MERRITT HAWKINS
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White Paper Series

Examining topics affecting the recruitment and retention of physicians and advanced practice professionals

Rural Physician Recruiting Challenges and Solutions

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions company in the United States.

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Introduction

The challenges facing rural hospitals and other healthcare facilities are numerous and well documented.

A 2015 study completed by iVantage Analytics in partnership with the National Rural Health Association (NRHA) focused a bright light on some of these challenges. According to the study, 673 rural hospitals, or one out of three, are under financial duress and 210 are at high risk of closing. Hospitals in Southern states are particularly vulnerable. The study found that 79 percent of Mississippi rural hospitals are at risk, as are 53 percent of Georgia rural hospitals, 58 percent of Louisiana rural hospitals and 50 percent of rural Texas hospitals. Since 2010, 67 rural hospitals have closed nationwide.

The 673 rural facilities referenced in the study provide care to about 11.7 million people, employ 100,000 healthcare workers, 137,000 ancillary workers, and account for $277 billion in economic activity (see *Critical Action Needed for Critical Access Hospitals, HealthLeaders, February 17, 2016*).

The tenuous financial state of many rural hospitals is a result of various factors, including the 2013 budget sequestration which cut Medicare payments by 2 percent, as well as reductions in payments included in the Affordable Care Act (ACA). Nationally, mandated payment cuts have cost rural hospitals $2.8 billion in Medicare reimbursement, according to the iVantage study.

This includes cuts to disproportionate share (DSH) payments made to rural hospitals. These cuts were intended to be offset by Medicaid expansion as outlined in the ACA, but approximately 20 states have elected not to expand Medicaid. In addition, patients have not been signing up for the ACA-established state insurance exchanges in rural areas at the same rate that they have in urban areas.

Physician Staffing Challenges

Financial challenges facing rural hospitals often are compounded by physician staffing challenges. Just like professional sports teams, opera companies and gourmet restaurants, physicians tend to be located more frequently in large urban centers than they do in smaller, rural communities.

There are now over 6,080 Health Care Professional Shortage Areas (HPSAs) for primary care in the United States, about double the number identified by the Health Resources and Services Administration (HRSA) 15 years ago. Over 65 million people live in a primary care HPSA and 67 percent of HPSAs are in rural areas. The ratio of primary care providers to patients in these areas is less than one per 3,000. HRSA projects it would take 17,000 additional primary care clinicians to achieve a ratio of one primary care doctor per 3,000 patients in the nation's 6000-plus HPSAs.

HRSA also currently designates approximately 3,300 mental health HPSAs nationwide in which 80 million Americans live. These are areas in which there is less than one psychiatrist per 30,000 people. Rural areas in particular struggle to maintain psychiatric services. Texas, a large rural state, has 185 counties with no psychiatrist (see *The Physician Workforce in Texas,* a study of Texas physician demographics and distribution completed by Merritt Hawkins on behalf of the North Texas Regional Extension Center).

The chart below highlights the relative misdistribution of physicians, who tend to be concentrated in mostly urban states and diffused in mostly rural states.

Physicians per 100,000 Population by State

Alabama	206.0	Connecticut	337.8
Arkansas	198.1	Delaware	266.8
Idaho	189.6	Maryland	370.6
Mississippi	184.7	Massachusetts	432.4
Utah	207.5	Rhode Island	346.5

Source: Association of American Medical Colleges

Physician generally are trained in large metro areas and tend to stay in these areas after training. Many physicians are married to fellow professionals who may have limited job opportunities in smaller towns. The chart below illustrates the degree to which medical residents prefer larger communities to smaller ones.

Final-Year Medical Resident Practice Location Preferences by Community Size

10,000 or less	1%
10,001 – 25,000	2%
25,001 – 50,000	4%

50,001 – 100,000	10%
100,001 – 250,000	16%
250,001 – 500,000	20%
500,001 – 1 million	23%
Over 1 million	24%

Source: Merritt Hawkins 2015 Survey of Final-Year Medical Residents

As these numbers show, fewer than three percent of newly trained physicians prefer a community of 25,000 or less, while the majority (59%) prefer a community of 100,000 or more. According to the NRHA, only 9% of physicians practice in rural areas though 20% of the overall population lives in rural areas.

Rural Physicians and Spouses

In regard to spouses, the Journal of the American Medical Association (JAMA) in March, 2016, published a study showing that the number of physicians with highly educated spouses has increased significantly over the last several decades. According to the study, "The proportion of married physicians with highly educated spouses increased from 8.8% in 1960 to 54.1% in 2010." The study also notes that compared with other married physicians, physicians with a highly educated spouse were 38% less likely to work in a rural HPSA." In addition, "Single physicians were also less likely to work in a rural HPSA as were physicians who were young, women, black or Hispanic." (*Association Between Having a Highly Educated Spouse and Physician Practice in Rural Underserved Areas.* JAMA. March 1, 2016).

The Impact of Physician Shortages

The primary impact a lack of physicians has in rural areas is on quality of care. Lack of access to physicians can mean delays in getting care, poor continuity of care, lack of specialty services, lack of patient education, and related problems.

There also is the economic impact to consider. Merritt Hawkins' *2016 Survey of Physician Inpatient/Outpatient Revenue* indicates that physicians, on average, generate over $1.56 million a year in revenue for their affiliated hospitals. Without primary care physicians to admit patients, and without revenue generated by surgical and diagnostic specialists, rural hospitals can be put in an untenable financial bind.

A lack of physicians also can have a profound economic impact on the overall community.

A recent AMA-sponsored report estimated the total economic impact of patient care physicians in each of the 50 states, the District of Columbia and in the nation as a whole, using as barometers physician output, jobs, wages and benefits and state and local tax revenue. Highlights of physician economic contributions include:

Total economic output: The combined economic output of patient care physicians in the United States is $1.6 trillion.

Per capita economic output: Each physician supports a per capita economic output of $2.2 million.

Jobs: On average, each physician supports about 14 jobs.

Wages and benefits: On average, each physician supports a total of $1.1 million in wages and benefits.

Tax revenues: On average, each physician supports $90,449 in local and state tax revenues.

Strategies and Solutions: Maximize What You Can Control

Virtually all hospitals, medical groups, Federally Qualified Health Centers (FQHCs) and other healthcare facilities face challenges of one kind or another when it comes to recruiting physicians.

Some facilities are located in remote areas that historically are medically underserved. Others may have a prohibitively high cost of living, or feature weather extremes that make it difficult to generate physician interest, or suffer from depressed economies.

These and similar geographic, social and economic factors fall into the category of things healthcare facilities cannot control. They are what they are.

Rural healthcare facilities can do nothing about the fact that they may be in remote areas. What rural healthcare facilities can control to a significant extent is the quality of practice they offer physicians. Since physicians will be spending most of their time in the practice, and derive their professional satisfaction from it, it is imperative that the practice be as appealing as possible.

Due to the transformational changes taking place in healthcare today, many physicians are looking for a place where the “grass is greener,” so it is particularly important to offer a practice opportunity that stands out from others that physician candidates may be seeking.

Characteristics of a Positive Rural Practice Opportunity

A positive rural practice opportunity capable of drawing physician candidate interests includes the following elements:

Autonomy, Communication, Input

These are three key practice characteristics that many physicians value and which are increasingly difficult to find in large practice environments today.

Because rural facilities are small, communication between all stakeholders, including administration, is easier for physicians than in large bureaucratic institutions. Physicians can have a greater voice, can more effectively shape policy, and will not be cogs in the wheel of a major employer. Crucially, they also can maintain their clinical autonomy and enjoy more fulfilling physician/patient relationships than often is the case in larger facilities where treatment protocols and "cookbook" medicine are a fact of life. There are still a considerable number of physicians who value their independence, and rural areas are the last bastion of traditional private practice ownership. Even in cases where physicians are employed in rural areas they are likely to have a relatively high level of practice and clinical autonomy. The promise of autonomy can be a true ace in the hole for rural facilities seeking physicians.

Competitive Compensation Amount and Structure

Rural facilities often can demonstrate that the need in their area for the physician is high, competition limited, and the financial potential relatively high, allowing for competitive salary offers. For example, the average salary offer made to family physicians in all locations was $198,000, as tracked in Merritt Hawkins *2015 Review of Physician and Advanced Practitioner Recruiting Incentives.* The average salary offer made to family physicians in rural locations, however, was $212,762. (Note that both these numbers are likely to change in Merritt Hawkins *2016 Review of Physician Recruiting Incentives).*

While the financial offer should be as remunerative as possible, how physicians are compensated today is just as important as how much they are compensated. The key is to keep compensation formulas clear, understandable, and logical. In rural areas where volume/fee-for-service reimbursement remains more prevalent than in larger communities where capitated/value-based contracts are more standard, physicians can still feel confident that they will be rewarded based on objective standards such as patient volume and net collections. Additional compensation features such as educational loan forgiveness and housing allowance also can be attractive.

Flexibility

Physicians are becoming more diverse in many ways and one practice size may not fit all, particularly when it comes to schedules. Part-time schedules and other flexible practice options are becoming more important to physicians than most others factors, including compensation. Schedule flexibility may be difficult to achieve in rural areas, but physicians should be given as much scheduling latitude as possible, and this may include the use of locum tenens physicians.

United Health Centers of San Joaquin Valley, a seven-site FQHC based in rural Parlier, California, has had considerable success recruiting and retaining physicians. Physicians, on average, stay for ten years at the center. One reason is that the practice structure has built-in flexibility.

Ron Yee, M.D., former Chief Medical Officer at Parlier and Chief Medical Officer of the National Association

of Community Health Centers (NACHC) attributes the center's recruiting and retention success to personal communication with each physician, which leads to practice customization (Note: Merritt Hawkins is NACHC's preferred permanent physician search provider). "I find out if there is a niche physicians want to fill and allow them to do that," Dr. Yee indicates. "Our staff has flexibility and feels supported." Below is the Parlier physician recruitment and retention model:

Parlier Physician Recruitment/Retention Model

- 7 weeks of leave, day one. Includes 4 weeks of vacation, 1 week of CME, 9 paid holidays, including the physician's birthday
- Call not required
- 40 hour work week
- Flex-time available, 9 am to 5 pm not required. Physicians can modify schedules to fit family events, etc.
- Part-time practice is an option. Ten of the center's 25 doctors are part-time
- Latitude to physicians who want to perform specific procedures
- Three exam rooms and two medical assistants for each physician
- Productivity bonus: $17,000 for those who average 23 patients per day; about $29,000 for those who average 25 patients a day
- $6,000 bonus for taking call
- $5,000 to $7,000 signing bonus
- Additional pay for services provided to the hospital
- Some physicians earn $200,000 with salary, production bonus and call pay

Not all rural practices can be structured in this way, but rural facilities should make every effort to tailor the practice to the preferences of worthy candidates rather than taking a one size fits all approach. Often, it is the ability of rural facilities to respond to the unique needs of each physician that allows for physician recruiting success. Such personal attention and responsiveness is harder to achieve at larger facilities and can set rural practice opportunities apart.

Support

Rural physicians are by circumstances more professionally isolated than urban physicians and can feel they are on an island. Administration can show support by adding services through the use of nurse practitioners, physician assistants, locum tenens physicians, and telemedicine. Support also may range from areas like practice marketing to ensuring the physician's wife and children have the community resources they need. When possible, it is particularly important to assist the spouse in finding employment opportunities, as many physicians today are married to professionals and may be reluctant to move to rural areas if there are no employment opportunities for the spouse.

Additional Rural Physician Recruiting Strategies

Creating the most positive practice environment possible is one key to effective rural physician recruiting. However, there are other strategies rural healthcare facilities can employ to enhance their physician recruiting success. These include:

A Sense of Urgency

Smaller facilities can benefit by showing physician candidates that "they want it more" than other facilities candidates may be considering Unhampered by the bureaucratic decision making and process turnaround structures of larger organizations, rural facilities can be more nimble and responsive to candidate requests for information and decisions.

In addition, by putting on a "full court press" during interviews they can show candidates that they are truly wanted in the community. The pro bono search effort that Merritt Hawkins conducted for the hospital in Weiser, Idaho provides one such example. During the physician interview, there were signs in shop windows welcoming the physician and his spouse, a float recognizing him in the homecoming parade, and the physician was introduced to the crowd at the half-time of the football game. Every effort was made to make the physician and his spouse feel welcomed, and by the end of the visit the physician was virtually obliged to accept the offer, which he did.

Physician candidates are in short supply virtually everywhere, and rural facilities need to make it a priority to accommodate candidate schedules on interviews, be as competitive as possible on compensation, and be highly responsive and flexible during the recruiting process.

A Knowledgeable Board

There are instances where hospital or FQHC board members may not understand the need to be financially competitive or otherwise accommodating to physician candidates in the recruiting process. Data regarding the current physician recruiting market and current physician compensation levels can help educate board members to the realities of physician recruiting today. Merritt Hawkins provided content to the Texas Healthcare Trustees' (THT) *Trustee Guidebook: Physicians and Medical Staff,* an informational resource on the physician market for hospital trustees that outlines current physician recruiting challenges. Merritt Hawkins can provide the Guidebook, along with a number of surveys and white papers examining the current physician recruiting market, to rural facilities that need to educate their boards on these topics.

Practical Candidate Parameters

The ideal physician candidate often fits a certain mold. Ivy Leagued-trained with movie star looks is what many healthcare facilities, both rural and non-rural, have in mind when formulating candidate parameters. The reality, however, is that the right candidate is the one who wants to be in your community, communicates well, has a strong work ethic and the requisite clinical skills. It is more effective to focus on these qualities

than on an idealized image of what a candidate should be. Candidate parameters should be set in writing before the search and should be inclusive of all physicians who possess the needed attributes, whether they are older than 50, female, a minority member or internationally trained. The first candidate who possesses the majority of the necessary commitment, skills, and personality should be made an offer. It is a mistake to "comparison shop" in today's market, because candidates who do not receive a timely offer usually move on.

Obtain a HPSA Designation

There are many reasons why a rural hospital, medical group or other healthcare organization would want to ensure that its service area be federally designated as a HPSA (Health Professional Shortage Area) or a MUA (Medically Underserved Area).

HPSA or MUA designation may qualify a healthcare facility or a community for 29 federal programs or benefits, including status as a Federally Qualified Health Center (FQHC), ***the ability to use National Health Services Corps physicians***, funding for electronic health records, scholarships for students interested in becoming doctors, and a 10% increase in Medicare reimbursement.

Healthcare facilities also need HPSA or MUA designation to sponsor internationally-born physicians on J-1 visas for a waiver of the two-year home residency requirement. This is the rule that compels physicians on J-1 visas to return to their home countries for two-years before practicing in patient care roles in the United States. A waiver of this rule can be obtained if the physician can find employment with a sponsoring healthcare facility in a federally designated HPSA or MUA.

Approximately 6,000 to 7,000 of all final-year medical residents and fellows entering the workforce each year in the United States are international medical graduates (IMGs) – or one quarter of the total. Of these, the great majority are born overseas and train in the United States on J-1 or H-1 visas. Since those on J-1 visas almost always seek out employment in underserved areas in order to obtain J-waivers, they can be an important resource for rural healthcare facilities in such areas requiring physicians.

In addition, most international doctors wishing to obtain green cards using National Interest Waivers (an expedited form of green card processing) must practice in a designated shortage area for five years before being granted permanent residence. Suggestions for obtaining HPSA designation are included in the Merritt Hawkins' white paper, *Recommendations for Obtaining a HPSA Designation for the Purpose of Sponsoring International Physicians for J-Waivers.*

Grow Your Own

Many rural healthcare facilities have had success "growing their own" physicians. In some cases, this may mean identifying local students interested in medical careers and sponsoring their education in return for their commitment to practice in the community. Dr. Jasmine Sulaiman, who was named 2016 Country Doctor of the Year by Staff Care (Merritt Hawkins' sister company and a division of AMN Healthcare) began a program of speaking at the local high school in Cleveland, Texas on the topic of medical careers. A local student now is in medical school and in several years may provide the help that Dr. Sulaiman needs. Dr. Sulaiman also

has recruited a total of seven physician assistants and nurse practitioners to the FQHC where she serves, all of whom rotated through her practice. Dr. John Haynes of Vivian, Louisiana, Staff Care's first Country Doctor of the Year (1992) worked with academic centers in his state to establish a rural residency program in his practice which has placed over ten primary care physicians in rural practice. Physicians on staff who have a mission for rural medicine can be an important asset in "growing your own."

Leverage Your Web Site

Before the Internet, physician candidates generally had to visit a community before they could truly visualize it. Now, as soon as they learn where an opportunity is, they can visit a chamber of commerce site or use Google Maps to take a virtual tour. It therefore is important that the facility offer as many positive images as possible through its web site and that the hope page include a link to a section of the site devoted to recruiting physicians and other healthcare professionals. This section should feature video testimonials from current staff physicians extolling the benefits of the practice and the community. Perhaps the best recruiting resource available to healthcare facilities of all kinds is current staff physicians who are satisfied and welcoming, and these doctors should be leveraged on the site and during interviews. The site also may include virtual tours of the community, featuring images of schools, favorable real estate options, recreational areas and other highlights. It also is important to coordinate with the local chamber how the community is portrayed online so that the message is consistent and positive.

Leave No Stone Unturned

Rural facilities should be in continual "recruitment mode" to assure staffing needs are met. This means networking with clinicians already in the community as well as with other community members to determine if any have friends or relatives in medical school, in residency or in practice who would consider a rural practice. It also means creating relationships with residency programs state-wide, using resources available through the NRHA, and networking with state medical and specialty societies. When an active search is in progress, multiple sourcing tools are available, including personal mail, physician employment sites, social media, journals, physician conventions, and email. Personal mail offers a key advantage in that it allows rural facilities to target physicians born, trained or licensed in the state or those practicing in rural zip codes. It is physicians who are from rural areas or now practicing in rural areas who are more likely to select a rural practice and it is important to focus on these in sourcing efforts.

About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- Physician and Hospital Reimbursement: From "Lodge Medicine" to MIPS
- Telehealth: The Integration of Telecommunication into Patient/Provider Encounters
- Population Health Management and Physician Staffing
- Convenient Care: Growth and Staffing Trends in Urgent Care and Retail Medicine
- Psychiatry: "The Silent Shortage"
- The Aging Physician Workforce: A Demographic Dilemma
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- The Physician Shortage: Data Points and State Rankings
- Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- The Economic Impact of Physicians
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