



The Reyes Building, 801 Thompson Avenue, Ste 400, Rockville, MD 20852 | Conducted by Merritt Hawkins, an AMN Healthcare company | www.ihs.gov | © Indian Health Service

2011 SURVEY OF PHYSICIAN PRACTICE PATTERNS & SATISFACTION

A SURVEY EXAMINING THE PRACTICE CHARACTERISTICS, MORALE LEVELS, AND RECRUITING NEEDS OF INDIAN HEALTH PROGRAM PHYSICIANS

2011 SURVEY OF PHYSICIAN PRACTICE PATTERNS & SATISFACTION

A SURVEY EXAMINING THE PRACTICE CHARACTERISTICS, MORALE LEVELS, AND RECRUITING
NEEDS OF INDIAN HEALTH PROGRAM PHYSICIANS



IN THIS REPORT

| | |
|--|-------------|
| INTRODUCTION | PAGE 3 |
| METHODOLOGY | PAGE 4 |
| ABOUT MERRITT HAWKINS | PAGE 4 |
| KEY FINDINGS | PAGES 5-6 |
| SUMMARY | PAGE 6 |
| QUESTIONS ASKED AND RESPONSES RECEIVED | PAGES 7-17 |
| OVERVIEW - A QUESTION OF CONTEXT | PAGES 18-19 |
| ANALYSIS: ABOUT SURVEY RESPONDENTS | PAGES 20-21 |
| PRACTICE PATTERNS AND CHARACTERISTICS | PAGES 21-23 |
| NON-CLINICAL WORKS | PAGES 23-35 |
| PHYSICIAN COMMENTS | |
| POSITIVE AND NEGATIVE COMMENTS | PAGES 36-37 |
| PHYSICIAN COMMENTS | |
| QUESTION 1 AND QUESTION 2 | PAGES 38-49 |
| KEY PRIORITIES | PAGE 50 |
| CONCLUSION | PAGES 51 |

INTRODUCTION



Dr. Yvette Roubideaux
Director, Indian Health Service

What is the “state of the union” of physicians working with Indian health program facilities?
What common practice patterns and metrics do Indian health program physicians share?
What are their practice plans for the future and how satisfied are they in their careers?
What recruitment needs and challenges do they face and how do they compare working with Indian health program facilities to working in other settings?

Through Merritt Hawkins, a national physician search and consulting firm, the Indian Health Service (IHS) initiated its *2011 Survey of Physician Practice Patterns and Career Satisfaction* to provide answers to these and related questions. The goal of the survey is to identify common characteristics of Indian health program practices, to gauge the satisfaction levels of Indian health program physicians, and to determine ways in which IHS can support physicians on the front lines of care with their practice and recruiting needs.

The survey will be used to determine strategic directions and to allocate resources to assist Indian health program facilities with recruitment, retention and related issues.

IHS/KEY PRIORITIES

IHS is the principal federal health care provider and health advocate for Indian people providing a comprehensive health service delivery system for over 50 years. Indian health program facilities deliver health services directly to patients, many living in small, rural communities or urban areas that traditionally have been underserved, thereby raising the health of American Indians and Alaska natives.

The survey was conducted in support of IHS’s key priorities:

1. To renew and strengthen our partnership with tribes
2. To reform the IHS
3. To improve quality of and access to care
4. To make all our work accountable, transparent fair and inclusive

The Analysis section of this report examines survey responses and reviews how the survey advances and supports the key priorities listed above.

METHODOLOGY

IHS provided Merritt Hawkins with a list of some 400 Indian health program facilities and organizations to contact. In some cases, the list included the name of physicians affiliated with the facilities. In others, no physician names were attached to the facilities. A Merritt Hawkins' Research Director refined this list by calling each facility to obtain the names and emails of two physicians, where possible. In some cases, facilities on the list provided by IHS are engaged in community outreach or other services and do not provide clinical care. Surveys were not sent to physicians at these facilities. In other cases, facilities on the list have closed. In additional cases, facilities have no physicians on staff and are staffed by non-physician providers. Where two physicians were not present or otherwise unavailable, one physician's name and email were obtained. No names were obtained at those facilities without a physician.

The final list included 420 physicians located at 255 facilities.

Merritt Hawkins emailed the survey to these physicians on four separate occasions, once in December, 2010, twice in January, 2011, and once in February, 2011. Merritt Hawkins' Research Director called each physician on the list who did not respond to the initial email at least once and called a number of physicians on the list multiple times to encourage them to respond. IHS also emailed the survey to physicians who did not respond to initial emails sent by Merritt Hawkins.

A total of 114 responses to the survey were received for a response rate of 27%.



ABOUT MERRITT HAWKINS

Established in 1987, Merritt Hawkins is the largest physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AHS), the largest healthcare staffing organization in the country. Merritt Hawkins conducts over 2,500 physician search assignments for hospitals, medical groups, government facilities and other entities each year nationwide. A leading source of physician recruiting research and commentary, Merritt Hawkins has completed various surveys used throughout the industry to benchmark physician recruiting incentives, physician revenue generation, physician career plans and related topics. Data and commentary generated by Merritt Hawkins have been cited in hundreds of media outlets, including The New York Times, The Wall Street Journal, Fortune, The Economist, USA Today, The Washington Post, U.S. News & World Report, Hospitals & Health Networks, Modern Healthcare, American Medical News and many others. Executives with Merritt Hawkins have authored hundreds of articles on physician staffing topics as well as three books, including *Will the Last Physician In America Please Turn Off the Lights? A Look at America's Looming Physician Shortage*; *Merritt Hawkins Guide to Physician Recruiting*; and *In Their Own Words, 12,000 Physicians Reveal Their Thoughts on Medical Practice in America*.

KEY FINDINGS

Indian health program physicians and other clinical providers serve a unique patient population, often in rural or other traditionally underserved areas. While these providers face some of the same challenges common to physicians in other settings, they form a distinct medical workforce with its own procedures, processes, concerns and rewards.

The 2011 Survey of Physician Practice Patterns and Career Satisfaction offers an overview of the practice patterns of Indian health program physicians, the clinical staffing needs they perceive at their facilities, their current state of professional satisfaction, their future practice plans, and the ways in which they believe Indian health programs can support their practices and their clinical recruiting efforts. Findings of the survey are analyzed in this report through Merritt Hawkins' perspective as a national physician search and consulting firm, in order to place the practice metrics and satisfaction levels of Indian health program physicians in the context of the overall physician recruiting market.

Key findings of the survey include:

Practice metrics and characteristics revealed by the survey suggest Indian health programs offer a relatively favorable practice style. For example:

- The majority of Indian health program physicians surveyed (67%) work 50 or fewer hours per week, relatively fewer hours than physicians in non-Indian health program settings Merritt Hawkins has surveyed.
- Indian health program physicians generally spend fewer hours on non-clinical "paperwork" duties than physicians in other settings Merritt Hawkins has surveyed.
- The majority of Indian health program physicians (83%) see 20 or fewer patients per day, relatively fewer patients per day than physicians in other settings Merritt Hawkins has surveyed.
- Indian health program physicians spend more time per patient than non-Indian health program physicians.
- Eighty-nine percent of Indian health program physicians described their relationship with their local hospitals to be either sometimes supportive and positive or generally supportive and positive.
- Physicians cited "malpractice climate" as one of the most satisfying elements of practicing in an Indian health program facility. Malpractice climate generally is cited as a negative by other physicians Merritt Hawkins has surveyed.

Based in part on these metrics, the majority of Indian health program physicians (78%) said they find working for Indian health programs to be as satisfying or more satisfying than working in other settings.

Seventy-two percent of Indian health program physicians indicated that they find their practices to be somewhat satisfying to very satisfying, a higher number than physicians in other settings Merritt Hawkins has surveyed.

71% of physicians indicated that in the next one to three years they will continue practicing with Indian health programs, indicating a greater commitment to their current practice style than non-Indian health program physicians Merritt Hawkins has surveyed, only 26% of whom indicated they will continue in their current practice style over the next one to three years.

The majority of Indian health program physicians (51%) indicated there is an urgent need at their facilities for additional primary care physicians. A smaller number (26%) said there is an urgent need for non-physician clinicians such as PAs, NPs, registered nurses and others.

Seventy-two percent of physicians described physician turnover at their facilities as somewhat of a concern or a major concern.

The majority of physicians (66%) indicated that health care reform will either moderately increase or significantly increase the need for physicians and other clinicians at their facilities.

Physicians cited “paperwork/red tape,” “politics,” “human resources,” and “IHS policies and priorities” as the most unsatisfying elements of practicing in an Indian health program facility.

SUMMARY

The survey suggests Indian health program physicians are relatively satisfied in their practices and that Indian health programs have an attractive practice “brand” to offer recruiting candidates. However, it also points to a variety of challenges and concerns that should be addressed in order to enhance the satisfaction of Indian health program physicians and to improve physician recruiting and retention efforts.

A more detailed analysis of survey responses is included in this report.

Following is a breakdown of questions asked by the survey and responses received.

A controllable lifestyle is one of the most important, if not the most important, aspects of a practice opportunity candidates will consider when seeking a position. Many candidates today are seeking practices where they have little or no inpatient responsibilities and minimal to no on-call obligations.

QUESTIONS ASKED AND RESPONSES RECEIVED

1 WHAT IS YOUR PROFESSION?

| | |
|---------------------|--|
| Physician (MD) | 77% |
| Physician (DO) | 18% see discussion in the Analysis section |
| Nurse Practitioner | 4% |
| Physician Assistant | 1% |

2 WHAT IS YOUR MEDICAL SPECIALTY?

| | | |
|--------------------|-----|---|
| Family Medicine | 65% | Other: • Podiatry (4) • Naturopath • Optometrist • IM/Pediatrics • Medical Officer |
| Internal Medicine | 9% | |
| Pediatrics | 8% | |
| OB/GYN | 5% | |
| Anesthesiology | 0% | |
| General surgery | 3% | |
| Otolaryngology | 0% | |
| Emergency Medicine | 0% | |
| Orthopedic surgery | 0% | |
| Psychiatry | 2% | |
| Radiology | 0% | |
| Ophthalmology | 0% | |
| Other | 8% | |

3 WHAT IS YOUR GENDER?

| | |
|--------|-----|
| Male | 63% |
| Female | 37% |



4 HOW MANY YEARS HAVE YOU BEEN IN PRACTICE (POST RESIDENCY TRAINING?)

| | |
|-------|-----|
| 0-5 | 15% |
| 6-10 | 14% |
| 11-15 | 20% |
| 16-20 | 11% |
| 21-25 | 15% |
| 26+ | 25% |

5 HOW MANY YEARS HAVE YOU BEEN WITH INDIAN HEALTH PROGRAMS?

| | |
|-------|-----|
| 0-5 | 44% |
| 6-10 | 17% |
| 11-15 | 20% |
| 16-20 | 6% |
| 21-25 | 7% |
| 26+ | 6% |

6 IN WHAT SIZE COMMUNITY DO YOU PRACTICE?

| | |
|-------------------|-----|
| 0-5,000 | 32% |
| 5,001-10,000 | 19% |
| 10,001-25,000 | 27% |
| 25,001 to 100,000 | 12% |
| 100,001 or more | 10% |

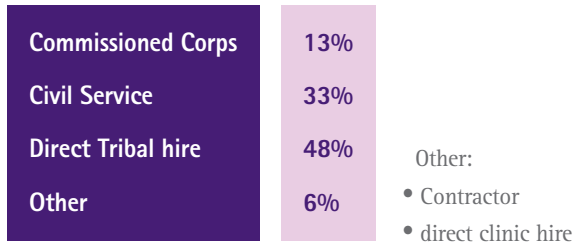
7 IN WHAT STATE DO YOU PRACTICE?

| | | | | | | | |
|------------|-----|------------|----|--------------|-----|----------------|-----|
| Oklahoma | 29% | Washington | 5% | Minnesota | 2% | Illinois | <1% |
| Arizona | 13% | Wisconsin | 5% | North Dakota | 2% | Maine | <1% |
| California | 12% | Oregon | 4% | South Dakota | 2% | South Carolina | <1% |
| New Mexico | 8% | Nevada | 4% | Colorado | <1% | Texas | <1% |
| Alaska | 5% | Montana | 2% | Idaho | <1% | Wyoming | <1% |

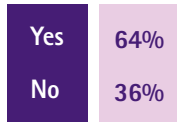
8 WITH WHAT TYPE OF FACILITY ARE YOU AFFILIATED?

| | |
|---------|-----|
| Federal | 46% |
| Tribal | 50% |
| Urban | 4% |

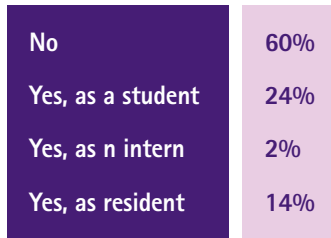
9 UNDER WHAT PERSONNEL SYSTEM ARE YOU EMPLOYED?



10 IS YOUR PRIMARY RESIDENCE IN A RURAL COMMUNITY?



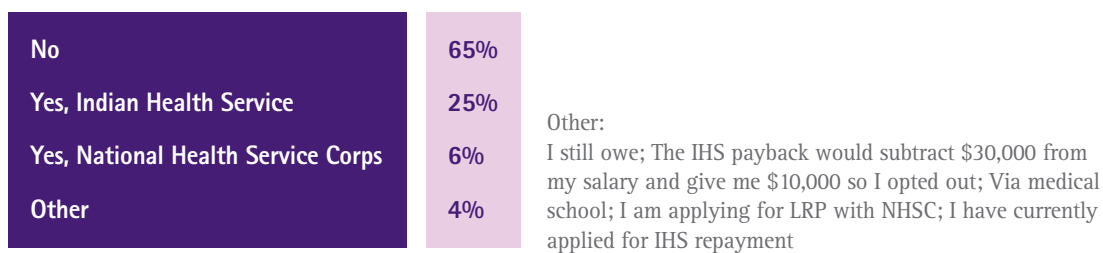
11 DID YOU ROTATE IN AN INDIAN HEALTH PROGRAM AS A STUDENT, INTERN OR RESIDENT?



12 DO/DID YOU HAVE A SCHOLARSHIP OBLIGATION?



13 ARE YOU/WERE YOU A LOAN REPAYMENT RECIPIENT?



Part II: PRACTICE CHARACTERISTICS

1 ON AVERAGE, HOW MANY HOURS DO YOU WORK PER WEEK?
(INCLUDE ALL TIME SPENT ON CLINICAL,
ADMINISTRATIVE AND OTHER DUTIES)

| | |
|------------|-----|
| 0-20 hours | 0% |
| 21-30 | 3% |
| 31-40 | 16% |
| 41-50 | 48% |
| 51-60 | 24% |
| 61-70 | 5% |
| 71-80 | 0% |
| 81 or more | 4% |

2 HOW MANY HOURS A WEEK DO YOU SPEND SOLELY ON NON-CLINICAL, ADMINISTRATIVE DUTIES?

| | |
|-----------|-----|
| 0-5 hours | 39% |
| 6-10 | 28% |
| 11-15 | 9% |
| 16-20 | 5% |
| 21-25 | 4% |
| 26-30 | 4% |
| 31-35 | 3% |
| 36-40 | 8% |

3 ON AVERAGE, HOW MANY PATIENTS DO YOU SEE PER DAY?

| | |
|------------|-----|
| 0-10 | 17% |
| 11-20 | 66% |
| 21-30 | 13% |
| 31-40 | 4% |
| 41-50 | 0% |
| 51-60 | <1% |
| 61 or more | 0% |

4 ON AVERAGE, ABOUT HOW MANY MINUTES ARE YOU ABLE TO SPEND PER PATIENT?

| | |
|---------|-----|
| 0-5 | 3% |
| 6-10 | 5% |
| 11-15 | 25% |
| 16-20 | 32% |
| 21-25 | 23% |
| 26-30 | 7% |
| Over 39 | 5% |

5 WHICH OF THE FOLLOWING BEST DESCRIBES YOUR CURRENT PRACTICE?

| | |
|--|-----|
| I usually have time to fully communicate with and treat all patients | 41% |
| I sometimes have time to fully communicate with and treat all patients | 41% |
| I am overextended and overworked | 18% |

6 ABOUT WHAT PERCENT OF YOUR PATIENTS FALL INTO THE FOLLOWING AGE GROUPS?

| | |
|-----------------|-----|
| 0-18 years old | 21% |
| 19-30 years old | 15% |
| 31-50 years old | 23% |
| 51-65 years old | 24% |
| 66 or older | 17% |

7 TYPICALLY, IF A PATIENT CONTACTS YOUR OFFICE OR IS REFERRED TO YOU, HOW LONG WOULD THAT PATIENT WAIT UNTIL THE FIRST AVAILABLE APPOINTMENT? SEE ANALYSIS SECTION.

| URGENT PATIENT | | NON URGENT PATIENT | |
|-----------------|-----|--------------------|-----|
| Same day | 75% | Same day | 7% |
| 2-5 days | 14% | 2-5 days | 27% |
| 6-10 days | 3% | 6-10 days | 17% |
| 11-20 days | 1% | 11-20 days | 11% |
| 21-30 days | 2% | 21-30 days | 9% |
| 31-40 days | 0% | 31-40 days | 11% |
| 41-50 days | 0% | 41-50 days | 4% |
| 51-60 days | 0% | 51-60 days | 5% |
| 61-70 days | 1% | 61-70 days | 2% |
| 71 days or more | 1% | 71 days or more | 5% |
| not applicable | 3% | not applicable | 2% |

8 WHICH BEST DESCRIBES YOUR ABILITY TO REFER PATIENTS TO SPECIALISTS IN YOUR AREA?

| | |
|--|-----|
| Ready access to specialists (0-7 days) | 11% |
| Moderate access to specialists (7-21 days) | 60% |
| Poor access to specialists (more than 21 days) | 27% |
| Not applicable | 2% |

9 HOW ARE YOU COMPENSATED?

| | |
|--|-----|
| Title 38 | 27% |
| Title V | 4% |
| Recruitment, Retention, Relocation Incentive (3Rs) | 7% |
| Physician Comparability Allowance (PCA) | 10% |
| Other | 52% |

Other:

Straight salary from the clinic; Commissioned Corps; Commissioned Corps; Commissioned Corps; Don't know Salary; Public Health Service; Negotiated salary; Tribal hire salary; Not sure; Direct Tribal hire; MOA; I have no idea; By tribal payment; Tribal hire; Tribal contract; Salary; Salary; Tribal hire; Don't understand question; Salaried; Unsure; Negotiated salary; Commission Corps base pay and retention bonuses; Self employed contractor; Not really sure; Salary; Contract negotiation; Direct hire compacted tribe; Tribal salary

10 DO YOU HAVE INPATIENT DUTIES AT YOUR SITE OR AT THE LOCAL HOSPITAL?

| | |
|-----|-----|
| Yes | 35% |
| No | 65% |

11 WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ON-CALL ARRANGEMENT?

| | |
|-----------------------------------|-----|
| I have no on-call duties | 58% |
| I have minimal on-call duties | 28% |
| I have significant on-call duties | 20% |

13 HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH THE LOCAL HOSPITAL OR HOSPITALS?

| | |
|-------------------------------|-----|
| Generally supportive/positive | 65% |
| Sometimes supportive/positive | 24% |
| Rarely supportive/positive | 5% |
| NA | 6% |

1 HOW WOULD YOU RATE THE NEED FOR ADDITIONAL PRIMARY CARE PHYSICIANS AMONG THE POPULATION YOUR FACILITY SERVES?

| | |
|-------------------|-----|
| No immediate need | 13% |
| Moderate need | 36% |
| Urgent need | 51% |

2 HOW WOULD YOU RATE THE NEED FOR ADDITIONAL SPECIALISTS AMONG THE POPULATION YOUR FACILITY SERVES?

| | |
|-------------------|-----|
| No immediate need | 14% |
| Moderate need | 50% |
| Urgent need | 36% |

3 IS YOUR PRACTICE/FACILITY CURRENTLY RECRUITING PHYSICIANS?

| | |
|-----|-----|
| Yes | 64% |
| No | 36% |

4 HOW DIFFICULT IS IT TO RECRUIT PHYSICIANS TO YOUR PRACTICE/FACILITY?

| | |
|---------------------------|-----|
| Very difficult | 43% |
| Moderately difficult | 45% |
| Not difficult | 5% |
| Not applicable/don't know | 7% |

5 HOW WOULD YOU RATE THE NEED FOR ADDITIONAL NON-PHYSICIAN CLINICIANS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, PHARMACISTS, DENTISTS, NURSES, ETC.) AT YOUR PRACTICE/SITE?

| | |
|-------------------|-----|
| No immediate need | 24% |
| Moderate need | 50% |
| Urgent need | 26% |

6 IS YOUR PRACTICE/SITE CURRENTLY RECRUITING NON-PHYSICIAN CLINICIANS?

| | |
|-----|-----|
| Yes | 56% |
| No | 44% |



7 HOW DIFFICULT IS IT TO RECRUIT NON-PHYSICIAN CLINICIANS TO YOUR PRACTICE/SITE?

| | |
|---------------------------|-----|
| Very difficult | 16% |
| Moderately difficult | 50% |
| Not difficult | 37% |
| Not applicable/don't know | 17% |

8 HOW WOULD YOU DESCRIBE PHYSICIAN TURNOVER AT YOUR SITE?

| | |
|---|-----|
| Low – turnover not a concern | 28% |
| Moderate – turnover somewhat of a concern | 52% |
| High -- turnover is a major concern | 29% |

9 WHAT EFFECT DO YOU BELIEVE HEALTHCARE REFORM WILL HAVE ON THE NEED FOR PHYSICIANS AND OTHER CLINICIANS IN YOUR AREA?

| | |
|--|-----|
| No effect | 32% |
| Will decrease need for physicians/other clinicians | 2% |
| Will moderately increase need for physicians/other clinicians | 42% |
| Will significantly increase need for physicians/other clinicians | 24% |

1 OVER THE PAST ONE TO TWO YEARS, HAVE YOU FOUND PRACTICE TO BE:

| | |
|--------------------------|-----|
| More satisfying than now | 31% |
| Less satisfying than now | 24% |
| No change | 45% |

2 HOW DO YOU NOW FIND YOUR PRACTICE?

| | |
|-----------------------|-----|
| Very satisfying | 25% |
| Somewhat satisfying | 47% |
| Very unsatisfying | 16% |
| Somewhat unsatisfying | 12% |

3 WHAT DO YOU FIND SATISFYING ABOUT PRACTICING IN AN INDIAN HEALTH PROGRAM?

| | VERY SATISFYING | SOMEWHAT SATISFYING | LEAST SATISFYING |
|--------------------------------------|-----------------|---------------------|------------------|
| Prestige of position | 10% | 41% | 49% |
| Working with the IHS system | 24% | 46% | 30% |
| Overall IHS practice style | 33% | 54% | 13% |
| Overall clinical autonomy | 40% | 46% | 14% |
| Work schedule/free time | 40% | 49% | 11% |
| Professional/collegial relationships | 46% | 47% | 6% |
| Mission-driven care | 51% | 38% | 11% |
| Intellectual stimulation | 52% | 40% | 8% |
| Patient relationships | 74% | 22% | 4% |
| Malpractice climate | 65% | 31% | 4% |

The most positive aspect of Indian health program practice cited by physicians was malpractice climate.

4 HOW WOULD YOU RATE THE EFFECT OF THE FOLLOWING FACTORS ON YOUR EMPLOYMENT IN AN INDIAN HEALTH PROGRAM?

| | SATISFYING | NEUTRAL | UNSATISFYING |
|---|------------|---------|--------------|
| Spousal support/opportunities | 29% | 55% | 16% |
| Pay | 46% | 39% | 14% |
| Paperwork/red tape | 9% | 32% | 59% |
| Adequacy of housing | 30% | 59% | 11% |
| Mobility | 21% | 69% | 11% |
| Schools | 21% | 61% | 18% |
| Politics | 7% | 35% | 58% |
| Short-term/long-term training opportunities | 22% | 54% | 24% |
| Equipment | 32% | 46% | 23% |
| IHS policies and priorities | 15% | 46% | 39% |
| Professional isolation | 13% | 58% | 29% |
| Appreciation in community | 55% | 30% | 15% |
| Support staff | 53% | 27% | 20% |
| Administrative duties | 17% | 59% | 24% |
| Administrative support | 23% | 40% | 37% |
| Health care | 51% | 38% | 11% |
| Safety | 40% | 50% | 11% |
| Child care | 9% | 72% | 19% |
| Cultural amenities | 33% | 53% | 14% |
| Human resources | 19% | 42% | 39% |
| Information Technology | 30% | 36% | 35% |

5 HAVE YOU WORKED IN MEDICAL SETTINGS OTHER THAN INDIAN HEALTH PROGRAMS?

| | |
|-----|-----|
| Yes | 85% |
| No | 15% |

6 IF YES, HOW DO YOU RATE WORKING WITH INDIAN HEALTH PROGRAMS COMPARED TO WORKING IN OTHER SETTINGS?

| | |
|---|-----|
| Working with Indian health programs is more satisfying | 44% |
| Working with Indian health programs is less satisfying | 22% |
| Indian health programs and other settings are equaling satisfying | 34% |

7 IN WHAT WAYS COULD INDIAN HEALTH PROGRAMS ASSIST YOU IN YOUR PRACTICE?

| | VERY IMPORTANT | SOMEWHAT IMPORTANT | LEAST IMPORTANT |
|--|----------------|--------------------|-----------------|
| Assist with physician recruiting | 59% | 25% | 15% |
| Assist with NP/PA recruiting | 41% | 35% | 24% |
| Assist in dental & pharmacy recruiting | 30% | 45% | 25% |
| Improve financial incentives | 57% | 37% | 5% |
| Reduce paperwork | 66% | 31% | 3% |
| Fewer hours/more personal time | 27% | 55% | 18% |
| Flexible hours | 52% | 35% | 13% |

8 WHAT DO YOU PLAN TO DO IN THE NEXT ONE TO THREE YEARS? (CHECK ALL THAT APPLY)

| | |
|--|-----|
| Continue working as I am | 71% |
| Retire | 7% |
| Seek a clinical position outside Indian health programs | 18% |
| Seek a non-clinical position within Indian health programs | <1% |
| Seek advanced education/training | 4% |
| Other | 12% |

Other:

Seek another clinical position with IHS; Seek new position in IHS program at different location; Continue working but consider retirement; Plan to stay as long as a new clinical director is hired within this calendar year; 30 years in 3 years six months then double back; Always looking for a GS15 position; Wish for reduced hours; Need more \$ for kids college, will moonlight in Urgent Care; I'd like a part time position with IHS

9 DOES YOUR SITE HAVE A RECRUITMENT AND RETENTION PLAN IN PLACE?

| | |
|------------|-----|
| Yes | 33% |
| No | 25% |
| Don't know | 42% |

Merritt Hawkins' analysis and commentary regarding survey responses follows.

OVERVIEW - A QUESTION OF CONTEXT

The Indian Health Services' 2011 Survey of Physician Practice Patterns and Career Satisfaction was conducted during a time of profound change in the medical profession.

The traditional paradigm of physician practice, characterized by solo or small group practitioners operating as independent business owners, is rapidly evolving into a more corporate model, in which physicians are employed by hospitals, medical groups or other entities. According to a Medical Group Management Association (MGMA) survey, the number of active physicians employed by hospitals has increased 75% since 2000, with 75% of hospital leaders stating they plan to employ a greater percentage of physicians over the next two to three years.¹

Similarly, Merritt Hawkins, which tracks the characteristics of its physician search assignments each year, has observed a significant shift toward employed settings and away from private practice settings. In 2004, 11% of the physician search assignments Merritt Hawkins conducted nationwide featured hospital employment of the physician. By 2011, that number had grown to 56%.²

Physicians are seeking alternatives to traditional private practice in order to escape from what they perceive is an increasingly untenable practice environment marred by problematic reimbursement, excessive regulation, the threat of malpractice, rising costs and a rift in the physician/patient relationship. In a survey of some 12,000 physicians Merritt Hawkins conducted on behalf The Physicians Foundation, a non-profit grant making organization composed of over 20 state and regional medical societies (see www.physiciansfoundation.org), 78% of physicians surveyed said that the practice of medicine had become less satisfying in the last five years. Only six percent described the morale of doctors as positive.³

In a subsequent survey of physicians Merritt Hawkins conducted, also on behalf of The Physicians Foundation, 49% of doctors said their attitude toward medicine prior to passage of the 2010 health reform bill was somewhat negative or very negative. After health reform passed, 65% of physicians said their attitude toward medicine was somewhat negative or very negative.⁴

Results of the former survey were included in a book Merritt Hawkins authored with executives of The Physicians Foundation, including Louis Goodman, Ph.D., Chief Executive Officer of the Texas Medical Association, entitled *In Their Own Words, 12,000 Physicians Reveal Their Thoughts on Medical Practice in America*. In addition to results of the survey, the book includes written comments from hundreds of physicians, many of whom are dissatisfied with the current state of the medical profession.

Results of the latter survey were included in a white paper Merritt Hawkins authored on behalf of The Physicians Foundation entitled *Health Reform and the Decline of Physician Private Practice*. The white paper explores why physicians are opting out of traditional practice styles and are embracing employment, part-time practice, locum tenens, medical home practice, concierge practice and other emerging practice styles, or are abandoning clinical roles altogether.

¹ Kocher R, Sahni N. Hospitals race to employ physicians. *Health Policy and Reform/New England Journal of Medicine*. March 30, 2011

² Merritt Hawkins 2011 Review of Physician Recruiting Incentives.

³ The Physician's Perspective: Medical Practice in 2008. The Physicians Foundation.

⁴ 2010 Survey of Physicians and Health Reform. The Physicians Foundation.

⁵ Dill MJ, Salsberg ES. Association of American Medical Colleges. The complexities of physician supply and demand. Nov. 2008



The white paper also addresses another trend impacting the physician market and the health care system in general – the growing shortage of physicians. The national physician shortage – which the Association of American Medical Colleges projects will create a deficit of 159,300 physicians by 2025 – is in part being driven by how physicians practice.⁵ The practice models many physicians are embracing – including part-time work, locum tenens, concierge practice, hospital employment and other models – tend in general to reduce overall physician full-time equivalents (FTEs).

Responses to the Indian Health Service's 2011 Survey of Physician Practice Patterns and Career Satisfaction therefore must be evaluated in the context of an evolving and frequently embattled medical profession. Merritt Hawkins will review results of the survey within the framework of our experience recruiting physicians nationwide, prevailing market trends, and previous research.

Our goal is to determine as far as possible the practice patterns, recruiting needs, and professional satisfaction levels of Indian health program physicians relative to the physician market as a whole. Strengths and weaknesses of the Indian health program model can then be evaluated from the recruiting perspective and compared to other practice models physician recruiting candidates may be considering. Indian health program facilities and the Indian Health Service may then promote perceived benefits of the Indian health program practice model as revealed by the survey, address potential drawbacks, and position Indian health program opportunities within the context of today's physician recruiting environment.

An analysis regarding responses to the survey follows.

ANALYSIS: ABOUT SURVEY RESPONDENTS

The survey was emailed exclusively to physicians, who represent 95% of total respondents. However, of the remaining five percent, four percent are nurse practitioners (NPs) and one percent physician assistants (PAs). It is apparent that a few physicians who received the emailed survey directed it to an NP or PA to complete. Nevertheless, the survey is almost entirely reflective of the physician experience and respondents are generally referred to throughout this report as physicians.

Of physician respondents, 83% are allopathically trained (MDs) and 17% are osteopathically trained (DOs). According to the American Medical Association's Physician Master File, 94% of physicians in active patient care are MDs and 6% are DOs. However, family physicians comprised 66% of physician respondents to the survey, and the percent of DOs among family physicians (13%) is higher than in most specialties, to some extent explaining the relatively high number of DOs among respondents. In addition, DOs have a tradition of serving in rural areas such as those serviced by Indian health program facilities. Eighteen percent of physicians in rural areas are DOs (D LaRavia. Keeping Physicians in Rural Practice. American Academy of Family Practice. Sept. 2002). The survey therefore suggests that the composition of Indian health program medical staffs is similar to what is generally prevalent in rural areas. Of physicians who responded to the survey, the majority (82%) are engaged in primary care practice, defined as family practice, general internal medicine and pediatrics. The survey therefore largely represents the experience of primary care physicians, and to a lesser extent the experience of obstetrician/gynecologists, general surgeons and psychiatrists, who comprised 10% of survey respondents. Other specialists are minimally represented in the survey.

The majority of respondents (63%) are male, the remaining 37% female. This equates to virtually the same gender breakout as the general population of physicians in active patient care, 64% of whom are male, 36% of whom are female, according to the AMA's Physician Master File.

Eighty-five percent of respondents are experienced providers who have been in practice for six or more years beyond residency training, while the remaining 15% have been in practice for five years or less. Most of the physician respondents therefore have a seasoned perspective on medical practice and an informed basis for comparison regarding practice patterns, variance in administrative techniques, staffing needs, etc. In particular, written comments provided by physicians on the survey regarding Indian health program practice can generally be assumed to reflect the insight of experienced practitioners.

The majority of respondents (56%) also have extensive experience with Indian health programs, having worked for such programs for six years or more. However, the remaining 44% are relatively new to Indian health program practice and may have a less in-depth perspective or basis for comparison regarding how Indian health program practice and procedures have evolved over the years and where they stand today relative to five, ten or more years ago.

Seventy-eight percent of physicians surveyed serve communities of 25,000 or less and 64% said their primary residence is in a rural community. The majority of respondents may therefore be considered to serve in moderate to small, rural settings, and their experiences should be compared to non-Indian health program physicians who work in similar settings.

Seventy-seven percent of respondents practice in one of seven states – Oklahoma, Arizona, California, New Mexico, Alaska, Washington and Wisconsin. Geographic variance in the survey is therefore limited.

Half of physicians (50%) are affiliated with tribal facilities, 46% with federal facilities and 4% with urban facilities. A plurality of physicians (48%) were direct Tribal hires, 33% were Civil Service hires, 13% were Commissioned Corps hires and the remaining six percent fell into the "other" category.

The majority of respondents (60%) did not rotate in an Indian health program facility as a student, intern or resident, and it may be presumed that their initial hire was their first exposure to this style of practice. However, a robust minority (40%) did have exposure to Indian health program practice during their education and/or training, either as a student (24%), an intern (2%) or a resident (14%), underlining the significant impact on-site training has on recruiting physicians to Indian health program facilities.

The majority of physicians (75%) do not have a scholarship obligation and it can be presumed their continued service with Indian health program facilities will be more a function of career satisfaction than of financial obligation. Of the remaining 25%, 11% have an IHS scholarship obligation, 13% have a National Health Service Corps (NHSC) obligation, and 1% have some other type of scholarship obligation.

About two-thirds of physicians (65%) are not now loan repayment recipients, nor were they in the past. However, a robust minority (31%) are or were loan repayment recipients, 25% through IHS and 6% through NHSC, underscoring the substantial impact on physician recruitment of these programs.

PRACTICE PATTERNS AND CHARACTERISTICS

The survey asked Indian health program physicians to provide information regarding their practice patterns and characteristics, including hours worked, patients seen, and related metrics. Survey responses provide some common characteristics of Indian health program practice, suggesting that this practice style differs in several ways (some of them positive) from physician practice patterns Merritt Hawkins has observed in private and other commercial settings.

WORK HOURS

In recent years, work hours have become an increasingly important issue for physicians evaluating practice opportunities, as younger physicians in particular seek a more controllable lifestyle. In a survey of final-year medical residents conducted by Merritt Hawkins, 81% of residents said that “adequate call/personal time” was a somewhat important or very important factor in their assessment of a practice opportunity.⁶

As a general rule, physicians of all ages and both genders are working fewer hours today than they have in the past, a trend observed in a study published by the Journal of the American Medical Association and cited in the February, 25, 2010 edition of HealthLeaders. (see chart below)

PHYSICIAN WORK HOURS PER WEEK

| | |
|-------------|-------------------|
| 1977 - 1997 | 55 hours per week |
| 1996 - 2008 | 51 hours per week |

⁶ Merritt Hawkins 2008 survey of Final Year Medical Residents.

The authors of the JAMA study estimated that the 7% drop in physician work hours represented in the chart above equates to a loss of 36,000 physician FTEs nationwide. A strong correlation was found between the decline in physician work hours and the decline in real physician earnings that took place from 1996-2008. This correlation was stronger than any other single correlating factor, including physician age and gender.

In a recruiting context, questions will arise among candidates regarding the work hours they can expect at Indian health program facilities. Indian health program physicians surveyed were asked to indicate the number of hours they work per week. Merritt Hawkins included a similar question on the survey of 12,000 physicians it conducted on behalf of The Physicians Foundation referenced above. The chart below provides a comparison between hours worked by Indian health program physicians and non-Indian health program physicians.

HOURS WORKED PER WEEK

| INDIAN HEALTH PROGRAM PHYSICIANS | | NON INDIAN HEALTH PROGRAM PHYSICIANS | |
|----------------------------------|-----|--------------------------------------|-----|
| 0 - 20 | 0% | 0 - 20 | 3% |
| 21 - 30 | 3% | 21 - 30 | 4% |
| 31 - 40 | 16% | 31 - 40 | 11% |
| 41 - 50 | 48% | 41 - 50 | 18% |
| 51 - 60 | 24% | 51 - 60 | 25% |
| 61 - 70 | 5% | 61 - 70 | 16% |
| 71 - 80 | 0% | 71 - 80 | 13% |
| 81 Or more | 4% | 81 Or more | 19% |
| Average: 48 hours per week | | Average: 56 hours per week | |

Comparison: Indian health program physicians are working 7% fewer hours than non-Indian health program physicians.

A majority of non-Indian health program physicians (59%) indicated they work 51 or more hours a week. By contrast, only 33% of Indian health program physicians indicated they work 51 hours or more a week. However, a somewhat greater number of non-Indian health program physicians are working less than a full schedule (30 hours or fewer a week) than are Indian health program physicians. Seven percent of non-Indian health program physicians are working 30 hours or fewer a week, compared to only three percent of Indian health program physicians.

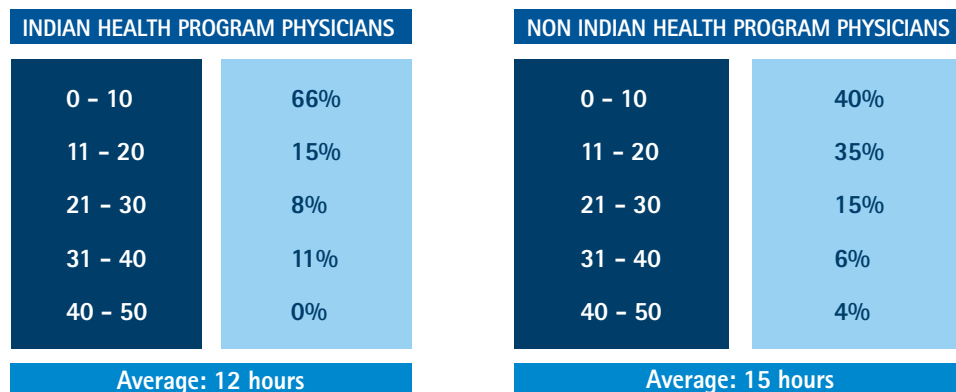
As stated earlier, a growing number of physicians are seeking alternatives to traditional medical practice, including part-time practice. The number of physicians working part-time is growing rapidly and more Indian health program physicians and recruitment candidates can be expected to prefer and/or request this option. Whatever steps can be taken to accommodate these candidates will have a positive effect on Indian health program physician recruiting efforts.

While on average Indian health program physicians are putting in a full week's work, it is a considerable recruiting advantage to be able to credit Indian health program practices as offering a less-demanding schedule than other styles of practice, as indicated by both the JAMA study referenced above and by the Merritt Hawkins' survey of non-Indian health program physicians. The fact that Indian health program facilities often offer relatively favorable work hours may not be commonly known among physician candidates and should be emphasized during the recruiting process.

NON-CLINICAL WORK

A favorable practice environment by today's standards features both reasonable work hours and the opportunity for physicians to focus primarily on patient care. The survey asked Indian health program physicians to indicate how many hours per week they spend on non-clinical "paperwork" duties. Merritt Hawkins asked a similar question in its survey of 12,000 physicians noted above. A comparison of the responses is depicted in the chart below

HOURS SPENT ON NON-CLINICAL "PAPERWORK" DUTIES PER WEEK



Comparison: Indian health program physicians spend 25% fewer hours on non-clinical "paperwork" duties than do non-Indian health program physicians.

The majority of Indian health program physicians (67%) indicated they spend 10 hours or less per week on non-clinical "paperwork" duties, while the remaining 33% spend 11 hours a week or more on paperwork. By contrast, only 40% of non-Indian health program physicians indicated they spend ten hours or less per week on paperwork, while the remaining 60% spend 11 hours a week or more. On average, Indian health program physicians indicated they spend 25% fewer hours per week on paperwork than do non-Indian health program physicians.

In Merritt Hawkins' experience, these numbers are very likely to be counterintuitive to most physicians in the general market, who are predisposed to believe that federal or state government related practice is rife with paperwork. Virtually all types of medical practices require considerable paperwork obligations (including Indian health program practices), and reducing such paperwork is a principal reason why many physician are seeking alternative practice styles. The survey offers Indian health program facilities some basis for contending that their facilities generally feature no greater paperwork obligations than other types of facilities, and in fact may feature fewer such obligations.

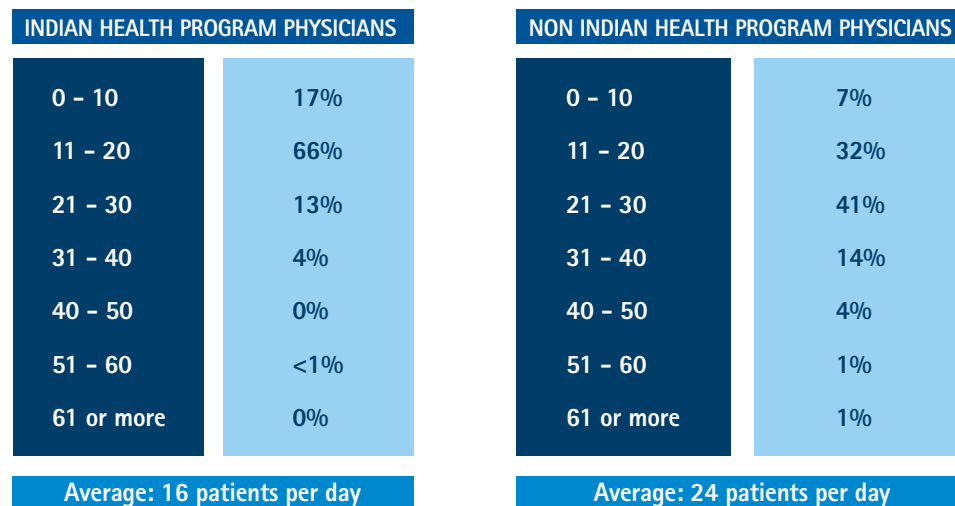
Despite some causes for dissatisfaction with Indian health program employment, the survey indicates that the majority of physicians rate Indian health practice as favorably or more favorably than other practice settings in which they have worked.

PATIENTS PER DAY

A key metric for measuring physician productivity is patients seen per day. The great majority of practices in the private sector track patients seen per day and/or work units (RVUs) performed to determine physician productivity. Typically, productivity measures are then tied to physician compensation, usually through some type of bonus structure. Given rising costs and declining reimbursements, many physicians in the private sector are obligated to increase their productivity by seeing more patients or performing more work units. Both quality of care and physician satisfaction can erode as the pressure to increase productivity grows.

In a recruiting context, a model that allows physicians to see a limited number of patients per day will be attractive to many candidates. The survey asked Indian health program physicians to indicate how many patients they see per day. Merritt Hawkins asked a similar question of non-Indian health program physicians in the survey of 12,000 physicians referenced above. The chart below provides a comparison of responses to this question.

PATIENTS SEEN PER DAY



Comparison: Indian health program physicians see 50% fewer patients per day

The majority of Indian health program physicians (83%) indicated they are seeing 20 patients a day or fewer. By contrast, only 39% of non-Indian health program physicians said they are seeing 20 patients a day or fewer, while 30% said they are see 30 patients a day or more. On average, non-Indian health program physicians are seeing 50% more patients per day than Indian health program physicians, an average of 16 per day versus 24.



The survey therefore gives Indian health program facilities a basis to contend that Indian health program practice often can be more patient care oriented and therefore more satisfying than other practice settings. A principal attraction of concierge medicine, a growing practice style, is the opportunity it offers physicians to know their patients and better manage their care. An additional attraction of concierge practice is that it relieves physicians of the burden of dealing with multiple payers and their attendant reimbursement policies. These are two attractions that concierge practice and Indian health program practice have in common – a fact that in Merritt Hawkins’ experience also may be counterintuitive to many physician recruiting candidates.

TIME SPENT PER PATIENT

Time spent per patient is an important metric to physicians, as an effective diagnosis is generally conceded to depend on a thorough patient examination. Primary care physicians in particular point to hasty examinations as a cause for over reliance on pharmacology and specialist referrals. In a recruiting context, the opportunity to spend time with patients generally will be viewed as a strong positive incentive.

The survey asked Indian health program physicians to indicate the average amount of time they are able to spend per patient. The great majority (92%) indicated they are able to spend more than 10 minutes per patient. Sixty-seven percent indicated they are able to spend 15 minutes or more per patient. On average, Indian health program physicians indicated they are able to spend 19 minutes per patient.

Merritt Hawkins does not have internal data regarding physician time per patient. External data dating from 2004 indicates an average family physician per patient time of 17 minutes.⁷ However, in Merritt Hawkins’ experience the pace of physician practice has accelerated in recent years and many primary care physicians are compelled for financial reasons to limit patient encounters to ten minutes or fewer. The survey therefore gives Indian health program facilities a basis for promoting its practice opportunities as allowing for more in-depth and more satisfying patient relationships than other styles of practice.

To further support this contention, the majority of Indian health program physicians surveyed (82%) described themselves as either sometimes or usually able to fully communicate with and treat patients. Only 18% indicated that they are “overextended and overworked.” By contrast, in the Merritt Hawkins’ survey of non-Indian health program physicians referenced above, 31% of physicians indicated they are “overextended and overworked.”

PATIENT ACCESS

In addition to time-per-patient, patient access to services is an important metric physician candidates use to evaluate practice opportunities. The survey asked Indian health program physicians to indicate how long patients with urgent problems must wait for the first available appointment at their practices. Merritt Hawkins asked a similar question of non-Indian health physicians. A comparison of responses is provided in the chart in the next page.

.....
⁷ Gottschalk R, Flocke S: Time spent in face-to-face patient care, annual of family medicine. 3:488 – 493 (2005)

HOW LONG MUST URGENT PATIENTS WAIT FOR AN APPOINTMENT WITH YOUR OFFICE?

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|-------------------|----------------------------------|--------------------------------------|
| Same day | 75% | 71% |
| 2-5 days | 14% | 20% |
| 6-10 days | 3% | 4% |
| 11-20 days | <1% | 4% |
| 21 or more | 4% | 1% |
| N/A | 3% | 0% |
| Average: 2.7 days | | Average: 2.6 days |

As the numbers above indicate, there is only a minimal difference between wait times for urgent patients reported by Indian health program physicians and non-Indian health program physicians, another favorable metric that can be used to promote the Indian health service practice environment.

The survey also asked Indian health program physicians to indicate how long patients with non-urgent problems must wait for an appointment at their practices. Merritt Hawkins asked a similar question of non-Indian health program physicians in the survey referenced above. A comparison of responses is provided below.

HOW LONG MUST NON-URGENT PATIENTS WAIT FOR AN APPOINTMENT WITH YOUR OFFICE?

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|--------------------|----------------------------------|--------------------------------------|
| Same day | 7% | 10% |
| 2-5 days | 27% | 39% |
| 6-10 days | 17% | 21% |
| 11 or moew | 47% | 30% |
| N/A | 2% | 0% |
| Average: 10.5 days | | Average: 8 days |

In the case of non-urgent patient wait times, Indian health program physicians reported longer times than did non-Indian health program physicians. The survey does not suggest any definitive explanation for this, though the relatively fewer hours Indian health program physicians' work and the comparatively longer time they spend with patients may push appointments back. By extension, the pressure non-Indian health program physicians feel to "churn" patients may push their appointment times up.

ACCESS TO SPECIALISTS

Access to medical specialists often is a concern for physician candidates considering smaller communities and rural areas typically served by Indian health program facilities. The survey asked Indian health program physicians about their ability to refer patients to specialists in their areas. Only 11% indicated their patients have ready access to specialists (referral times of seven days or less). The majority (60%) said their patients have moderate access to specialists (referral times between 7 and 21 days). Over one-quarter (27%) said their patients have poor access to specialists (referral times of more than 21 days). These wait times are not out of line with what Merritt Hawkins sees in other small markets and even in some major markets, as a shortage of specialists is leading to longer referral times in many areas.

For example, in a survey Merritt Hawkins conducted of patient appointment wait times in 15 major cities, the average new patient appointment time to see an orthopedic surgeon in Dallas was 45 days.⁸ The specialist referral wait time's Indian health program physicians reported in this survey should therefore not be a significant impediment to physician recruiting.

INPATIENT AND ON-CALL DUTIES

As referenced above, a controllable lifestyle is one of the most important, if not the most important, aspects of a practice opportunity candidates will consider when seeking a position. Many candidates today are seeking practices where they have little or no inpatient responsibilities and minimal to no on-call obligations.

The survey asked Indian health program physicians to describe their inpatient duties and their on-call arrangements. The majority (65%) indicated they have no inpatient duties and therefore practice outpatient-only medicine, a style of practice appealing to many physician candidates. Eighty percent described their on-call duties as minimal to non-existent, while only 20% said they have significant on-call duties. These are additional metrics Indian health program facilities can use promote the generally favorable practice style they offer.

COMPENSATION SOURCE

Indian health program physicians were asked to indicate how they are compensated and were offered five choices: Title 38; Title V; Recruitment, Retention, Relocation Allowance; Physician Comparability Allowance; or other.

The majority (52%) selected the "other" category, and cited the Commissioned Corps, tribal hire, salary and other forms of compensation. Several indicated they are unsure or don't know how they are compensated. There appears to be some uncertainty among Indian health program physicians regarding how they are compensated, suggesting that more time needs to be devoted to this topic during the recruiting and on-boarding process.

.....
⁸ Merritt Hawkins 2009 Survey of Patient Appointment Wait Times

HOSPITAL RELATIONS

The traditional relationship between physicians and hospitals often can best be described as a wary truce, with conflicts over scheduling, patient information, recruiting and even parking a part of the status quo. In many markets, physicians and hospitals have engaged in direct and sometimes bitter competition for patients, widening the gulf between them. It is only comparatively recently that some physicians have “thrown in the towel” and opted to join hospitals rather than conflict with them.

Candidates today are therefore particularly attuned to physician/hospital relations and understandably prefer a symbiotic environment to one characterized by conflict. The survey asked Indian health program physicians to describe their relationship with their local hospital or hospitals. The great majority (89%) said their relationship was either somewhat supportive and positive or very supportive and positive. Only six percent said their relationship was rarely supportive or positive. In Merritt Hawkins’ experience, in which we have interviewed hundreds of physicians as part of hospital medical staff plans, responses to this question suggest a considerably higher degree of physician/hospital compatibility among Indian health program physicians than often is found in the general market. This is a further positive that Indian health program facilities may use in promoting their practice opportunities to candidates.

In general, the practice characteristics of Indian health program facilities as described by the survey are in tune with the preferences of today’s physicians and should be leveraged aggressively during the recruiting process. Many candidates may find the practice metrics and characteristics referenced above to be counter to their perceptions of Indian health program practice and cause them to give more consideration to this practice style.

STAFFING NEEDS

As referenced above, the nation is in the midst of a growing physician shortage that is apparent not only in traditionally underserved communities but in medical markets nationwide. The staffing needs expressed by Indian health program physicians in this survey should be viewed within this context.

PRIMARY CARE PHYSICIANS

Indian health program physicians were asked to rate the need for additional primary care physicians at their facilities. Fifty-one percent of physicians indicated there is an urgent need for more primary care physicians in their service areas, 36% indicated there is a moderate need and 13% indicated there is no immediate need. Merritt Hawkins asked a similar question of non-Indian health program physicians in the survey of 12,000 physicians referenced above. The chart below offers a comparison:

RATE THE NEED FOR ADDITIONAL PRIMARY CARE PHYSICIANS IN YOUR SERVICE AREA

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|-------------------|----------------------------------|--------------------------------------|
| No immediate need | 13% | 29% |
| Moderate need | 36% | 49% |
| Urgent need | 51% | 22% |

Indian health program physicians generally expressed a more urgent need for primary care physicians in their areas than non-Indian health program physicians, a response that may be driven in part by Indian health program service area demographics and by the relatively competitive environment in which private sector physicians operate which sometimes causes physicians to downgrade the need for additional physicians in their service areas. Forty-eight percent of non-Indian health physicians referenced in the chart above practice in communities of 100,000 people or less, the remainder practice in communities of 100,001 people or greater. The non-Indian physician numbers above therefore reflect a more urban experience generally than the Indian health program physicians, which may explain in part why Indian health physicians perceive a more urgent need for primary care physicians than non-Indian health physicians.

SPECIALIST PHYSICIANS

Eighty-six percent of Indian health program physicians indicated there is a moderate to urgent need for specialists in their service areas, while 14% indicated there is no immediate need. As Merritt Hawkins has observed in other settings, the physician shortage is not confined to primary care. Many facilities in a variety of settings are in need of additional medical specialists, and the survey suggests that Indian health program facilities are no exception.

The majority of Indian health program physicians (64%) indicated their facilities currently are recruiting physicians. This number is in line with the non-Indian health program physicians Merritt Hawkins surveyed, as the chart below indicates.

IS YOUR PRACTICE CURRENTLY RECRUITING PHYSICIANS?

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|-----|----------------------------------|--------------------------------------|
| Yes | 64% | 65% |
| No | 36% | 35% |

These numbers further underline the need for physicians at both traditionally underserved medical practices such as Indian health programs and at facilities that in the past have not been underserved.

Indian health program physicians were asked to rate how difficult it is to recruit physicians to their facilities. Merritt Hawkins asked a similar question of non-Indian health program physicians it surveyed. A comparison is provided in the chart below:

HOW DIFFICULT IS IT TO RECRUIT PHYSICIANS TO YOUR PRACTICE?

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|---------------------------|----------------------------------|--------------------------------------|
| Very difficult | 43% | 45% |
| Moderately difficult | 45% | 44% |
| Not Difficult | 5% | 11% |
| Not applicable/don't know | 7% | 0% |

Again, these numbers reinforce the general difficulty of recruiting physicians in today's market for practices and facilities in a wide variety of settings. The physician recruiting challenges and frustrations that Indian health program facilities may be experiencing also are being experienced by many other types of facilities. The market has changed in this regard in recent years and there are few facilities – even industry brand names that formerly had their choice of physicians – that do not struggle to recruit doctors.

NON-PHYSICIAN CLINICIANS

The majority of Indian health program physicians (56%) said their practices or facilities currently are recruiting non-physician clinicians such as NPs, PAs, pharmacists, dentists and nurses. About three quarters (76%) said there was a moderate to urgent need for these providers, though in general the need is somewhat less urgent than for primary care physicians. The majority (66%) indicated that these providers are either moderately difficult or very difficult to recruit, though generally not as difficult to recruit as physicians.

Included in the evolution of physician practice referenced above is shift toward a team approach to health care delivery in which physicians will “quarterback” an expanding group of clinicians. This approach is necessitated by the physician shortage, which requires physicians to delegate services they previously delivered to other types of clinicians. It also is part of the general integration process being promoted through accountable care organizations and other models that feature coordinated care. The demand for non-physician providers, PAs and NPs in particular, will therefore likely grow and Indian health program facilities can anticipate that recruiting these providers will become increasingly difficult.

IMPACT OF HEALTH REFORM

Looming on the horizon is the implementation of health reform, which by 2019 is projected to add 32 million people to the ranks of the insured. Indian health program physicians were asked what effect health reform will have on the need for physicians and other clinicians in their areas.

Most providers (66%) believe health reform will moderately or significantly increase the need for physicians and other clinicians at their sites. Health reform takes modest steps to increase the supply of primary care physicians and provides considerable additional funding to the National Health Service Corps (NHSC), actions which may benefit Indian health program facilities. However, as Merritt Hawkins outlines in the white paper *Health Reform and the Decline of Physician Private Practice*, these steps are unlikely to counterbalance demand for physician services created by 32 million newly insured patients. As previously uninsured patients begin to access insurance in 2014 and beyond, physician supply resources will be further strained, most conspicuously in settings where resources already are limited.

PHYSICIAN MORALE AND SATISFACTION

Shifting practice paradigms, flat or declining reimbursement, ongoing malpractice concerns, a heavy regulatory burden and other factors have eroded physician morale in recent years. Based on Merritt Hawkins' experience and research, many doctors, though still engaged by patient care, are disenchanted with the “hassle factors” of medicine.

The survey asked Indian health program physicians questions pertaining to their morale and professional satisfaction, and their responses should be placed in the context of physician morale generally. Within this context, the survey suggests that the morale of Indian health service physicians is in some cases better

than what Merritt Hawkins has observed in the general physician population. There are elements of Indian health program practice that physicians find unsatisfying, but as a general rule they find Indian health program practice to be as satisfying or more satisfying than other settings in which they have practiced.

The survey asked Indian health program physicians to indicate if their practices are more satisfying now than they were two years ago, less satisfying, or if there has been no change. Merritt Hawkins asked non-Indian health program physicians a similar question on the survey of 12,000 physicians referenced above. The chart below offers a comparison:

OVER THE LAST TWO YEARS, I HAVE FOUND MY PRACTICE TO BE

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|-----------------|----------------------------------|--------------------------------------|
| Less satisfying | 31% | 78% |
| More satisfying | 24% | 6% |
| No change | 45% | 16% |

**In the Merritt Hawkins survey of non-Indian health program physicians the question asked about the last five years.*

While about one third of Indian health program physicians said they find practice to be less satisfying now than formerly, over twice that number of non-Indian health program physician said their satisfaction had decreased.

Indian health program physicians were asked how they now find their practices, as were non-Indian health program physicians Merritt Hawkins surveyed. The chart below offers a comparison:

HOW DO YOU NOW FIND YOUR PRACTICE?

| | INDIAN HEALTH PROGRAM PHYSICIANS | NON INDIAN HEALTH PROGRAM PHYSICIANS |
|-----------------------|----------------------------------|--------------------------------------|
| Very satisfying | 25% | 5% |
| Somewhat satisfying | 47% | 29% |
| Very unsatisfying | 16% | 18% |
| Somewhat unsatisfying | 12% | 48% |

**Phrased as “less satisfying” in Merritt Hawkins’ survey of non-Indian health program physicians.*

Though 28% of Indian health program physicians said they find their practice to be somewhat to very unsatisfying, the majority (72%) said they find their practice to be somewhat to very satisfying. By contrast, only 34% of non-Indian health program physicians said they find their practice to be somewhat to very satisfying. Dissatisfaction among some Indian health program physicians, as revealed by survey responses and by written comments included at the end of this report, should not be discounted. However, the survey suggests that Indian health program physicians appear to be no more dissatisfied, and may even be more satisfied, than physicians in the private sector.

CAUSES FOR SATISFACTION

Physicians were asked what they find satisfying about practicing with an Indian health program facility, and their answers suggest why they may be more satisfied as a general rule than non-Indian health program physicians.

The most positive aspect of Indian health program practice cited by physicians was malpractice climate. Ninety-six percent of physicians ranked this aspect of Indian health program practice as very satisfying or somewhat satisfying. This is in direct contradiction to the experience of most physicians in the private sector. In the Merritt Hawkins' survey of non-Indian health program physicians referenced above, three quarters of physicians (75%) ranked malpractice as a very or somewhat unsatisfying part of medical practice.

The fact that Indian health program physicians are not subject to the same malpractice concerns of private sector physicians is an obvious selling point that should be leveraged aggressively during the physician recruiting process.

In addition, 89% of physicians cited work schedule/free time as a somewhat positive or very positive aspect of working for an Indian health program facility. By contrast, 62% of non-Indian health program physicians surveyed by Merritt Hawkins ranked long hours and lack of personal time as a very or somewhat unsatisfying aspect of their practice.

Mission driven care was cited by 89% of physicians as a somewhat positive or very positive aspect of working for an Indian health service program facility. For many private sector physicians, the emotional rewards they expected to reap from their profession have been eroded by the business aspects of medicine. To recapture those feelings they may embark on medical missions to other countries. The survey suggests that many Indian health service physicians enjoy a sense of mission in their daily practices and that such practices should have a strong appeal for physicians seeking more emotional rewards.

Eighty-seven percent of physicians cited "overall IHS practice style" as a somewhat satisfying or very satisfying aspect of working with an Indian health program facility, underscoring the positive effects on morale of the favorable practice metrics regarding work hours, time with patients, etc. referenced above.

However, it should be noted that "working with the IHS system" was ranked least satisfying by 30% of physicians, and received the highest number of least satisfying ratings (and the lowest number of very satisfying ratings) of all the factors listed, with the exception of "prestige of position."

Physicians were further asked to rate how various factors affect satisfaction with their employment in an Indian health program facility. "Appreciation in the community" was cited as a satisfying factor by 55% of physicians, tied with "support staff" for the most highly rated factor. This may be a useful metric for Indian health program facilities recruiting candidates who have expressed concern about how they will be received by Indian patients.

Somewhat surprisingly, "pay" was the third highest rated factor, cited as satisfying by 46% of physicians and as unsatisfying by only 14% of physicians. Compensation for Indian health program physicians generally lags behind the private sector (see IHS' 2011 Clinical Staffing and Recruiting Survey). Nevertheless, the survey indicates that the majority of physicians (86%) consider pay either a positive or a neutral aspect of their employment with an Indian health program facility.

CAUSES FOR DISSATISFACTION

It should be noted that the most frequently cited causes for dissatisfaction among physicians can be directly or indirectly attributed to the bureaucratic and political challenges of working in an Indian health program facility.

Fifty-nine percent of physicians rated “paperwork/red tape” as an unsatisfying aspect of their employment with an Indian health program facility, the highest response in the unsatisfying category. This was followed by “politics,” rated as unsatisfying by 58% of physicians, “human resources,” rated as unsatisfying by 39% of physicians, and by “IHS policies and procedures,” rated as unsatisfying by 39% of physicians.

These aspects of Indian health program employment were more unfavorably rated than “professional isolation,” “spousal support /opportunities,” or “cultural amenities.” In Merritt Hawkins’ experience, these three factors – rather than paperwork or bureaucracy – typically are the most common “deal breakers” in efforts to attract physicians to smaller communities. Many Indian health program physicians appear to have “gotten past” the typical objections to rural practice, such as lack of professional opportunities for their spouses. They appear to be more concerned about the dynamics of IHS practice.

The positive aspect of this finding is that the elements which tend to erode physician satisfaction in Indian health program facilities can be addressed and adjusted. Minimal employment opportunities for the spouse, professional isolation, the lack of theaters, concerts and other cultural amenities are typically beyond the control of practices located in traditionally underserved communities. Human resources and related bureaucratic processes and procedures, by contrast, can be modified in ways likely to improve the professional satisfaction of physicians. This topic is addressed in more detail below in the section regarding physician comments.

INDIAN HEALTH VS. OTHER SETTINGS

Despite some causes for dissatisfaction with Indian health program employment, the survey indicates that the majority of physicians rate Indian health practice as favorably or more favorably than other practice settings in which they have worked.

Eighty-five percent of physicians surveyed indicated they have worked in both Indian health program settings and other settings, and therefore have a basis for comparing the two. Of these, 44% said that working with Indian health programs is more satisfying than working in other settings. Only half that number (22%) indicated the opposite – that other settings are more satisfying than Indian health programs. Over three quarter (78%) rated Indian health programs as either equally satisfying compared to other settings or more satisfying, again underlying the positive effects on satisfaction and morale of the favorable practice metrics cited above.

METHODS OF ASSISTANCE

Physicians were asked in what ways Indian health programs could assist them in their practice. The most frequently cited method of assistance was “reduce paperwork.” Ninety-seven percent of physicians indicated this would be a somewhat important or very important way to assist them. This was followed by “improve financial incentives,” cited by 95% as somewhat important or very important. Despite the fact that most physicians surveyed indicated that pay was a positive or neutral aspect of their employment with Indian health programs, many believe additional financial incentives are needed.

In general, the practice characteristics of Indian health program facilities as described by the survey are in tune with the preferences of today’s physicians and should be leveraged aggressively during the recruiting process.

As referenced earlier in this report, many physicians today are seeking part-time work and flexible schedules. This is reflected by the survey. Eighty-seven percent of physicians said flexible hours would be a somewhat important or very important way for Indian health programs to assist them. In Merritt Hawkins’ experience, it is becoming increasingly difficult to staff hospitals, medical groups and other facilities without offering part-time positions and flexible hours. Offering these options is likely to increase the recruiting effectiveness of Indian health program facilities.

“Assist with physician recruiting” was the fourth most highly rate method by which Indian health programs can assist physicians, cited by 85% of physicians as being somewhat important to very important. While physicians clearly see a need for additional physician recruiting resources, 67% said their facilities either do not have a recruitment and retention plan in place or do not know if they have one in place. The survey therefore suggests that Indian health program physicians may be somewhat detached from the recruiting process. In Merritt Hawkins’ experience, physician involvement often is the key to recruiting success, as physicians can bring value to the process as advocates for their facilities. By contrast, those who are not involved or not supportive of recruitment often undermine the process.

PRACTICE PLANS

Physicians were asked what they plan to do in the next one to three years. Seventy-one percent indicated they plan to continue as they are. This is in contrast to the response Merritt Hawkins received to a similar question it asked in a survey of 2,400 physicians it conducted on behalf of The Physicians Foundation. Only 26% of non-Indian health program physicians in this survey indicated they will continue to practice as they are over the next one to three years. The majority on non-Indian program physicians (74%) indicated they will take one or a combination of steps that would be likely to reduce the amount of patient care they provide or remove them from clinical roles altogether. A comparison of response to this question is provided in the chart below:

WHAT DO YOU PLAN TO DO IN THE NEXT ONE TO THREE YEARS? (CHECK ALL THAT APPLY)

| INDIAN HEALTH PROGRAM PHYSICIANS | |
|--|-----|
| Continue as I am | 71% |
| Retire | 7% |
| Seek a clinical position outside Indian health programs | 18% |
| Seek a non-clinical position within Indian health programs | <1% |
| Seek advanced education/training | 4% |
| Other | 12% |

While 18% of Indian health program physicians indicated they will seek a clinical position outside of Indian health programs, and others will retire or seek advanced training, Indian health program physicians appear to be a more stable group than non-Indian program physicians. This finding underscores again the relative benefits of the Indian health program style of practice and suggests that this model may be attractive to candidates seeking alternative practice styles.

NON-INDIAN HEALTH PROGRAM PHYSICIANS

| | |
|---|-----|
| Continue as I am | 26% |
| Cut back on hours | 19% |
| Retire | 16% |
| Switch to a cash or concierge practice | 16% |
| Relocate to another practice/community | 14% |
| Work locum tenens | 14% |
| Cut back on patients seen | 12% |
| Seek a non-clinical job within healthcare | 12% |
| Seek a job/business unrelated to healthcare | 12% |
| Seek employment with a hospital | 11% |
| Work part-time (20hours per week or less) | 8% |
| Close my practice to new patients | 6% |
| Other | 4% |

PHYSICIAN COMMENTS

Physicians completing the survey were given the opportunity to provide written answers to the following two questions:

1. If you could make a statement to fellow clinicians regarding the benefits and drawbacks of working with Indian health programs, what would you say?
2. If you could make a statement to Indian health programs administrators and clinical directors about how they could enhance the quality of your practice and improve recruitment/retention to Indian health programs, what would you say?

Though physicians as a rule are extremely busy and not prone to taking extra time to provide written comments on surveys, the many Indian health program physicians did so. Forty-three percent of physicians surveyed provided written comments to the first question and 52% provided written comments to the second question.

POSITIVE COMMENTS

Comments in response to both these questions echo responses to the survey questions above. The positive comments regarding working for Indian health programs center mostly on the style of practice offered, i.e.:

“As a doctor in the classic meaning – I am a doctor. I still get to treat my patients how I see fit.”

“Working for IHS is very rewarding.”

“I find working in the Indian Health System very satisfying. I love the benefits, the vacation time, and the healthy salary. The patients are so appreciative of your efforts because they aren't worrying about your bill. I love the freedom from stress that comes from not having to worry about the latest Medicare pay cuts or the high cost of malpractice. A wise physician will see the benefits of Indian Health.”

“The rewards that come from patient care In IHS settings are enormous.”

“Overall enjoy patient population.”

“Intellectually challenging and diverse population that will definitely stimulate you.”

“I really believe that IHS provides the best possible medicine to low income populations in the US. Better than most of the middle class medical services. Access in our clinic is better than any clinic I have worked in.”

“If you care about your fellow human and you want to make a difference, work here.”

“An Organization with a Mission like a Siren's Song for those who view practice as a calling: Incredible opportunity to share with Native Americans. Incredible people with the Agency and with the Tribes.”

“The incentive is on providing quality care, not on profit.”

“The benefit is that it is the best quality of life I have experienced as a physician.”

“This is the best job I have ever had and I will never work in the private sector again to make profits for any individual or corporation and the expense of sick people. I enjoy being able to practice medicine purely to help people”

“Overall far more appreciative patient population. You know you are making a difference. Practicing in suburbia is boring in comparison.”

NEGATIVE COMMENTS

The negative comments regarding working with Indian health programs center mostly on the regulatory/human resources/bureaucratic aspects, i.e.:

“Unbelievable inertia related to working in a government system, nothing happens in an appropriate time frame.”

“The most stifling, inflexible, unresponsive bureaucracy I’ve ever encountered.”

“I think the IHS is essentially rotting from the inside with irrational and knee-jerk responses to very deep seated problems.”

“Human Resources and Finance restrictions, inability to “play” with the recruitment team to help bring interested parties on board has caused us a lot of internal stress and makes it feel like a waste of time to spend so many hours recruiting and talking to physicians only to lose them because we cannot process them through HR and make a timely offer.”

“Enough with the paperwork. You can’t see the forest because all the trees have been turned into paper!”

“Change HR to allow hiring. There are lots of interested providers both mid-level and MD. However, we lose their interest because of the prolonged process.”

“To get this job I’m sure I had more than 100 pages of per work to 2 different organizations.”

“I was not able to get a loan repayment as I do not work 40 hours a week. I think in this day and age that is very antiquated and may affect my retention.”

“Get Human Resources, Acquisitions, and Finance to cut the red tape and do their jobs.”

“Be creative in allowing more flexible scheduling.”

“The snafu in personnel hiring with the new background checks has made it almost impossible to hire anyone for any position no matter how desperately needed. It is unreasonable to expect new hires to wait 6 months to start work. All of that paperwork k needs to be expedited.”

“Many of our consultants no longer come here because they spend most of their day in HR instead of providing the very outreach services that we need”

“Reduce the red tape and politics.”

“Streamline the Human Resources and hiring process.”

“Organizationally crippling ingrained HR practices.”

“Offer more part-time positions and/or short term contracts to specialists.”

The written comments in their entirety are listed below. They are included as written with no attempt to correct spelling, grammar, punctuation, etc.

PHYSICIAN COMMENTS

QUESTION 1:

If you could make a statement to fellow clinicians regarding the benefits and drawbacks of working with Indian health programs, what would you say?

1. With a few exceptions, work here is wonderful

2."The benefits have to do with loan repayment programs and knowing that you are helping your patients. The drawbacks are by far internal politics, personal and professional isolation and lack of support."

3."work is great. Administration micro management is the problem."

4. "I was a solo physician with 1 FTE FNP/PA for 13 years, now have expanded to 2-3 Physicians and have 3 FNP/PA's. I have been able to practice medicine with great respect from the administration, we have been able to change practice processes and modify them to improve patient care and maintain a very positive staff, our numbers are good compared to other areas but need improvement, the improvement training is slow, I like having M-F, 8-5 or so hours, no call, occasional home visits or hospice, but otherwise perfect family practice panel, as we have grown we experience challenges, other challenges are personnel but I let administration deal with it, I stick to the medicine which is ideal. It's a small foothill community and a beautiful location for me and my family. Good schools and stores nearby."

5. "Very satisfying in being intellectually challenging, interesting, worthwhile work that gives one the satisfaction of knowing that you are making a real contribution. One must be willing to put up with the frustrations of working in an overburdened, underfunded, bureaucratic system."

6. "The IHS could really help by having more spots for pediatricians. I find the population has a more complex make up with more disadvantaged children. This requires someone that can work with the child the family and the outside entities. Also having a better association of the existing pediatricians with biannual meetings and CME."

7. "It could be worse - it's a screwed up system, but it's a single screwed up system, not the hodge-podge you get in private practice."

8. "The Indian Health Service is a single-payer health care system, which means you don't have to worry about coverage or reimbursement. There is a minimum of patient care paperwork. Working with people of different cultures means you are always learning something really new. At the same time, our patients are unusually sick and the IHS is almost unbelievably underfunded (the VA gets more than 3 times as much funding per patient). Working conditions can be terrible (rats, asbestos, etc), and it is sad to see people sitting in hallways waiting for hours for care."

9. "The indian health service is too focused on regulations - healthcare takes a back seat to jumping through the hoops of administrative procedures - physicians are not respected as professionals (at my facility) and the whole system is geared toward perpetuating the system instead of providing patient care - I have never been more shabbily treated as a professional as I have in this system. Working with IHS has been an overall gratifying experience. Generally speaking, the patients are genuinely nice folks that appreciate the care given. We have a dedicated staff that tries exceptionally hard to make patient care their top priority. The downside is we clearly need more Physician/Nursing/support staff. There is also a need for upgrade of equipment. It certainly is not a bad place to work and I am very proud of my affiliation

with IHS. I believe that is and always will be a “work in progress” and that there is a general commitment to improve things. It just is not going to happen all at once. I strongly encourage young physicians/nurses/ etc. to consider working for IHS for a few years. It is a challenge that will provide valuable experience in any aspect of medicine.”

10. “IHS provides a good career opportunity that is especially attractive because of improved lifestyle. Under Title 38, pay is very competitive for primary care physicians, but not as attractive for specialists. The providing of care in the Native American community can be very satisfying professionally, and certainly challenging. Constipated governmental processes and the frequent inability to provide standard of care services can be very frustrating to dedicated health care providers. On the otherhand learning to do more with less, improvise, and think outside of the box to accomplish “the mission” can be satisfying as well.”

11. “Slow process to hire, upward mobility, retention and outside referrals. The contract health system is poorly functioning, EHR and equipment are very modern in my facility. Staff is very good but sometimes inefficient.”

12. “Benefits: Working for IHS is very rewarding, I have had the opportunity to be a role model for my Tribe. I find it very rewarding to deal with my elders. There is a tremendous amount of history in the Native American population. Most sites are at areas with great tourist attractions and there is a lot of outside activities.”

17. “Drawbacks: Not enough money to adequately provide all health care services needed. Pay is lower even with incentives and now appears we are not going to get our standard cost of living increase. Increasing demands to increase patient load, while trying to implement patient centered care. Pt also do not understand the value of the medical care they are getting, sometimes they can be very demanding and critical. It is difficult to see the self destruction that is common with alcohol abuse as well as medical noncompliance. IHS is a challenging place to work. I believe burn out is inevitable.”

14. “Drawbacks: unbelievable inertia related to working in a government system. nothing happens in an appropriate time frame. the level of administrative expertise in hospitals and area offices is very poor, so there is inadequate support for recruitment, HR issues such as hiring, etc. benefits: patients are great.”

15. “The rewards that come from patient care in IHS settings are enormous. Clinicians will see things and do things that they can rarely experience elsewhere. Patients are truly appreciative of our work and clinicians can go home each day knowing they have made a difference in populations at need. The unfortunate transition of the IHS to a highly regulated and bureaucratic organization is an unfortunate trend. The burden of regulatory compliance on providers working in Indian Health settings has now equaled and in many cases exceeded those experienced by our private sector colleagues. The lack of such burdens was once a major attraction to Indian Health sites, but this plus has now been lost.”

16 “The benefit is it’s the best overall quality of life I have experienced as a physician. The primary drawback is inadequate annual salary. The Choctaw nation could “lock me up for the rest of my professional life: if they increased my annual salary a minimum of \$20-30,00. per annum immediately. There are plenty of opportunities already going to make primary care physicians all the more sought after, and at a time when our relative numbers are declining (supply/demand > \$).”

17. "I find my work very satisfying professionally and personally. i am able to pratice a style of medicine I would not be able to in another setting."

18. "Very appreciative patients in an area of high Medical need practicing in a very collegial atmosphere."

19. "Overall enjoy patient population. Do not like amount of secreterial work I have to do such as calling for medical records, faxing, making appointments with specialists."

20. "I would suggest that clinicians enter practice situations that are collegial and that they have a good working relationship with management."

21. "This is the BEST job I've ever had, and I will NEVER work in the private sector again to make profits for any individual or corporation at the expense of sick people. I enjoy being able to practice medicine purely to help people. I no longer refer to the population of this reservation as "underserved," as I feel that they have access to BETTER health care in general than at any place I've ever practiced medicine in the private sector."

22. "I find that working for indian health service to be very satisfying. Less overall micro managment. still able to spend time with patients. We still try to monitor and stay on budget. We have independance and lass administrative interference and workin closely with management to keep our pateints healthy."

23. "Working with complex medical and psychosocial conditions is both a great challenge and a great opportunity. Working in tribal settings allows one the chance to positively influence the health of individuals and communities for years to come. But we really need to support and help each other for this to be possible and for us to retain our perspective and hope."

24. "As a member of an Indian tribe there is a great sense of satisfaction helping others in my tribe. it is an ineffecient system, if you like to work hard, see lots of patients you will be discouraged. patients are wonderful, lots of pathology and vary complex, intellectually challenging. We are not held to the same standards as the private sector. Metrics and standards or patient encounters have never been uniformly developed. These standards allow providers to choose how hard they want to work."

25. "Intellectually challenging and diverse population that will definitely stimulate you mentally. Patient population is often afflicted with drugs, alcohol, abuse and lack of education."

26. "Challenging but rewarding work. Patient's either appreciate you or are impatient with your efforts, very little middle ground."

27. " I really believe that IHS provides the best possible medicine to low income populations in the US. Better by far than the average medicaid clinic. And better than most of the middle class medical services. Access in our clinic is better than any clinic I have worked in."

28. "The biggest drawback is the involvement of personal & Indian politics into healthcare. Some pts think that their connection to a board member makes them special. The overall staff are very supportive and enjoyable to work with. Some of the work standards make for slow healthcare. Current IHS fiscal standards may be the new standard (eg, spend your budget until it's gone, don't actually cap spending) but make no sense."

29. "Benefit and drawback at the same time: an amazing amount of pathology that you usually only read about. I was in private practice in a nearby community before my tribal job. The amount of complex and serious pathology that we see several times a day is amazing. If you want an easy job where you don't have to think, don't work here. If you care about you fellow human and you want to make a difference, work here."

30. "Nice deserving folks with fascinating pathology, but limited access to care, especially expensive diagnostic imaging & elective surgical procedures (e.g. joint replacement)."

31. "Pros: Good benefits, competitive pay. Cons: The primary drawback is that nonmedical administrators seem completely disconnected from the realities of medical practice, this resulting in lack of support and respect for medical care providers."

32. "I have enjoyed working at this facility. When in private practice, I constantly spoke to drug reps in order to keep samples on hand for those patients with no drug plan or insurance. The ability to make referrals to outside specialists is available. There are multiple rules and regulations to keep in mind. HMO's and private insurance as well had their own rules to follow. We are in the midst of becoming part of the Improving Patient Care 3 process. It is all a work in process. It is exciting to know that this program is available. We can learn from others in the same situations as our clinic and those who are not."

33. "There are definitely good and difficult issues. Some of the regulations and rules can be very frustrating, but in general the longer I am here the more I appreciate the people and the community."

34. "The opportunity to work to work with AI/AN patients is life-enriching and it is a wonderful calling. It is a wonder how come many providers enjoy going to third world countries to serve yet they do not realize what a privilege it is to serve the American Indian/Alaska Native communities."

35. "Benefit: An Organization with a Mission like a Siren's Song for those who view practice as a calling; Incredible opportunity to share with Native Americans; incredible people in the Agency and Tribes. Direct services are free to patients; Fed Tort Claims Act limits liability concerns; variety of opportunities available; supportive organization; Initiatives generally make sense.

Drawbacks: Limited resources from Congress; Slow pace of change or assistance at times; Required administrative trainings can seem excessive and inconvenient; Billing becoming more and more important for programs to remain viable -- more documentation requirements have followed; EHR comprehensive but not user friendly when portions of the system are compared to commercial market."

36. "Benefits: you can make a difference. Drawbacks: the most stifling, inflexible, unresponsive bureaucracy I've ever encountered"

37. "Working with tribal members as patients has been very rewarding and challenging clinically, never a dull day. It is very rewarding to work in an environment where care is about helping the patient rather than profit oriented like it is in a lot of private clinics."

38. "Excellent physicians. Great fund of knowledge. Patient ownership may be a slight problem. Not aggressive in taking care of own patients. Happy to let them be seen by anybody."

39. "Overall a far more appreciative patient population. You know you are making a difference. Practicing in suburbia is boring in comparison. Benefits are the opportunity to make a difference in improving

the health of a population, cultural experience, opportunities to learn/expand skill sets. Drawbacks are administrators who get their positions based on IP or Commissioned Officer status alone but who possess no real "human" or leadership qualities."

40. "I work with a self-governance tribe which is not part of the IHS. The freedom to practice the way I want to is great, maybe too great. Politics and high turnover of key administrative positions has caused a great deal of turmoil within the health programs."

41. "The IHS provides an opportunity to provide full-service care to wonderful people. It is always challenging and also richly rewarding in terms of your ability to make a difference in the lives of the people you serve."

42. "I have always found Clinicians working for Indian Health programs to be dedicated and hardworking. Many could work less and be compensated better in the private sector."

43. "The incentive is on providing quality care, not on profit. This is the main difference from private practice. There are some limits placed on types of services available or pharmacy formulary, but these are not a significant burden. The IHS seems focused on improving patient care!"

44. "I would warn off any fellow clinicians from coming to work for IHS, fairly strongly, qualifying that only with whether they themselves are Native American and might therefore find a much more satisfying environment for effecting change and gaining rapid promotion. I think that IHS is essentially rotting from the inside with irrational and knee-jerk responses to very deep seated problems in giving good patient care. I think that while numerically the staff to support a physician look to be available, there is very poor supervision and leadership over this staff, they are lazy and relative to the private sector not held nearly accountable to professional standards at their level. As a result, the patients themselves complain to me constantly about all the other services they get at the clinic, poor and even ugly attitudes, indifferent handling and care, utter lacking of compassionate responses, arrogant attitudes that offend the patient, etc. There is a prevalent sentiment among my patients, and I see exactly what they are talking about, that most of the staff at our clinic put patient care LAST, and mainly because they put their own personal agendas, whether schedule flexibility, political relationships with the tribes, financial or benefit considerations first."

45. "Human Resources and Finance restrictions, inability to "play" with the recruitment team to help bring interested parties on board has caused us a lot of internal stress and makes it feel like a waste of time to spend so many hours recruiting and talking to physicians only to lose them because we cannot process them through HR and make a timely job offer."

46. "The people and the culture is great but the living conditions, pay, benefits, and workload, work hours, politics and dealing with narcotics is not worth it. The area I'm in is so poor and the doctors are treated so bad that these people can not keep any doctors to stay more than 3 months. There is no cell phone reception, no land line access, no TV and no internet. Administration does not care to invest in better living conditions so they would recruit more MD and RN. Therefore, most employees stay short period of time then leave. Continuity of care is lost, and patient care is compromised."

47. "Your survey would be more accurate if we could give more than one answer to a question, such as rotating as student or intern I did both."

48. "I find working in the Indian Health System very satisfying. I love the benefits, the vacation time, and the healthy salary. The patients are so appreciative of your efforts because they aren't worrying about your bill. I love the freedom from stress that comes from not having to worry about the latest Medicare pay cut or the high cost of malpractice. A wise physician will see the benefits of Indian Health."

49. "I work for the Cherokee Nation and onsite at an IHS facility as part of my responsibilities with the Cherokee Nation. In our circumstance, the Cherokee Nation has significantly more resources, more funds for contract health, a broader pharmacy and a better plant. Thus, it becomes an issue of individual preference, geographic desires / potential for someone seeking to participate in either independent tribal or IHS facilities - recognizing that there are differences between the two."

QUESTION 2.

If you could make a statement to Indian health programs administrators and clinical directors about how they could enhance the quality of your practice and improve recruitment/retention to Indian health programs, what would you say?

1. "Get enough nice housing to provide for all professional employees rather than using unmaintained, 50 year old delapidated, poorly insulated housing that the windows are either stuck open or shut throughout the year. We are always in a housing crunch and loose providers due to housing issues more than any other reason. Professional people should not be required to live in structures that would be condemned in Harlem as substandard. Congressmen should be required to come live here for a month in the winter and then see how they appropriate funds for IHS housing."

2. "Reduce the red tape and politics. Run the place like a private corporation and things will improve exponentially."

3. "stop micromanaging"

4. "Work with your Clinical staff, find common ground, provide incentives other than salary to keep them coming back, instill the value of a long term commitment and keep that in the philosophy, provide the staff they need to do the work you want them to do, allow them to attend IHS and IHI conferences to improve their skills with providing care, provide them with adequate IT staff and CAC staff for EHR, this is vital to the stability of the clinical providers, find out what they enjoy about their work and stay in touch with how that is going, the rest will take care of itself..."

5. "Streamline the Human Resources hiring process. Work to reduce/eliminate time consuming bureaucratic hurdles. Allow clinical directors to have the authority to offer jobs to potential recruits. Work to reduce/eliminate the discrepancies between the mission of IHS vs. Commissioned Corps. Give more recognition for those practicing in rural, under-served areas (eg. the sixth precept)"

7. "IHS work is very challenging; administration needs to recognize this and do a better job getting physicians what they need to do their job. We are understaffed and underfunded, handling the load of a much larger clinic with very limited resources. Contract health funding and administration are poor and this is a barrier to the best possible care."

8. "Stop hiring and retaining incompetents solely because they are Indian. When you do hire competent people, train them to do the job."

9. "I think the per capita funding differential between the VA and the IHS is a result of blatant racism. I dream that somehow a case will get to court that would result in funding parity with other federal health programs (military, VA) on the basis of civil rights law."

10. "treat physicians like professionals that are the reason the clinic exists, and not as just another employee equal with the medical records clerks in decision making process"

11. Like everybody else I would like to move up the ladder. My position is a GS14. For retirement purposes I must find a GS15 position for 3-4 years. If that means leaving IHS to do so, so be it. I enjoy IHS as a work environment and am grateful for the opportunity to work here. I certainly can see myself here for the next 14 years. However, I need to look at the overall picture for my long term goals of retirement and feel it is of the utmost importance that I attain a level of GS15 for three years to satisfy my "high three" requirement for retirement."

12. "Ridiculous amount of duplication of paper work. Support staff is unable to help. Here's an example. MD should not be scheduling patients for OR. A secretary should schedule physician referred patients for surgery and send preop instructions. Mandates come down for training such as the AMS program that do not link with our computers. Our buildings are old, disgusting(4 bed wards) and a health hazard. Our equipment is broken. Broken equipment is not replaced. Patient care is done in trailers. I find that offensive. I would not choose to see a medical practice that operates out of a trailer anymore than I would bank in a trailer."

13. "I am a Clinical Director at a very rural IHS Clinic, so the following comments would be primarily addressed to Area leadership and above. My biggest frustrations are 1) whoefully inadequate third party billing practices and hence a suboptimal operational budget; 2)A business approach to IHS delivery of health care is essentially absent thus making what could be a very efficient and progressive health care delivery system something very much less. 3) organizationally crippling ingrained HR hiring practices - misuse / misapplication of IP policy; 4) Personnel productivity issues and ineffective HR disciplinary policies - much of this being reflective of the Union bargaining agreements and IHS reaction to this; 5) Contracting, which really needs more delegation to the service unit level if improved efficiency is to be achieved; 6) individuals in principal leadership positions that have neither the qualifications nor administrative accumen to be in such positions, reflective in many instances of #3 above."

14. "Since Native Americans have a high rate of DM and related issues, social issues related to poor \$ issues- we need more time to see patients. It usually takes me a long time for a patient to trust me (high MD turnover), and it takes a while in each visit to clear the air, and get to know them so that they will feel free to trust me. Cookie cutter clinics where MD's are on a hamster wheel do not work in Indian Country. Many medical problems are under reported to the provider, while pain and depression issues are legion. THis is not unique to Native Americans, but to all poorer folks everywhere. Hence, the challenge is to deal with and navigate through the latter to get at the former. YOU CANNOT DO THAT IN 15 MINUTES".

15. "Help a little more with recruitment incentives and loan repayment programs."

16. "Perhaps the greatest frustration working in a tribal clinic setting in California is, we have no central IHS referral site, no Hospital in California area as they do in Arizona, Alaska, Oklahoma. In this community in Northern California, it is our best patients who have Medi-Cal coverage. Those patients are often left out in the cold when it comes to finding them an Orthopedic Surgeon, a Urologist, an Endocrinologist. Perhaps one of the Tribal or Urban clinics could serve as the Area-wide referral center for Urology, Neurology, Endocrinology, Rheumatology and other such specialties where it is hard to find a physician who will see a Medi-Cal patient."

17. "Timely step increases productivity bonus, comp time for it, increase CME and training. Admin. Time for records."

18. "Incentives need to be increased to the national average for medial professionals. Administrators need to listen to the requests of the physicians, after all we are the people providing the service. When we ask for more nurses or additional doctors, we do this not to decrease the number of pt we are seeing, but to increase and provide better more comprehensive care."

19. "increase salaries. hire effective support staff such as secretarial staff, nursing, etc. have some basic educational and experience requirements for hospital adminstrators beyond a high school education."

20. "Back off on the regulatory burdens (security clearences, backgrounds checks, mandated trainings, on-line modules, etc.)."

21. "First, and formost, increase the annual compensation as above (especially for primary care.) Bolster loan repayment sums and opportunities significantly (again especially for primary care)! Understand that physicians are among the most highly trained, highly mptivated, and responsible people you are ever going to work with. As a system wide generalization only, please view us and treat us this way."

22. "we need clerical support to help with administrative stuff (writing policies, doing surveys, and etc.) so that we can co a better job of taking care of our community, we Providers don't have time to do this, but need . we need the feds and state to embark on a campaign re drugs and pain management, like they did with antibiotics and viral illnesses, to help us as front line providers help our people see that there are other ways than pills to manage pain and help us get a handle on the prescription drug abuse problem.... I could go on, I need space and support for group programs - like obese kids a and support for the teachers and threapists to run them - teaching traditions, self care and wellness..."

23. "I have found the IHS to give inadequate support with regards to RPMS and the shifting to EHR."

24. "1) 4 day 40 hours week. 2) More attention to personal needs: after teaching ACLS in trama centers for 12 years, was unable to obtain premission for outside work last year. It was not the money for teaching I midded, it was complete review of trauma topics and the joy of teaching residents, fellows and other physicians in an university setting. very disappointing!"

25. "IHS needs to name brand with every student/resident/Physician in the US. Mailings, facebook, twitter etc --- IHS still using outdated methods to gets its brand recognized.

2) IHS needs to support "home grown" talent --meaning in rural areas local people are more likely to stay once they receive their education and return.

3)Recognize that each location has a unique set of recruiting issues and a global aproach will only go so far.

4) Enough flexibility to meet the needs of all professionals wanting to work in IHS."

26. "More communication with staff at outlying clinics would be helpful."

27. "Don't interfere with practices that are meeting the service unit mission and are working collegially."

28. "Offer more part time positions and/or short term contracts to SPECIALISTS to come in and help get some of those services (ortho, dermat, GI, etc.)"

29. "Spend more time and effort listening to the perceptions and the felt needs of the folks in the trenches. Make sure your workers feel heard and supported."

30. "Enough with the paperwork. You can't the forest because all trees have been turned into paper! The IHS is a bigger bureaucracy than anything else I have encountered in my practice--replete with all of the negative things found in a large bureeaucracy. The patient is the only reason we exist, not to make big time powerful bureaucrats."

31. "Change HR to allow hiring, there are lots of interested providers both mid-level and MD. However, we lose their interest because of the prolonged process. I am a clinical director and have lost out on many oppurtunities. Retention starts at the Area offices, when providers leave Area directors and Chief Medical Officers need to get more proactive. The appearance is one of "oh well, they were not a good fit". All providers: mid-levle to MD/DO should be brought in at market rates. Not just MD, if they want to worry about succession planning, look at the future of primary care, we must be competitive for pay or we will not recruit new blood."

32. "Provide adequate support staff and time/education to staff and physicians. Most of us are here because we care about the patients and because we enjoy taking care of them. We don't want to run them through like cattle and turn them into a number."

33. "You need to offer 10 to 20% better incentives than the surrounding area in order to attract quality providers. Otherwise you often get those who cannot find a job in the private sector."

34. "RESPECT"

35. "I think in recruitment they are quite good, and make many promises. In reality and retention they are abismal. To get this job I'm sure I had more than 100 pages of paper work to 2 different organizations. I have run into time keepers in IHS who have jipped me about 20 days of comp time. And none of the medical directors listened. Improvement in scheduling is not even a consideration. Now that I am not paid overtime, I am expected to work about 1 hour over time every day without compensation. My last patient comes in 5 min before the "end" of my work day. I have no scheduled admin time, if I'm lucky I eek in a few minutes for lunch do admin work at the same time. If I am even lucky one of our weekly meetings will be canceled giving me 2 hours (this morning is the first one for 3 months) or one will stop early and give me maybe a 1/2 hour. So of course burn out is a major problem for IHS physicians at the clinics I have worked at. One just hopes they find another job before it affects patient care."

36. "Encourage patient 's compliance and regular follow up instead of showing up when they are sick. Have a way of decreasing walk-ins when appointments are less than 50 % show up. Make patient's responsibl;e for there care instead of blaming providers for thier poor health. Should have a way of retaining providers that are already recruited."

37. "LESS PAPERWORK FEWER COMMITTEES FEWER MEETINGS. EXTENDED CLINIC HOURS - This would improve patient access to providers better than IPC care teams do!!! Better pay, better comminications between those of us in the field and the decision makers. I find out way too often, after I've completed some duties, I find out my supervisors wanted it done differently. Frustrating and not very productive."

38. "Update EHR; ours is archaic. Clear guidelines re: rationing of healthcare resources"

39. "Patient care and recruitment/retention could be dramatically improved if administrators would become informed about and give recognition to the increasing time demands on medical care providers as a result of the EHR and the growing prevalence of chronic health problems in the native American population."

40. "The recruiters for Aberdeen area need help with expediting applications for providers who want to come to this area. Submission of applications is currently bogged down by the process. The wait can be so long that the applicants take jobs in other areas while their application has not even started to be processed in Aberdeen. I started inquiring in July 2005 about a job. I started working in October 2005. I didn't even have my orders about when to start. The movers came and I left. I remained patient during all the process of getting employed in Sisseton."

41. "I was not able to get a loan repayment as I do not work 40 hours a week. I think in this day and age that is very antiquated and may affect my retention."

42. "Promote and bridge benefits competitive with the private sector. Additional line item funding from Congress."

43. "Adequate clinical and support staff, and consider additional staffing with Medical Office Assistants wherever EHR exists; More time for community involvement and program improvements; Expand Behavioral Health Programs; Increase staffing for HR to improve turn-around time for communications/assistance; Continue commendable efforts to increase training for supervisors, leadership, and change; Continue to provide and increase opportunities to meet with peers face-to-face."

44. "Get Human Resources, Acquisitions, and Finance to cut the red tape and do their jobs."

45. "Reduce typing and computer time, seriously simplify and upgrade the charting system, especially the medication lists, have a patient face sheet that includes patient hx, fam hx, meds, allergies, permanent physical findings, maintenance care done, etc. all on one page instead of searching all over, avoid logging in extra to access imaging when already in EHR. Makes no sense to have the most expensive member of the team type records."

46. "Nonclinicians making clinical decisions is horrible. For example, a recent change in our policy is that no one will be triaged 'out'. That is to say that everyone will be seen when they come in. That is fine if you have the staffing package to support that, but if you don't, then you get horrible healthcare and suboptimal treatment of your patients."

47. "I currently am the acting clinical director. I am seeing more patients now than I was when I was strictly clinical. Our clinic is so understaffed that I can take maybe 5% of my time to try to do my administrative tasks. On top of this, I have received no increase in salary and no supervisory training. I have 2.5 FTE clinicians in a practice that would support 4. For the first time in years, the clinic has a stable permanent staff and the quality of care has increased significantly. However, administration appears to be blind to the reality that by overworking the clinicians, they are forcing us to consider leaving the clinic."

48. "CEO's need to pay attention to the physicians and not just how great the Clinical Director tells you everything is. Elicit and use Exit Interview information in a proactive way to make changes to retain physicians and don't blame the physicians themselves for leaving. Put into positions, CEO's and CD who have real leadership capabilities and are not just after the prestige and salary and get the job based on their IP status alone, especially when they have no real leadership qualities."

49. "Offer more stability in key administrative positions. Help establish an EHR and robust policies and procedures".

50. "I would find it more satisfying if the professional's input were truly sought, received/heard, and sometimes even utilized. The "top-down" approach seems to continue be the norm. Egs. "This is what 'we' have decided." "The computer system won't allow us to do that."

51. "Be creative in allowing more flexible scheduling. Competitive salary and benefits as budget allows."

52. "The snafu in personnel hiring with the new background checks has made it almost impossible to hire anyone for any position no matter how desperately needed. It is unreasonable to expect new hires to wait 6 months to start work. All of that paperwork needs to be expedited. Also, as a civil service employee, I have no good resource person for personnel issues. No one can give a correct answer on step increases and pay questions. Why not? Who is helping us after we are hired? "

53. "There is an utter lack of leadership skill in the appropriate skill sets at IHS and this seems to be getting worse, not better. The drive to give preference in every aspect, including even just participation in decision making, never mind actual decision making positions, to Native Americans is leading to a hemorrhaging out of the system the good, committed non-Native staff, and this is accelerated by hateful and quite blatantly racist attitudes of local staff, whether or not Area Office staff are aware of it. I was in clinic previously where the newly appointed CEO announced at her first all-staff meeting that one of her personal and professional goals at the clinic would be to see staff converted entirely and 100% to Native staff. The (all non-Native) doctors and dentists and some other key clinical staff were stunned, protested this over the months to come, but were actually told by this CEO that she felt it was a non-issue! The clinic where I currently work has been out of the frying pan into the fire, with blatant racism even among the Native American staff. To pretend that this is anything less than regression to hate mongering, and wouldn't have a negative effect on the ultimate goal of good patient care, is ludicrous, but that's exactly what is happening in IHS. Additionally, I believe it is a travesty to the Federal system that a tribe is allowed much if any influence over the hiring of staff, and worst of all the CEOs of the clinics, unless and until they commit to the 638 of their programs. It is wrong that the Federal government has a program by which a tribe may opt to assume both more responsibility and more autonomy over their own health care and resource allocations (the 638 program) but the tribe gets to opt out of this, and yet insists on (and is being granted) increasing rights to determining everything from the appointment of such a vital position as CEO, right down to who is allowed to set up "concessions" or sell drugs or services in the halls and facilities owned by the Federal government. The entire system is convoluted,, designed to confuse and confound, hopelessly unresponsive to rapid-fire needs for changes in processes and procedures. This is in part the fault of the Federal government, since as a government they have failed to properly monitor and rationalize the funding and organization of IHS (and most objective observers say either that this is because the Feds don't care, or the Feds are too afraid of being accused of discrimination or racism if they point out the problems). But it is just as much if not more the fault of IHS administrators who incorrectly or in self-serving fashion "interpret" such things as guidelines for PMAPs, complaint processes, etc. with complete disregard to fairness, to hearing all sides, to thorough and honest investigation of complaints, etc. It is a well-known and oft-quoted axiom in IHS that the worst of IHS rises to the top like cream, precisely because in order to get them OUT of where they are making trouble, without being then dragged through endless processes of EEO complaint, they are PUT in a position in Area office rather than fired, thus allowing them to "infect" the whole system and have more authority with their poor judgment and incompetence. This is less my opinion as it is that of many many people I've met who have been in the system much longer than I. My observation locally (in the one clinic in which I am currently working)

is that much of this is due to tribal political connections, corruption, infighting, that results in ignoring, looking the other way, at even criminal behavior within the clinic, never mind the unethical behaviors that are rampant (with respect to access to patient records, use of leave and other benefits, excessive lunch/"smoking" breaks, unauthorized use of "key" privileges in such things as ITAS or access email accounts, and multiple other things)."

54. "EHR immediately reduces the number of patients it is possible for me to see in a day by 1/2. Dictating would give me full capability. Dragon Speak is a big problem"

55. "Working with the IPC projects through the IHI was the best thing that has happened to the IHS - this has clearly improved our retention and recruitment. Please continue to support programs in medical education and collaborative agreements with outside universities - this is key to the 3R program for recruitment as well as retention. When you make decisions in Rockville please consider the implications at our rural sites; ie: fingerprinting requirements. Many of our consultants no longer want to come here because they spend most of their day in HR instead of providing the very outreach services that we need (ie: volunteer dermatologists, hand surgeons, pediatric neurologists, etc.). We will also have a harder time recruiting students and residents to our site, and were told to have them come to our site (4 hours from any airport) for fingerprints before their tour of duty to be processed - this is unreasonable and illogical. And by the way - I have worked here for 6 years and rotated here 9 years ago as a resident - and none of my fingerprints were ever cleared. We have surveyed our medical staff and found that security, the condition of our hospital facilities (playground, ball field), and lack of childcare were some of our leading causes of dissatisfaction that could be addressed by our organization. Instead of just saying "we have no money" maybe we should think of creative ways of trying to show the IHS community that leadership is trying to improve safety, and address tenant concerns for individuals and their families."

56. "Be careful of hiring only midlevel providers without regards to hiring physicians. While midlevel providers do a wonderful job at taking care of the routine and moderate risk patients, higher risk patients need management by physicians."

57. "Extend clinic hours. Open later in the day, open on Saturday mornings. More flexibility than just 8 to 5 M - F. Our patients would absolutely love the extended hours mentioned above. Some of our local employers punish our patients when they come in for medical care during work hours!!! It would make things a little harder for recruiting non-medical provider staff, but nurse aids/medical assistants, clerks, etc are a little easier to find in a small town than an internist, endocrinologist, experienced family practitioners (MDs, DOs ARNPs), etc."

58. "I would make sure that the doctors are running the nurses and not the other way around. Physician satisfaction is low when less experienced personnel are making decision for them. It is the powerlessness that physicians are sometimes rendered that leads to the greatest dissatisfaction. When physician control their schedule layout, have the power to select and retain nursing staff, and are able to set the duties they expect of their nurses, things work best. Nurse administrators and nurses should answer to the doctors they serve. The heirarchy sometimes gets screwed up."

59. "There is a fundamental issue of adequacy of resources and priority for expending funds consistent with the needs of the patients and the health care providers. This may not always be the case - an MRI machine in a facility is fine but not if you are lacking primary care physicians, hospitalists, and an adequate supply of specialized pharmaceutical agents."

KEY PRIORITIES

This survey was conducted in support of IHS' key priorities, as referenced above. IHS has actively sought the opinions and insights of Indian health program physicians through the survey in part to renew and strengthen our partnership with tribes. Communication is central to this effort. The survey provides insights from physicians on the front lines of care that will enable IHS to better understand how it can support the needs and challenges of tribes and act as a more effective and informed partner.

IHS also is committed to reforming its policies and practices. This reform will be shaped by input from physicians and other leaders at Indian health program facilities obtained through surveys such as this one. Responses and comments included in this survey will have a direct impact on IHS clinician recruiting and retention policies, which will be reformed to enhance the staffing capabilities of Indian health program facilities.

IHS' third key priority, improving quality and access to care, is in many ways a function of improved recruiting and retention methods. Using input from this survey, IHS will seek to enhance recruiting techniques and resources, attracting qualified clinicians to Indian health program facilities and thereby enhancing access to care for the patients they serve.

IHS seeks to be accountable, transparent, fair and inclusive. The survey underscores IHS' commitment to include physicians and other Indian health program leaders in the policy making process. The survey puts on record how physicians perceive Indian health program practice and the ways in which physicians believe IHS can help improve the quality of their practices and recruiting efforts. IHS now is accountable for responding to input from this survey, which it will do in accordance with the key priorities listed above.



CONCLUSION

IHS' 2011 Clinical Staffing and Recruiting Survey was conducted in a context of change. Prompted by a new health care reform law and by a wide range of market factors, the healthcare delivery system is moving toward new models designed to enhance quality and efficiency. These changes, and a number of ongoing challenges such as declining reimbursement, rising costs, and other factors, have created uncertainty and consternation among many physicians. As a result, physicians in greater numbers are seeking alternative practice styles and settings that offer them a favorable practice environment. The 2011 Clinical Staffing and Recruiting Survey suggests that Indian health program facilities offer many of the practice characteristics physicians are seeking, including reduced malpractice exposure, time with patients, a balanced quality of life, and a mission-driven purpose. As a consequence, Indian health program physicians express higher levels of professional satisfaction than many physicians in other settings.

Indian health programs therefore offer a favorable practice “brand” that should be aggressively leveraged during the physician recruiting process. An opportunity exists to position Indian health program practice as an attractive alternative for doctors seeking greater emotional rewards and a haven from the slings and arrows of modern medical practice.

However, the survey indicates that to effectively pursue this opportunity, Indian health programs must address human resources and bureaucratic inefficiencies that tend to erode physician satisfaction and undermine physician recruiting efforts, provide enhanced recruiting resources where possible, and encourage physician involvement in the recruiting process.

For additional information about this survey contact:

Project Leader: Travis Singleton

Lead Analyst/Author: Phillip Miller

Research and Response Director: Elaine Peng

Data Director: Tonia Reeder

For additional information
about this survey, contact:

- Travis Singleton/Project Leader
- Phillip Miller/Lead Analyst and Writer
- Elaine Peng/Research and Response Director
- Tonia Reader/Data Director

Merritt Hawkins
5001 Statesman Drive
Irving, TX 75063
www.merritthawkins.com



© Indian Health Service
www.ihs.gov

The Reyes Building,
801 Thompson Avenue,
Ste 400, Rockville,
MD 20852