their organization versus another. And the interviewees cited a couple of additional factors that they believed enabled organizations to be successful in doing that.



Interviewees were permitted to list areas of strength that helped them to be successful in physician recruitment. The results were summarized as themes and tabulated based on “Number of Mentions.”

Committed Leadership

As in many strategic initiatives, there is the need for an internal “champion” to drive the agenda, lead the cause and make it happen. According to those interviewed the same holds true in physician recruitment. The interviewees’ highlighted specific actions that were displayed by their leadership that enabled them to achieve desired outcomes in this area. These include:

- **Leader is Front and Center:** Several cited that they enjoyed having a senior leader at the center of the recruitment effort. They ensure that the internal structures, skills and systems supporting the recruitment process are barrier free and that the recruitment team has “open access” to them for prompt action and decision-making. And if the organizational CEO has designated another member of the senior leadership team to drive recruitment (such as the CMO or VPMA), with that delegation also comes the empowerment and expectation to make it happen.
- **Connect the Dots:** Beyond driving the recruitment agenda, study participants noted leadership communication as key. Good communication from leadership ensures that all of the organization understands the purpose of physician recruitment and link it to the broader organizational strategic agenda. The entire organization receives ongoing communication about the urgency to recruit and the role each plays in creating an attractive recruiting environment. The medical staff, individually and collectively, is also engaged in dialogue to gain their buy-in or at the very least “cooperation to not undermine the process.
- **Prioritize to Ensure Success:** Interviewees also noted that their leaders understood not every recruitment opportunity could carry equal priority

and enjoy equal resource investment. They know the recruitment agenda has to be prioritized based not only on what the organization needs most, but also on what opportunities are ready for recruitment. B/Mc's consulting work in this area has found senior leaders need market intelligence to help them rank the order for recruitment options, because they are willing to put the organizational weight behind those that are both needed and ready. And if a situation is not ready, then they make the tough decision to put it on hold, or restructure the situation to make it market attractive and recruitment friendly.

Adequate Recruitment Resources

Beyond leadership as a central resource to success, there were other elements also cited as critical to the recruitment effort. While dollars is part of the mix, particularly as it relates to marketing the organization's opportunities in the recruitment market, success sources also includes the structures and systems in which the staff must work to navigate prospects and candidates through the process. Some critical areas identified by those interviewed include:

- **Match Resources to Objectives:** The ability to set realistic recruitment expectations and allocate the funds needed to effectively promote the opportunity, process candidates through the pipeline and establish them effectively in practice is a skill that is developed as recruitment functions mature. As noted earlier in the report, this is an individual benchmark that differs by market, medical staff, organizational mission and strategic agenda. B/Mc advocates that recruitment functions track the experience over time so that the ability to expend only what is necessary on only priority searches improves with increased understanding of what works and what doesn't – by specialty and practice situation. For this reason, many leaders interviewed believe physician recruitment must remain a core organizational competency and not be a function that comes and goes.
- **Strategically Directed Recruitment Plans:** B/Mc has seen that experience also enables recruitment functions to identify and implement those recruitment tactics that make the most sense for the position available. It moves the sourcing process away from a "cookie cutter" approach and builds tactics that are based on the candidate criteria desired and most effective ways to reach that target population. Whether it is direct mail, advertising, databases and search engines or use of external firms; no one tactic is right for every situation. The strategic mix should be evaluated and allocated based on the search criteria, the organization's market and the search behaviors of the specialty being sought.

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- Minimize “Penny Wise and Pound Foolish” Practices: For most organizations, recruitment budgets are high. There is always a sense that maybe more is being expended than needs to be – and can more boundaries be put upon the recruitment funds to provide some controls and limits? Several interviewees said they did not have to live within these micro-management confines, which they viewed as positive. They know through networking or prior positions that some organizations make policy decisions such as 1) using search firms but not allowing purchases of physician recruitment sourcing databases or 2) allowing the physician and spouse/significant other to site visit but not the children or other members of the household. B/Mc has seen clients make these choices and watched as these restrictions lengthened the search process resulting in higher than expected costs to fill positions. So while the intention is to improve the cost effectiveness of the effort – it actually causes the opposite. Those interviewed applauded their organizations for not making such decisions. They believed that they were successful in physician recruitment in part because the leadership let the “experts” make these choices. This is not to say that they had “carte blanche” to whatever dollars they needed – rather they had to explain their choices and recommendations. But they were not held to arbitrary budgetary parameters that could result in short term savings but longer search efforts and higher costs in the long run.

Positive Practice Environment

It is often difficult to describe what a positive practice environment is for a physician – but the verbatim comments below offer some insight.

- Good community care delivered – will purchase state of art equipment
- Collegial medical staff atmosphere, plenty of work for all physicians; quality medicine
- Medical quality good in the area – depth of specialists;
- On-boarding practice in place – team effort on this now; physician mentor in place post recruitment as well as personal integration of family; financially doing well so have dollars to work with.
- Have EMR & hospitalists – 24/7 supports quality of life; senior leadership relationship with physicians very team oriented; hospital executive vice president is a physician which also helps
- A team of people working collaboratively, including the chief medical officer; support from the medical staff
- Flat organizational structure; open door communication approach; very flexible; employed group and other models to offer physicians
- Medical staff and CEO sells really well

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- No medical staff turnover; organizational culture very physician friendly, fair and honest communication
 - Management committee of physicians for employed group so they make all their own decisions; warm internal culture; lifestyle balance
 - Physician friendly leadership team; physician relations program to support new recruits; practice marketing support
 - Part of progressive health system; financially strong/stable – always in the black; proactive in meeting community need – develop centers of excellence; quality patient and physician relationships; genuine culture
 - Physicians very engaged and take ownership in the process – responsive
 - Existing medical staff – diverse specialties, young and collegial, really enjoy practicing medicine there

B/Mc would describe this as a positive hospital-physician “engagement.” In this type of environment, physician prospects sense the encouragement and support of new physicians by the medical community and administration. These organizations identify “tenured” physicians who will help new recruits navigate the internal system and prevent them from stepping into political landmines. And the administration recognizes their contribution and desires physician participation in decision-making – advocating new recruits become actively engaged as quickly as possible.

“Best practices” in this area, as observed by B/Mc, continues as the physician navigates through the interview process with hospital operations and practice management systems that demonstrate a readiness to facilitate productivity. The organization is proud of the quality care delivered and places in high regard positive experiences for patients and their families. These organizations invest in tools and resources that smooth the progress of medical practice including hospitalists, EMRs and clinical technology.

Those interviewed said that prospects are convinced, through the testimonials of others, that they will develop a successful practice in that market – where there is definite need for more of their specialty and assistance will be present to ensure a continuous pipeline of new patient volume. The availability of practice support options – from full employment to practice management start-up services – is a concrete way that these organizations convince candidates that the organization is “physician friendly” and welcoming of diversity of goals and interests.

Conclusion

Barlow/McCarthy was pleased to have the opportunity to support the New England Society for Healthcare Strategy through this research project. After recently finishing a similar national study, it was of great interest to identify those common areas of struggle for all hospitals and health systems versus the unique challenges that face this region of organizations.

A study such as this always provides the opportunity to do more – more research, more education, more changes, and more improvement. Unfortunately the recruitment marketplace won't stand still long enough to ponder these next actions for long. In B/Mc's observation, some organizations will gain greater success with just small upgrades that can elevate their efforts to a higher level. Whereas others face a broader cultural transition that will require a well-grounded vision, ongoing communication, several wins – however small – to generate momentum and public rewards for early adopters and supporters.

As a collective body, B/Mc sees the opportunity for the New England organizations to work together with the area medical education and training venues to 1) broaden the perspective of students and residents about New England practice opportunities and 2) dialogue with program leadership about student and trainee selection and identify ways in which the retention rate can be enhanced.

While the questions did not ask specifically, Vice Presidents and Directors interviewed said they need more leadership “action” around physician practice models. They expressed to B/Mc a struggle in trying to sell something that was desired in the market but either unavailable or an “ethereal concept” that had yet any concrete underpinnings to illustrate something real. The opportunity may be for future programs, panel discussions or focus groups – bringing together these professionals with C-Suite representatives – to increase understanding of the challenges and help generate some plans for progress.

Finally, there was also a desire to come together as physician recruiters and dive deeper into the issues identified in this report. While there is always comfort in commiserating with others, these recruiters wanted more than that. They believed that through continued dialogue, additional ideas can be shared, more “best practices” identified, and the overall recruitment capability for all participating organizations could be enhanced.

The report sponsors are delighted that there was both interest and a willingness to share so that this study could be completed. Our thanks to all of the individuals and organizations that participated. We hope the study not only achieved solid learning but also the desire to grow and improve in this area.

List of Participants

Those who participated in the survey interviews are listed below in alphabetical order by facility. Our thanks to them and the time they invested in this effort.

BayState Medical Center – Springfield, Massachusetts

Dr. Gordon Josephson, Chief Operating Officer

John Larsen, Senior Recruiter

Brattleboro Memorial Hospital, Brattleboro, Vermont

Prudence MacKinney, Vice President Planning/Professional Services

Caritas Holy Family, Methuen, Massachusetts

Megan D’Eramo, Director, Network Development

Caritas St. Elizabeth’s Medical Center, Boston, Massachusetts

Melinda Upton, Vice President, Business Development

Central Vermont Medical Center, Barre, Vermont

Sarah Child, Physician Recruiter

Dartmouth Hitchcock Medical Center, Lebanon, New Hampshire

David Brooker, PhD, Director Clinical Human Resources

Jan Kilfeather, Clinical Faculty Recruitment Coordinator

Eastern Connecticut Healthcare Network, Manchester, Connecticut

Theresa Harper, Director of Physician Relations

Eastern Maine Medical Center, Bangor, Maine

Ann Homola, Director, Provider Recruitment and Retention

Elliot Hospital, Manchester, New Hampshire

Maureen Cragon, Director, Physician Recruitment

Emerson Hospital, Concord, Massachusetts

Christine Gallery, Vice President, Planning and Market Development

Exeter Hospital/COR Physicians LLC, Exeter, New Hampshire

Ron Goodspeed, Physician Recruiter

Goodall Hospital, Sanford, Maine

Darlene Stromsted, Chief Executive Officer

Hallmark Health, Melrose, Massachusetts

Donald Bellefeuille, Vice President, Business Development

Lawrence & Memorial Hospital, New London, Connecticut

Sally Williams-Gaenzele, Manager, Physician Recruitment

Lowell General Hospital, Lowell, Massachusetts

Karen McArdle, Director, Medical Staff Services

Maine General Health, Augusta, Maine

Gail Evans, Senior Vice President Marketing and Strategy

Lisa Nutter, Manager, Physician Recruitment

Midstate Medical Center, Meriden, Connecticut

Karen Goyette, Assistant Vice President, Planning and Business Development

Greg Folta, Assistant Vice President, Physician Services

Quincy Hospital, Quincy, Massachusetts

Vicki Divaio, Director, Physician Services

Roger Williams Medical Center, Providence, Rhode Island

Dominic DeCristofano, Vice President, Corporate Planning

Rutland Regional Medical Center, Rutland, Vermont

Larry Jenson, (former) Vice President Corporate Development

South County Hospital, Wakefield, Rhode Island

Cynthia Wyman, Vice President Planning and Market Development

Southcoast Health System, New Bedford, Massachusetts

Debra Pickup, Director, Human Resources and Physician Group

St. Joseph's Hospital, Nashua, New Hampshire

Julie Eberhart, (former) Vice President Planning and Marketing

St. Joseph Hospital, Providence, Rhode Island

Kathy Locarno, Director, Medical Staff Development

St. Vincent Health System, Bridgeport, Connecticut

Laura Flavell, Director, Physician Services

The Hospital of Central Connecticut, New Britain, Connecticut

Dr. Steven Hanks, Senior Vice President of Medical Affairs and Chief Medical Officer

Claudio Capone, Strategic Planning Analyst

University of Massachusetts Medical Center, Worcester, Massachusetts

AJ Avila, Senior Director, Human Resources

Wentworth-Douglas Hospital, Dover, New Hampshire

Norman Heine, Senior Director, Contracting and Business Development

Meet the Author

Allison McCarthy, MBA



As a consultant, Allison focuses on providing valuable insights to her clients on physician recruitment and relations, medical practice development and tracking and reporting tools for results management. She has worked in healthcare for more than 20 years, first as an allied health professional and then moving into physician strategies leadership positions in both community and academic medical centers.

With a keen ability to integrate strategy and tactical detail, Allison successfully brings the projects she leads to completion with tangible success. She brings her passion for strong hospital-physician relations to speaking engagements as at national and regional conferences and is a lead faculty member at the Physician Recruitment Intensive Training program provided by the American Academy of Medical Management (AAMM). She is the author of [*A Practice Development Primer*](#) and past president of the New England Society for Healthcare Strategy.