2011 CLINICAL STAFFING AND RECRUITING SURVEY

A SURVEY OF INDIAN HEALTH PROGRAM FACILITY ADMINISTRATORS EXAMINING THEIR CLINICAL STAFFING NEEDS AND RECRUITING PATTERNS

 | The Reyes Building, 801 Thompson Avenue, Ste 400, Rockville, MD 20852 | www.ihs.gov

Conducted by Merritt Hawkins, an AMN Healthcare company

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IN THIS REPORT

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INTRODUCTION

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What types of physicians and other clinicians are Indian health program facilities seeking?

What challenges are they facing in recruiting these clinicians?

What methods are they using to recruit, and which are the most effective?

How long does the recruitment process take and what are the typical cost/benefits involved?

Through Merritt Hawkins, a national physician search and consulting firm, the Indian Health Service (IHS) initiated its 2011 Clinical Staffing and Recruiting Survey to provide answers to these and related questions. The goal of the survey is to identify common recruiting patterns at Indian health program facilities, to place these patterns in the context of the general clinical recruiting market, and to identify how Indian health program facility administrators believe IHS can assist them with their recruiting needs.

To this end, the survey asked Indian health program facility administrators to provide data and commentary regarding their clinical staffing requirements, challenges, and incentives, and to suggest ways in which IHS can assist them in their recruiting and retention efforts.

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 undeserved, thereby raising the health of American Indians and Alaska natives.

The survey was conducted in support of IHS' key priorities:

1. To renew and strengthen our partnership with tribes
2. To reform IHS strategies and processes
3. To improve quality and access to care for Indian health program patients
4. To make all of our work accountable, transparent, fair and inclusive

This report includes results of the survey and an analysis by Merritt Hawkins regarding the survey's findings and implications, as well as a summary regarding how the survey acts to forward IHS' key priorities outlined above.

METHODOLOGY

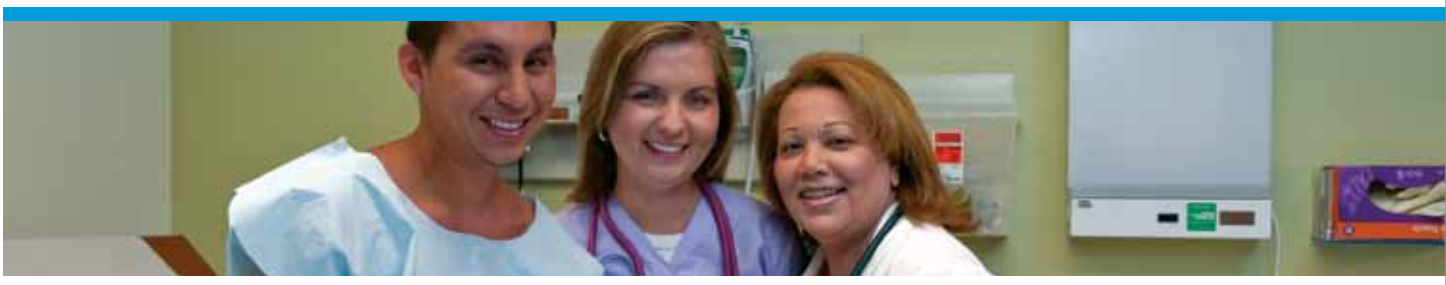
IHS provided Merritt Hawkins with a list of some 400 Indian health program facilities and organizations to contact. In some cases, the list included the names of administrators affiliated with the facilities. In others, no names were attached to the facilities. A Merritt Hawkins' representative refined this list by calling each facility to obtain the names and emails of two administrators, where possible. In some cases, facilities on this list were community relations or general information offices only and do not provide clinical care. Surveys were not sent to administrators at these facilities. In other cases, facilities on the list have closed. In additional cases, facilities were branch offices of larger facilities administrated by the same person or persons. Merritt Hawkins' representative identified the most appropriate person or persons to which to send the survey at each facility. Where two administrators were not present or were otherwise unavailable or unwilling to be contacted, one administrator's name and email was obtained.

The final list included 380 administrators located at 255 facilities.

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

A total of 81 administrators responded, for a response rate of 21%.

A breakdown of key survey findings and an analysis of findings are included in this report.



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 facilities serve a unique population of patients through Federal, Urban Indian and Tribal hospitals and clinics. Many of these facilities are in small, rural communities or urban areas that traditionally have been medically underserved.

Consequently, a key challenge facing Indian health program facilities is the recruitment and retention of clinical professionals, including physicians, nurse practitioners, physician assistants, dentists, nurses and pharmacists. The 2011 Clinical Staffing and Recruiting Survey reflects the level of need for various clinicians at Indian health program facilities, the types of clinicians they are seeking, their typical recruiting costs and methods, turnover rates, and factors which enhance or impede their recruiting efforts.

KEY FINDINGS OF THE SURVEY INCLUDE

Indian health program facility administrators indicated that primary care physicians are more urgently needed than any other type of clinical professional. 45% of Indian health program administrators indicated their facilities have an urgent need for primary care doctors, while 38% indicated they have a moderate need. Only 17% are fully staffed and have no immediate need for primary care physicians.

The average vacancy rate for physicians reported by Indian health program administrators was 22%, considerably higher than the vacancy rates experienced by facilities in the private sector. Vacancy rates for other clinicians also are higher for Indian health program facilities than is generally seen in the private sector.

Indian health program facility administrators indicated that 25% of physicians on their staffs are 61 years old or older, indicating that staff attrition looms as a serious challenge. Only 5% of all physicians in active patient care are 61 or older.

Indian health service administrators report losing more clinicians in the last year than they were able to replace. Administrators report losing an average of 3.1 clinical professionals in the last 12 months but have only replaced an average of 1.7 of those they have lost.

50% of Indian health program facilities currently are recruiting primary care physicians.

Dentists follow primary care physicians as the most urgently needed type of clinician. 38% of administrators indicated they have an urgent need for dentists, 33% said they have a moderate need, and 29% said they have no immediate need.

57% of Indian health program facilities currently are recruiting dentists.

The majority of administrators (54%) said that a shortage of primary care physicians has compromised access to care in their service areas, while 48% said a shortage of dentists has compromised access to care. To a significant but lesser degree, access to care also has been compromised by shortages of specialist physicians, physician assistants, nurse practitioners, nurses, and pharmacists.

Close to half of administrators (46%) said quality of care in their service areas has been compromised due to a shortage of primary care physicians, while 41% said a shortage of dentists has compromised quality of care.

The majority of administrators see a moderate to serious need for other types of clinicians. 55% are recruiting nurses, 49% are recruiting nurse practitioners, 37% are recruiting pharmacists, and 37% are recruiting physician assistants.

Specialist physicians are considered the most difficult type of clinician to recruit by administrators, followed by primary care physicians and dentists.

Though challenges persist, Indian health program facilities are enjoying some recruiting success. 64% of administrators said they had been successful recruiting one or more physicians in the last 12 months and 60% said they had been successful recruiting a dentist or nurse in the last 12 months. Administrators rate online advertising/clinical job sites, personal networking, and job postings on their own facility's site as the most effective methods for recruiting clinical professionals.

Administrators' identify "paperwork/red tape" as the factor having the most negative effect on clinician turnover at their facilities, followed by IHS policies and priorities, professional isolation, and spousal support/opportunities.

78% of administrators indicated they must interview at least three physicians to fill one opening.

Administrators reported an average physician interview cost of $3,815

Salaries offered to physicians by Indian health program facilities tend to be significantly lower than national averages.

Only 33% of administrators indicated that their facilities have a clinical recruitment and retention plan in place.

Administrators are divided regarding the effect health reform will have on demand for clinicians at their facilities. 48% said health reform will greatly increase or somewhat increase demand for primary care physicians, while 52% said reform will either decrease demand for primary care physicians or have no effect on demand.

SUMMARY OF KEY FINDINGS

The survey indicates that Indian health program facilities are encountering recruiting challenges similar to private sector facilities, and, despite comparatively limited resources and strategic planning, are achieving some recruiting success. However, clinical vacancy rates are comparatively high at Indian health program facilities, and some facilities are challenged in addressing vacancies due to staff attrition, lack of planning, a dearth of resources, and administrative inefficiencies that may be hampering recruiting efforts.

The recruiting patterns, metrics, challenges and requirements of Indian health program facilities are discussed in more detail later in this report.

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

QUESTIONS ASKED AND RESPONSES RECEIVED

1 WHAT IS YOUR TITLE?

Various, including:
Executive Director, Health System Administrator, Clinical Director, Department Head, Acting CEO, Facility Director, Vice Chief of Medical Staff, Administrative Officer, PI Officer/IPC Coordinator, Administrator, CEO, Interim CEO, Health Director Assistant, Chief Medical Officer, Director of Human Services, SMSC Health Administrator, Health Administrator, Division Director/Health and Human Services, Chief Dental Officer/Acting Clinical C, Health Director, Clinic Administrator, Director of Health Services, Clinical Service Chief, Clinical Administrator, Human Resource Director, Physician, Health System Specialist, Director of Health Programs, Supervisor, I.H.S. Director

2 IN WHAT STATE IS YOUR FACILITY LOCATED?

California	18%
Oklahoma	18%
New Mexico	9%
Washington	9%
Arizona	7.5%
Alaska	4.5%
Minnesota	4.5%
Montana	4.5%
Wisconsin	4.5%
Oregon	3%
South Dakota	3%
Colorado	2%
Illinois	2%
Kansas	2%
Louisiana	2%
North Dakota	2%
Nevada	2%
New York	2%
Rhode Island	2%

3 WHAT TYPE OF FACILITY IS YOUR SITE?

Federal	35%
Urban Indian	5%
Tribal	60%

4 IN WHAT COMMUNITY IS YOUR FACILITY LOCATED?

Indian health program administrators were advised that they could complete the survey anonymously and that Merritt Hawkins would not share their names or locations or related data likely to identify them.

5 WHAT SIZE COMMUNITY DO YOU SERVE?

0–5000	30%
5,001–10,000	26%
10,001–25,000	21%
25,001–50,000	15%
50,001–100,000	4%
100,001 or more	4%

6 HOW WOULD YOU RATE THE NEED FOR ADDITIONAL CLINICAL PROFESSIONALS AT YOUR FACILITY?

	URGENT	MODERATE	NO IMMEDIATE NEED
Primary care physicians	45%	38%	17%
Specialist physicians	26%	32%	42%
Nurse practitioners/Physician assistants	29%	42%	29%
Dentists	38%	33%	29%
Nurses	28%	45%	27%
Pharmacists	19%	35%	46%

7 TO WHAT DEGREE IS A SHORTAGE OF THE FOLLOWING CLINICAL PROFESSIONALS A CONCERN TO YOUR FACILITY?

	SERIOUS	MODERATE	NO CONCERN
Primary care physicians	50%	33%	17%
Specialist physicians	24%	38%	38%
Nurse practitioners/Physician assistants	28%	43%	29%
Dentists	43%	29%	28%
Nurses	32%	40%	28%
Pharmacists	26%	36%	38%

8 IS ACCESS TO CARE IN YOUR SERVICE AREA COMPROMISED DUE TO THE SHORTAGE OF ANY OF THE FOLLOWING CLINICAL PROFESSIONALS?

	YES	NO	UNSURE
Primary care physicians	54%	42%	4%
Specialist physicians	46%	47%	7%
Nurse practitioners/Physician assistants	36%	59%	5%
Dentists	48%	47%	5%
Nurses	27%	65%	8%
Pharmacists	23%	66%	11%

9 IS QUALITY OF CARE IN YOUR SERVICE AREA COMPROMISED DUE TO THE SHORTAGE OF ANY OF THE FOLLOWING CLINICAL PROFESSIONALS?

	YES	NO	UNSURE
Primary care physicians	46%	49%	5%
Specialist physicians	40%	53%	7%
Nurse practitioners/Physician assistants	33%	59%	8%
Dentists	41%	54%	5%
Nurses	25%	65%	9%
Pharmacists	22%	68%	10%

10 IN THE LAST 12 MONTHS, HAVE YOU RECRUITED ONE OR MORE PHYSICIANS TO YOUR SITE?

Yes	64%
No	36%

11 IF YES, WHICH TYPES

Family physician	40%
General internist	15%
Pediatrician	7%
OB/GYN	7%
Anesthesiologist	5%
General surgeon	4%
Otolaryngologist	0%
Emergency physician	7%
Orthopedic surgeon	0%
Psychiatrist	11%
Radiologist	2%
Ophthalmologist	2%

Other:
- Neurologist,
- Endocrinologist
- Podiatrist
- Cardiologist
- Deputy clinical director
- Pediatrician
- Physical therapist
- Respiratory therapist

12 WHICH TYPES OF PHYSICIANS ARE YOU NOW RECRUITING?

Family physician	50%
General internist	14%
Pediatrician	10%
OB/GYN	9%
Anesthesiologist	6%
General surgeon	4%
Otolaryngologist	0%
Emergency physician	12%
Orthopedic surgeon	4%
Psychiatrist	14%
Radiologist	5%
Ophthalmologist	2%

Other:
- Optometrist
- Psychologist
- Independent social worker
- Podiatrist
- Community health aide

13 WHAT PERSONNEL SYSTEM DO YOU USE TO RECRUIT CLINICIANS AT YOUR SITE?

Commissioned Corps	49%
Civil Service	39%
Tribal hire	61%
Other	14%

Other:
• Locum tenens agencies (3) • Illinois Primary Health Care Association
• Contract nurses • IHS • Local advertisements • Word of mouth
• Letter to residencies • anything we can think of • Website for IHS.gov

14 IN THE LAST 12 MONTHS, HAVE YOU RECRUITED ONE OR MORE OF THE FOLLOWING?

Physician assistant	37%
Nurse practitioner	48%
Dentist	60%
Nurse	60%
Pharmacist	46%

15 ARE YOU NOW RECRUITING ANY OF THE FOLLOWING?

Physician assistant	37%
Nurse practitioner	49%
Dentist	57%
Nurse	55%
Pharmacist	37%

16 HOW DIFFICULT IS IT TO RECRUIT THE FOLLOWING CLINICIANS TO YOUR FACILITY?

	NOT DIFFICULT	SOMEWHAT DIFFICULT	VERY DIFFICULT
Primary care physicians	11%	37%	52%
Specialist physicians	19%	22%	59%
Nurse practitioners/Physician assistants	22%	51%	27%
Dentists	21%	30%	49%
Nurses	27%	48%	25%
Pharmacists	28%	41%	31%

17 HAS IT BECOME EASIER OR MORE DIFFICULT TO RECRUIT THESE CLINICIANS OVER THE LAST 12 MONTHS, OR HAS THERE BEEN NO CHANGE?

	EASIER	MORE DIFFICULT	NO CHANGE
Primary care physicians	10%	42%	48%
Specialist physicians	24%	24%	52%
Nurse practitioners/Physician assistants	21%	48%	31%
Dentists	22%	35%	43%
Nurses	26%	45%	29%
Pharmacists	29%	43%	28%

18 HOW DO YOU BELIEVE HEALTH REFORM WILL AFFECT THE NEED FOR CLINICAL PROFESSIONALS AT YOUR SITE?

	GREATLY INCREASE	SOMEWHAT INCREASE	NO CHANGE	DECREASE
Primary care physicians	33%	27%	19%	33%
Specialist physicians	44%	22%	20%	44%
Nurse practitioners/Physician assistants	37%	27%	19%	37%
Dentists	40%	23%	19%	40%
Nurses	38%	28%	22%	38%
Pharmacists	45%	23%	19%	45%

19 TYPICALLY, HOW LONG DOES IT TAKE TO RECRUIT A PHYSICIAN AT YOUR SITE, INCLUDING FROM THE TIME THE JOB IS POSTED TO THE CONTRACT IS SIGNED?

	PRIMARY CARE	SPECIALISTS
0–90 days	19%	6%
91–180 days	35%	13%
181–365 days	27%	48%
more than 365 days	19%	33%

20 TYPICALLY, HOW LONG DOES IT TAKE TO RECRUIT PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS TO YOUR SITE?

0–90 days	26%
91–180 days	41%
181–365 days	21%
more than 365 days	12%

21 ON AVERAGE, HOW MANY INTERVIEWS MUST YOU CONDUCT TO FILL ONE OPEN SPOT ON YOUR STAFF?

	PHYSICIANS	PAs/NPs
1–2	32%	35%
3–4	39%	45%
5–6	15%	13%
7–8	5%	5%
9–10	2%	2%
11 or more	7%	0%

22 WHAT ARE THE AVERAGE COSTS ASSOCIATED WITH CONDUCTING ONE PHYSICIAN INTERVIEW?

	LOW	AVERAGE	HIGH
Flights	$300	$905	$3,000
Rental car	$100	$204	$750
Accommodation	$100	$285	$2,000
Meals/entertainment	$65	$168	$1,000
Other	$12	$2,253	$20,000
Total	$577	$3,815	$26,750

Indian health program facilities are recruiting within the larger context of a rapidly evolving healthcare system and a medical staffing market characterized by clinician shortages. Many of these facilities express an urgent need for the same types of clinicians being sought by virtually all other types of medical facilities nationwide.

23 WHAT METHODS DO YOU USE TO RECRUIT CLINICAL PROFESSIONALS AND HOW EFFECTIVE ARE THESE METHODS?

	MOST EFFECTIVE	SOMEWHAT EFFECTIVE	LEAST EFFECTIVE
Online advertising/clinical job sites	27%	64%	9%
Networking with your staff/community	44%	41%	15%
Job openings posted on own website	23%	61%	16%
Networking with residency training programs	24%	56%	20%
IHS assistance/resources	26%	51%	23%
In-house recruiting personnel	19%	52%	29%
Exhibiting at professional conferences	14%	55%	31%
Journal advertising	10%	54%	36%
Contingent physician recruiting firms	6%	54%	40%
Retained physician recruiting firms	5%	52%	43%
Direct mail	5%	52%	43%

24 WHAT IS THE VACANCY RATE FOR THE FOLLOWING CLINICIANS AT YOUR SITE?

	AVERAGE
Physicians	22%
Nurse practitioners	19%
Physician assistants	7%
Dentists	20%
Nurses	16%
Pharmacists	8%

25 HOW MANY CLINICAL STAFF LEFT YOUR FACILITY IN THE LAST YEAR?

LOW	AVERAGE	HIGH
0	3.1	15

26 OF THOSE WHO LEFT, HOW MANY HAVE YOU REPLACED?

LOW	AVERAGE	HIGH
0	1.67	7

27 HOW HAS THE TURNOVER RATE FOR THESE CLINICIANS CHANGED OVER THE LAST 12 MONTHS?

	INCREASED	DECREASED	NO CHANGE
Physicians	21%	12%	67%
Nurse practitioners	18%	9%	73%
Physician assistants	13%	7%	80%
Dentists	17%	17%	66%
Nurses	37%	8%	55%
Pharmacists	13%	11%	76%

28 TO WHAT EXTENT IS TURNOVER A CONCERN AT YOUR SITE?

	MAJOR CONCERN	MODERATE CONCERN	NO CONCERN
Physicians	40%	35%	25%
Other clinicians	33%	40%	27%

29 HOW WOULD YOU RATE THE EFFECT OF THE FOLLOWING FACTORS ON TURNOVER AMONG CLINICIANS AT YOUR FACILITY?

	POSITIVE	NEUTRAL	NEGATIVE
Paperwork/red tape	10%	43%	47%
IHS policies and priorities	13%	52%	35%
Professional isolation	12%	53%	35%
Spousal support/opportunities	34%	32%	34%
Politics	15%	52%	33%
Child care	27%	42%	31%
Schools	29%	40%	31%
Human resources	25%	44%	31%
Adequacy of housing	31%	40%	29%
Pay	41%	31%	28%
Administrative duties	24%	51%	25%
Cultural amenities	37%	42%	21%
Administrative support	47%	34%	19%
Information Technology	51%	31%	18%
Mobility	21%	64%	15%
Short-term/long-term training opportunities	28%	56%	16%
Equipment	41%	43%	16%
Appreciation in community	53%	32%	15%
Support staff	64%	21%	15%
Health care	36%	51%	13%
Safety	40%	50%	10%

the key to successful recruiting begins with front-end preparation in which stakeholders, incentives, contracts, candidate parameters, and candidate sourcing methods are aligned.

30 WHAT IS THE AVERAGE SALARY FOR THE FOLLOWING CLINICIANS AT YOUR SITE?

	LOW	AVERAGE	HIGH
Family physicians	$120,000	$165,552	$250,000
General internists	$125,000	$174,423	$312,000
Pediatricians	$110,000	$173,563	$274,000
Ob/Gyns	$110,000	$182,227	$264,000
Anesthesiologists	$140,000	$200,950	$250,000
General surgeons	$175,000	$241,458	$290,000
Otolaryngologists	N/A	$175,000	N/A
Emergency medicine	$165,000	$187,810	$220,000
Ophthalmologists	$125,000	$150,000	$175,000
Orthopedic surgeons	$160,000	$167,500	$175,000
Psychiatrists	$70,000	$168,926	$312,000
Radiologists	$150,000	$155,175	$250,000
Nurse practitioners	$70,000	$92,911	$125,000
Physician assistants	$30,000	$84,582	$120,000
Pharmacists	$75,000	$105,674	$160,000
Dentists	$75,000	$129,487	$175,000
Nurses	$30,000	$65,103	$100,000

31 DO CLINICIANS AT YOUR SITE RECEIVE A STRAIGHT SALARY ONLY OR ARE THEY COMPENSATED WITH A SALARY PLUS A BONUS BASED ON PRODUCTIVITY, QUALITY, OR OTHER MEASURES?

Salary Only	65%
Salary and bonus	35%

32 DOES YOUR SITE OFFER LOCAL EDUCATIONAL LOAN FORGIVENESS/REPAYMENT OR SUPPLEMENTAL LOAN REPAYMENT AS PART OF THE RECRUITING INCENTIVE PACKAGE?

Yes	62%
No	38%

33 IF YES, WHAT IS THE TOTAL AMOUNT OF LOAN FORGIVENESS/REPAYMENT THAT YOU OFFER AND OVER WHAT TIME PERIOD?

	LOW	AVERAGE	HIGH
Total Amount	$5000	$39,684	$90,000

	LOW	AVERAGE	HIGH
Time Period (in months)	12	22.11	48

34 WHAT IS THE PAYER MIX AT YOUR SITE?

	LOW	AVERAGE	HIGH
Medicaid	10%	40%	80%
Medicare	4%	17%	45%
SCHIP	1%	9%	30%
Private pay	5%	21%	62%
Other	1%	30%	69%

35 PLEASE ESTIMATE HOW MUCH NET REVENUE (INPATIENT AND OUTPATIENT) ONE FULL-TIME EQUIVALENT PHYSICIAN GENERATES FOR YOUR SITE PER YEAR IN THE FOLLOWING SPECIALTIES

	LOW	AVERAGE	HIGH
Family physician	$100,000	$387,263	$890,000
General internist	$50,000	$290,000	$500,000
Pediatrician	$30,000	$411,000	$887,719
Ob/Gyn	$15,418	$321,000	$650,000
Otolaryngologist	N/A	$200,000	N/A
Ophthalmologist	$10,000	$145,102	$225,306
Orthopedic surgeon	$39,089	$126,363	$200,000
Psychiatrist	$20,000	$129,252	$300,000
Cardiologist	$200,000	$350,000	$500,000
General surgeon	$200,000	$525,000	$1,175,000

36 WHAT ARE THE AVERAGE DAILY GROSS CHARGES GENERATED BY THE FOLLOWING CLINICAL PROFESSIONALS AT YOUR SITE?

	LOW	AVERAGE	HIGH
Family physician	$177	$2,100	$8,000
General internist	N/A	$600	N/A
Pediatrician	$177	$1,925	$5,000
Ob/Gyn	N/A	$27,110	N/A
Otolaryngologist	N/A	NA	N/A
Ophthalmologist	N/A	$14,624	N/A
Orthopedic surgeon	N/A	$4,909	N/A
Psychiatrist	$190	$732	$2193
Cardiologist	N/A	N/A	N/A
General surgeon	N/A	$40,000	N/A
Physician assistant	$2,000	$2,348	$4,268
Nurse practitioner	$700	$2,570	$4,239
Pharmacist	$987	$2,004	$3,525
Dentist	$100	$1,266	$4,000

37 CONSIDER THE PHYSICIANS ON YOUR STAFF. HOW DO THEY BREAK OUT BY AGE?

40 or younger	26%
41-50	23%
51-60	26%
61 or older	25%

38 DO YOU HAVE A CLINICIAN RECRUITMENT AND RETENTION PLAN IN PLACE?

Yes	33%
No	67%

39 THE FOLLOWING FACTORS ATTRACT CLINICAL PROFESSIONALS TO INDIAN HEALTH PROGRAM FACILITIES?

	STRONGLY AGREE	MODERATLY AGREE	DO NOT AGREE
Practice style	58%	39%	3%
Cultural diversity	43%	52%	5%
Mission-driven focus	40%	53%	7%
Improving patient care	37%	51%	12%
Geographic location	36%	32%	32%
Financial rewards	32%	49%	19%
Equipment/facilities	29%	51%	20%
Lifestyle amenities	29%	46%	25%
Quality improvement	28%	60%	12%
Patient mix	27%	63%	10%

Administrators indicated that it typically takes them longer to recruit specialist physicians than primary care physicians, a not unexpected result given the difficulty of recruiting specialists to rural areas.

TRENDS AND OBSERVATIONS

OVERVIEW – THE RECRUITING MARKET

The Indian Health Services' 2011 Clinical Staffing and Recruiting Survey was conducted during a period of prevailing change in a health care delivery system characterized by a growing demand for physicians and other clinicians and a limited supply.

The Association of American Medical Colleges (AAMC) forecasts that in 15 years the United States will face a deficit of up to 159,300 physicians, over one-third of them in primary care.[1] This projection does not factor in the implementation of health reform, which is expected to increase the ranks of the insured by some 32 million people. Should health reform or other measures succeed in achieving near universal access to health insurance, an additional 31,000 physicians will be needed, the AAMC projects.

Physicians are not distributed evenly throughout the population, and consequently shortages tend to be concentrated in rural or inner city areas. The Department of Health and Human Services (HHS) currently designates over 6,200 primary care Health Professional Shortage Areas (HPSAs) nationwide in which 65 million Americans live. Sixty-seven percent of these areas are in non-metropolitan communities in which Indian health program facilities typically are located.

Physicians are not the only type of health professional in short supply. The number of dentists trained in the United States is not keeping pace with demand. The number of dental school graduates peaked in 1982 at 5,750, then declined for 16 consecutive years and stands at about 4,500 today.[2] During that time, over 75 million people were added to the U.S. population, according to the U.S. Census Bureau. An emerging shortage of dentists also is characterized by a maldistribution of providers in many rural and inner city areas. As of April, 2009, HHS designated 4,091 dental HPSAs in the U.S., in which 49 million people live.

Nurses also are in short supply, a trend that has been well documented in recent years. HHS has projected a national deficit of one million nurses in the coming decade. This projection has been tempered by the economic downturn which has seen a large number of nurses who were retired or engaged in non-clinical activities return to the clinical workforce. Nevertheless, noted academic Peter Beurhaus projected in the July/August 2009 issue of Health Affairs that the nurse shortage will grow to 260,000 registered nurses by 2025. A shortage of this magnitude would be twice as large as any nursing shortage experienced in the United States since the mid-1960s.

Nurse practitioners (NPs) and physician assistants (PAs) are being looked to throughout the healthcare industry as a supplement to a strained physician workforce. However, Richard Cooper, M.D. of the University of Pennsylvania projects that the supply of PAs and NPs will be 20% less than demand by 2025. In addition, like physicians, many NPs and PAs have chosen to specialize and therefore are not available to supplement the primary care physician workforce, where demand for doctors is considered to be greatest. Only 45% of PAs and only 59% of NPs practice primary care.[3]

[1] Dill MJ, Saldberg ES, Association of American Medical Colleges. The Complexities of Physician Suppl and Demand, November 2008.

[2] Staff Care Trends: The Growing use of Locum Tenens Dentists, March 2011.

[3] American Association of Nurse Practitioner database, 2009, and American Association of Physician Assistants: aapa.org

Emerging clinician shortages were apparent prior to health reform, which is expected to have a profound impact on how healthcare is delivered in the United States. Among other factors, health reform promotes efficiency gains by encouraging a restructuring of health care delivery into value rather than volume driven models such as Accountable Care Organizations (ACOs). It further promotes the use of preventive care and electronic medical records, measures which may have some effect on reducing utilization of healthcare services. Nevertheless, it is difficult to foresee how the addition of over 30 million patients to the ranks of the insured can be accomplished without a corresponding increase in demand for physicians and other clinical professionals.

It is within this context that IHS examined the staffing needs and patterns of Indian health program facilities through this survey. Merritt Hawkins' analysis of survey responses will seek to place these needs and patterns within the wider context of the current and projected clinical staffing market as viewed through existing research and our recruiting experience with hospitals, medical groups and other health care facilities nationwide. In addition, we will provide our opinion regarding the recruiting patterns of Indian health program facilities as depicted in this survey, indicating those areas where facilities appear to be operating efficiently and in line with recruiting industry standards and where there may be an opportunity for efficiency gains or practice modifications.

SURVEY RESPONDENTS

The 2011 Clinical Staffing and Recruiting Survey was sent by email to administrators and others with executive titles at Indian program facilities nationwide.

The majority of responses (60%) came from Tribal facilities, 35% came from Federal facilities and five percent from Urban Indian facilities.

The majority of responses (77%) were from administrators whose facilities serve 25,000 or fewer residents and can be considered semi-rural to rural. Nineteen percent were from administrators whose facilities serve moderate sized communities ranging from 25,001 to 100,000 people. Four percent were from administrators whose facilities serve urban areas of 100,001 people or more. The survey, then, largely represents a rural staffing experience that is most appropriately compared and contrasted to the experience of non-Indian health program facilities serving similar small communities with which Merritt Hawkins works.

Responses came from administrators from 19 states, with the majority of responses 54% coming from four states; California, New Mexico, Oklahoma and Washington. Geographic variance represented in the survey therefore is somewhat limited.

NEEDS, ACCESS AND QUALITY

It is assumed that virtually all Indian health program facilities provide some level of primary care services, either through primary care physicians or through non-physician clinicians such as PAs and NPs, while a lesser number provide specialty care, dental services, or pharmacy services.

AREAS OF NEED

Not surprisingly, the greatest need for clinicians as indicated by the survey is in primary care -- the broadest area of service provided. Forty-five percent of administrators indicated they have an urgent need for primary care physicians, while 38% expressed a moderate need. Fewer than one in five (17%) indicated they are fully staffed in primary care and have no immediate need.

This response is consistent with what Merritt Hawkins has observed nationwide among hospitals and medical groups. Family physicians and general internal medicine physicians are the two most requested search assignments we have received for the last five years. Approximately 65% of the healthcare facilities we have contacted in the last six months have indicated a need for primary care physicians.

The supply of primary care physicians has been constrained in recent years as medical school graduates have gravitated toward higher paying specialty areas. Indeed, the number of residents choosing primary care declined by 60% between 1998 and 2008.[4] Health reform includes provisions to stimulate medical student interest in primary care, but shortages are projected for the foreseeable future.

Though not all Indian health program facilities provide dental services, 43% of administrators indicated their facilities have an urgent need for dentists and 29% said they had a moderate need. The emerging shortage of dentists has been observed by Staff Care, a company affiliated with Merritt Hawkins which staffs temporary (i.e.,locum tenens) clinicians. Staff Care received virtually no requests for temporary dentists prior to 2005 but received requests to fill over 10,000 days with temporary dentists in 2010, mostly on behalf of government run or funded facilities.

In most cases, facilities are using locum tenens dentists to maintain services while they seek hard-to-find permanent candidates. The urgent need for dentists expressed by many Indian health program facility administrators is therefore in line with what Merritt Hawkins and its affiliated companies are seeing in the overall healthcare market.

[4] Newsweek: September 12th, 2008

Twenty-nine percent of administrators indicated their facilities have an urgent need for NPs and/or PAs, while 43% said they have a moderate need. Unlike primary care medicine and dentistry, where the number of providers being trained annually has been flat in recent years, the number of PAs and NPs trained annually has increased in recent years. In general, NPs and PAs are therefore often easier to recruit than physicians. However, demand for PAs and NPs is not likely to keep pace with supply in primary care as many PAs and NPs have chosen to specialize. In addition, the team approach to health care delivery, promoted by the health reform act through the "medical home" concept, is likely to increase demand for primary care PAs and NPs, who will be assuming more duties as primary care physicians focus on overall coordination of comprehensive care. Indian health program facilities and other facilities may therefore face increased challenges in recruiting these clinicians.

Twenty-eight percent of administrators indicated their facilities have an urgent need for nurses, while 45% said they have a moderate need. The severity of the nurse shortage has abated since the economic downturn began in 2008, as nurses otherwise occupied returned to the clinical workforce and as utilization of health services (particularly elective services) has declined. Nevertheless, only 27% of administrators indicated their facilities are fully staffed with nurses and have no immediate need for more. This is not generally consistent with what Merritt Hawkins and its affiliated nurse staffing companies are observing in the field, including in rural areas, suggesting Indian health program facilities may have particular challenges in nurse recruiting not being experienced throughout other segments of the healthcare system. In many cases, smaller communities are able to "grow their own nurses" and often do not have as high a nurse vacancy rate as larger, urban facilities. As a result, Merritt Hawkins' affiliated nurse staffing companies only infrequently work in rural areas. By contrast, Merritt Hawkins, which specializes in physician recruiting, often works in such areas, which often do experience high physician vacancy rates.

Twenty-six percent of administrators indicated their facilities have an urgent need for specialist physicians, while 32% said they have a moderate need. Media and policy maker attention has largely been focused on the shortage of primary care physicians in recent years, obscuring to some degree the fact that shortages in specialty areas also have emerged. Shortages are particularly acute in general surgery, where the supply of new surgeons is stagnant. In 1980, 945 newly trained general surgeons were certified in the U.S. In 2008, the number was virtually the same (972) despite a population increase of over 75 million people.[5] Shortages also are particularly acute in psychiatry, one of the oldest specialties in which 52% of practitioners are 55 or over, according to the American Medical Association's Physician Master File. Indian health program and other facilities can expect recruiting challenges in these two specialties to be particularly intense moving forward.

Nineteen percent of administrators expressed an urgent need for pharmacists at their facilities, while 35% expressed a moderate need. The economic downturn has suppressed demand for pharmacists, which was steadily escalating prior to 2008, largely as a result of the retail boom. Nevertheless, over half of those surveyed indicated a need for pharmacists at their facilities, though vacancy rates for pharmacists reported by IHS facility administrators are smaller than those for most other types of clinicians. These lower rates may be due in part to the fact that some IHS facilities are not staffed with pharmacists and therefore did not report vacancy rates. The relatively high rate of need for pharmacists indicated by the survey suggests Indian health program facilities may be experiencing particular challenges in recruiting pharmacists that are not generally being experienced by other segments of the healthcare system.

[5] Brown D. Shortage of General Surgeons endangers rural Americans, Washington Post, January 1st, 2009.

QUALITY OF CARE AND ACCESS COMPROMISED

Shortages of clinicians present a serious concern to Indian health program administrators responding to the survey, with the greatest concern focused on primary care physicians and dentists. Eighty-three percent of administrators indicated that a shortage of primary care physicians at their facilities was a cause of serious or moderate concern and 72% said a shortage of dentists was a cause of serious or moderate concern. However, concern about clinician shortages was reflected across the spectrum of providers. The majority of administrators (62%) expressed at least moderate to serious concern over shortages of specialist physicians, NPs and PAs, nurses, and pharmacists.

Administrators also indicated that clinician shortages have led to compromised access to care in their service areas. The majority (54%) said that a shortage of primary care physicians has compromised access to care in their areas, 48% said a shortage of dentists has compromised access, and 46% said a shortage of specialist physicians has compromised access. Shortages of PAs/NPs, nurses and pharmacists also have compromised access according to at least 23% of administrators.

Poor access to care often leads to poorer quality of care, which appears to be the case for some of the administrators surveyed. Forty-six percent said that a shortage of primary care physicians has compromised quality of care in their areas, 41% said a shortage of dentists has compromised quality, and 40% said a shortage of specialty physicians has compromised quality. Shortages of other clinicians also have compromised quality, though to a lesser degree. Thirty-three percent of administrators indicated a shortage of NPs/PAs has compromised quality of care in their areas, 25% said a shortage of nurses had compromised quality of care, and 22% said a shortage of pharmacists had compromised quality of care.

How these results compare to other segments of the healthcare system is difficult to ascertain. However, in a 2009 survey of acute care hospital administrators (none of them within the IHS system) conducted by AMN Healthcare (Merritt Hawkins' parent company) only 19% of administrators said that quality of care in their service areas had been compromised due to a shortage of physicians, only 11% said quality had been compromised due to a shortage of nurses, and only 5% said quality had been compromised due to a shortage of pharmacists. Of these administrators, 35% serve with hospitals in communities of 25,000 or less, and 32% serve with hospitals in communities of 25,001 to 100,000 people. The remaining 33% serve with hospitals in communities of 100,001 people or more. The majority (66%), therefore, serve in moderate to smaller communities where staffing challenges may parallel to some degree of IHS facilities.

LACK OF PLANNING

Given the urgent need for clinicians expressed by many Indian health program facility administrators, it is somewhat surprising that some two-thirds of administrators (67%) indicated their facilities do not have a clinician recruitment and retention plan in place. Similarly, in IHS' 2011 Survey of Physician Practice Patterns and Career Satisfaction, 67% of IHS facility physicians said their facilities either do not have a recruitment and retention plan in place or they do not know if such a plan is in place. In Merritt Hawkins' experience, lack of a staff plan is not uncommon in smaller healthcare facilities that are focused on daily rather than strategic challenges and which do not have personnel dedicated to recruitment. However, a formal plan featuring goals, benchmarks and physician involvement can be critical to consistent recruiting success.

RECRUITING PATTERNS

Indian health program facilities are actively engaged in the recruitment of a range of clinicians with a focus on dentists, nurses, family physicians and nurse practitioners.

Fifty-seven percent of administrators are recruiting dentists, 55% are recruiting nurses, 50% are recruiting family physicians and 49% are recruiting nurse practitioners.

In the last 12 months, Indian health program administrators have achieved some recruiting success. The majority (64%) have recruited at least one physician, while the remaining 36% have either been unsuccessful or have not attempted to recruit. In Merritt Hawkins' experience, many facilities serving small, rural populations can go a year and sometimes much longer without being able to recruit a physician, suggesting that the Indian health service model and the way it is being presented has generated some appeal among physicians. This point is further substantiated by IHS' 2011 Survey of Physician Practice Patterns and Career Satisfaction. Eighty-five percent of IHS facility physicians responding to this survey indicated they have practiced in both IHS and non-IHS facilities. Of these, 78% said working with IHS facilities is either more satisfying or as satisfying as working with non-IHS facilities. In addition, 70% of IHS physicians surveyed said they now find medical practice to be very satisfying or somewhat satisfying. By contrast, only 34% of non-IHS physicians surveyed by Merritt Hawkins said they now find medical practice to be very satisfying or somewhat satisfying.

The 2011 Clinical Staffing and Recruiting Survey indicates that forty percent of administrators have had success in the last 12 months recruiting primary care physicians, 15% have recruited general internists, and 11% have recruited psychiatrists, all difficult searches to fill. Fifty percent of administrators indicated they are now recruiting family physicians, 14% are recruiting general internists, and 14% are recruiting psychiatrists, 12% emergency physicians, and 10% pediatricians.

A majority of administrators (60%) have had success recruiting dentists and nurses in the last 12 months, while 48% have recruited nurse practitioners and 46% have recruited pharmacists. The majority (57%) are now recruiting dentists, 55% are recruiting nurses and 49% are recruiting nurse practitioners.

AREAS OF DIFFICULTY

Of these clinicians, physician specialists are deemed the most difficult to recruit by the administrators surveyed. Fifty-nine percent of administrators rated specialists as very difficult to recruit, a number reflecting the experience of many rural facilities with which Merritt Hawkins has worked. Specialists generally require a wider referral network, more sub-specialty support, and more sophisticated equipment than is typically available in small communities.

Fifty-two percent of administrators rated primary care physicians as very difficult to recruit, reflecting the limited supply and intense competition for providers in this area, while 49% rated dentists as very difficult to recruit. Nurses, by contrast, were only rated difficult to recruit by 25% of administrators, reflecting the general easing of supply constraints resulting from the economic turndown. Though the majority of IHS facility administrators (64%) have succeeded in recruiting at least one physician in the last 12 months, the process is nevertheless deemed to be challenging by many, and 50% of administrators describe the shortage of primary care physicians at their facilities as a serious concern.

In general, administrators indicated that clinicians have become more difficult to recruit over the last 12 months rather than less, as might be expected given the supply and demand trends referenced above. For example, 42% of administrators said primary care physicians have become more difficult to recruit while 10% said they have become less difficult to recruit. Administrators are mixed on their views of specialist physicians, however. An equal number (24%) said they have become easier to recruit as said they have become harder to recruit. This reflects trends in the overall specialist market in which payment and utilization patterns have suppressed demand for certain types of specialists (radiologists, anesthesiologists) who are now somewhat easier to recruit, while having little effect on others (general surgeons, psychiatrists) who remain difficult to recruit.

RECRUITING TIME-FRAMES

Nineteen percent of administrators indicated that it typically takes them 90 days or less to recruit a primary care physician. Based on recruiting industry standards, in which it is common for such searches to take 180 days or more, some Indian health program facilities are experiencing extremely efficient search completion times. An additional 35% of administrators indicated they are completing primary care physician searches between 91-180 days, also an efficient time frame. Just over one quarter (27%) are completing primary care searches between 181-365 days, a somewhat inefficient but not uncommon time frame. The remaining 19% are completing primary care searches in more than 365 days, a generally inefficient though not unheard of time frame.

Administrators indicated that it typically takes them longer to recruit specialist physicians than primary care physicians, a not unexpected result given the difficulty of recruiting specialists to rural areas. Only six percent of administrators indicated they typically complete specialist searches in 30 days or less, while 33% indicated it typically takes more than 360 days to complete a specialist search. In general, time frames to recruit primary care physicians to Indian program facilities are within industry efficiency standards, whereas time frames to recruit specialists are somewhat longer than industry standards.

Sixty-seven percent of administrators indicated they are able to recruit NPs and PAs within 180 days, a time frame consistent with industry standards. A minority (12%) require over 365 days to recruit NPs and PAs, a time frame typically longer than industry standards.

INTERVIEWS PER PHYSICIAN

The majority of administrators (71%) indicated they conduct four or fewer interviews in order to place one physician, while 29 percent require five or more interviews. Industry standards vary, but as a general rule an efficient physician search can be completed within two interviews, given clear candidate parameters and communication, though three to four interviews is not uncommon. While some administrators are interviewing efficiently, an opportunity appears to exist for many Indian health program facilities to achieve a more efficient interview to placement ratio. Such ratios typically are achieved through in-depth front-end preparation during which candidates are rigorously screened.

Administrators reported an average candidate interview cost of $3,815, including flights, rental car, accommodation, meals/entertainment and “other.” The unspecified “other” category accounted for $2,253 of the total average expense, and no data in the survey accounts for the nature of the “other” category. Excluding the “other” category, the average interview expense was $1,562, an amount closely in line with what Merritt Hawkins sees as a national average.

METHODS OF RECRUITING

Administrators indicated they use a range of methods to recruit clinicians, including online advertising, job postings on their web sites, journal advertising and a variety of others. Networking with their staff and community was rated a most effective recruiting method by 44% of administrators, followed by online advertising (27%), IHS assistance and resources (26%), networking with residency programs (24%), and posting jobs on their own web sites. Networking through personal contacts and residency programs has traditionally been the key method by which health facilities recruit, and online tools have largely replaced journal advertising, suggesting that Indian health program facilities are in tune with the general market in their utilization of recruiting resources.

Administrators were asked to rate the factors that attract candidates to Indian health program facilities. Fifty-eight percent said they strongly agree that practice style is an attraction, 43% strongly agree cultural diversity is an attraction, and 40% strongly agree a mission-driven focus is an attraction. In IHS's 2011 Survey of Physician Practice Patterns and Career Satisfaction, IHS facility physicians were asked what they find satisfying about working with IHS facilities. Eighty-seven percent said they find "overall IHS practice style" to be very satisfying or somewhat satisfying. IHS administrators responding to the Clinical Staffing and Recruiting Survey therefore are validated in thinking that the IHS practice "brand" is one of their strongest physician recruiting assets.

An even higher number of IHS facility physicians (89%) surveyed said they find "mission-driven care" to be a very satisfying or somewhat satisfying aspect of IHS practice. As noted in the 2011 Survey of Physician Practice Patterns and Career Satisfaction, many physicians today are disillusioned with the current medical practice environment and the diminishing emotional rewards it offers. Many such physicians embark on medical missions to experience these rewards. IHS practice allows physicians to achieve the emotional satisfaction derived from such missions in their daily practice, a key recruiting advantage and a central component of the IHS practice brand.

Indian health program facilities clearly are recruiting on the basis of a unique practice style that narrows the candidate pool to physicians who are seeking alternatives to the prevailing practice environment, which in Merritt Hawkins' experience is the appropriate approach.

TURNOVER RATES

Though Indian health program administrators face many of the same recruiting needs as private sector facilities, and achieve recruiting success in similar time frames in some cases, vacancy rates at Indian health program facilities appear to be higher than in non-Indian health program facilities. In a survey of non-Indian health program administrators conducted by AMN Healthcare, Merritt Hawkins' parent company, administrators were asked to indicate vacancy rates at their facilities for various providers. A comparison of responses from the AMN Healthcare survey and this survey are provided below.

AVERAGE VACANCY RATES FOR CLINICAL PROFESSIONALS

	INDIAN HEALTH PROGRAMS	NON-INDIAN HEALTH HOSPITALS
Physicians	22%	11%
Nurses	16%	5.5%
Pharmacists	8%	5%
Dentists	20%	N/A
Nurse Practitioners	19%	4.6%*
Physician Assistants	7%	4.6%*

**NPs and PAs were termed "allied professionals" in the AMN healthcare survey.*

The comparison above is not exact, as most of the IHS facilities represented in this survey are not hospitals. However, the majority of non-IHS hospitals (66%) referenced in the chart above serve smaller communities of 100,000 people or less. In addition, in Merritt Hawkins' experience, medical groups and smaller clinics in rural areas often have lower vacancy rates for nurses and allied health care professionals than do hospitals in larger communities. This generally does not apply to physicians or dentists, however.

Other surveys have put nurse vacancy rates under the 16% average for Indian health program facilities responding to the survey. For example, the American Hospital Association projects a hospital nurse vacancy rate of 8%. The survey indicates that Indian health program facilities appear to be facing considerably higher vacancy rates than facilities in the private sector, and, further, that these vacancy rates may be accelerating due to staff attrition.

Indian health program administrators indicated that an average of 3.1 clinicians left their facilities in the last year. Of those who left, an average of only 1.67 was replaced, suggesting that many Indian health program facilities may be challenged in addressing their comparatively high vacancy rates.

This issue may be of particular concern given the average age of Indian health program physicians as indicated by facility administrators. Administrators indicated that, on average, 25% of their physicians are 61 years old or older. By contrast, only five percent of all physicians in active patient care are 61% or older, according to the American Medical Association's Physician Master File.

A comparison of the age breakout of Indian health program physicians and physicians in active patient care is provided below:

PHYSICIANS BY AGE

	INDIAN HEALTH PROGRAM	ALL ACTIVE PHYSICIANS
40 or younger	26%	31%
41-50	23%	33%
51-60	26%	31%
61 or older	25%	5%

**Source: American Medical Association Physician Master File*

In general, more administrators reported that the turnover rate at their facilities had increased over the last 12 months than indicated turnover rates had decreased. Thirty-seven percent of administrators said that turnover rates for nurses had increased in the last 12 months, while only 8% said they had decreased. These numbers are somewhat counterintuitive as the general market has seen a decline in nurse vacancies since the economic downturn due to factors referenced above. Twenty-one percent of administrators indicated that turnover rates for physicians had increased over the last 12 months, while only 12% said they had decreased. These numbers also are somewhat anomalous as physician vacancies generally stabilize in a down market in which physicians often are less prepared or willing to relocate than they are in robust economic times. The majority of administrators, however, indicated that turnover rates for all clinician types had not changed over the last 12 months.

Turnover is considered a concern for the majority of administrators. Seventy-five percent indicated that physician turnover is a cause for serious or moderate concern, while 73% said that turnover of other types of physicians is a serious or moderate cause of concern.

Administrators were asked to rate the effect of various factors on turnover among their clinicians. These factors can generally be separated into two categories -- those over which IHS and Indian health program facilities have some control, and those factors over which they have little or no control. Cultural amenities, spousal opportunities, professional isolation, appreciation in the community, schools and adequacy of housing are factors that typically cannot be controlled. Merritt Hawkins therefore advises that in order to create the optimal recruitment environment, emphasis should be placed on factors over which facilities do have control.

Of these factors, several appear to be working in favor of Indian health program facilities. Sixty-five percent of administrators said support staff has a positive effect on turnover while only 15% said it has a negative effect. Fifty-one percent said that information technology has a positive impact on turnover, while only 18% said it has a negative impact. Forty-seven percent said administrative support has a positive impact on turnover at their facilities, while only 19% said it has a negative impact.

By contrast, only 10% of administrators indicated that paperwork/red tape has a positive influence over turnover, while 46% said it has a negative influence. Only 13% said IHS policies and priorities have a positive influence on turnover, while 35% said they have a negative influence. Only 15% of administrators said politics have a positive influence on turnover, while 33% said they have a negative influence. These finding parallel in some cases responses to HIS' 2011 Survey of Physician Practice Patterns and Career Satisfaction. IHS facility physicians were asked to rate how various factors affect their employment with IHS facilities. The chart below compares which factors IHS facility administrators believe have a positive effect on clinician turnover and which factors IHS physicians rate as having a satisfying effect on their employment.

	POSITIVE EFFECT ON TURNOVER, ACCORDING TO ADMINISTRATORS	SATISFYING, ACCORDING TO PHYICIANS
Paperwork/red tape	10%	8%
IHS policies/priorities	13%	13%
Professional isolation	12%	12%
Spousal support/opportunities	34%	28%
Politics	15%	7%
Child care	27%	9%
Schools	29%	20%
Human resources	25%	17%
Adequacy of housing	31%	31%
Pay	41%	46%
Administrative duties	24%	17%
Cultural amenities	37%	32%
Administrative support	47%	23%
Information technology	51%	31%
Mobility	21%	20%
Short and long-term training	28%	19%
Equipment	41%	31%
Appreciation in community	53%	52%
Support staff	64%	53%
Health care	36%	50%
Safety	40%	37%

As the numbers above indicate, few administrators or physicians cite “paperwork/red tape” or “politics” as being a positive or satisfying aspect of IHS practice. Bureaucracy and politics are endemic to many health care settings and are virtually impossible to eliminate entirely. However, the survey suggests that IHS make what efforts it can to streamline policies and procedures in order to reduce turnover and enhance the overall appeal of Indian health program facilities to physicians and other clinicians.

Administrators and physicians appear to be in general agreement regarding several aspects of IHS practice that are positive and satisfying. For example, the majority of administrators and physicians rated “support staff” and “appreciation in the community” as positive or satisfying. “Pay” also received a relatively high rating from both administrators and physicians.

In several cases, factors rated relatively highly by administrators were rated less highly by physicians. Twenty-seven percent of administrators indicated that “child care” has a positive effect on physician turnover, while only nine percent of physicians said “child care” is a satisfying part of their practice. “Administrative support” is rated positively by 47% of administrators, though only 23% of physicians rate “administrative support” as satisfying. It may be worthwhile for administrators to discuss these and other factors listed above with their physicians to see where perceptions match and where they do not. During the recruiting process, it is important that both administrators and physicians agree on the strengths and weaknesses of the practice opportunity being presented, so that candidates receive a consistent message from both parties.

SALARIES AND REVENUE

As noted above, the appeal of Indian health service facilities to clinicians is perceived to center around practice style and a mission-driven focus, rather than on economic or other considerations. Nevertheless, the survey indicates that salaries offered to recruit primary care physicians by Indian health program facilities, though lower than national averages, are at least within hailing distance. This may be contributing the ability of some Indian health program facilities to complete primary care searches in an efficient time-frame. The chart below compares average salaries for primary care physicians as reported by Indian health program administrators to average salaries/incomes as tracked by Merritt Hawkins and the Medical Group Management Association (MGMA)

AVERAGE ANNUAL SALARIES/PRIMARY CARE

	INDIAN HEALTH	MERRITT HAWKINS	MGMA
Family practice	$165,552	$170,000	$187,101
Internal medicine	$174,423	$217,000	$197,080
Pediatrics	$173,563	$183,000	$191,040

By contrast, salaries offered to specialist physicians by Indian health program facilities are well below averages considered to be customary and competitive, as illustrated in the chart below.

AVERAGE ANNUAL SALARIES/SPECIALIST PHYSICIANS

	INDIAN HEALTH	MERRITT HAWKINS	MGMA
General surgeons	$241,458	$336,000	$336,044
Ob/Gyn	$182,227	$282,000	$282,645
Anesthesiology	$200,950	$355,000	$423,547
Otolaryngology	$175,000	$359,000	$370.534
Emergency medicine	$187,810	$255,000	$262,475
Ophthalmology	$150,000	$270,000	$338,208
Orthopedic surgery	$167,500	$521,000	$473,770
Psychiatry	$168,926	$215,000	$191,267
Radiology	$155,175	$402,000	$471,403

The salary numbers above attributed to Merritt Hawkins and the MGMA are for all physicians, regardless of geographic location or size of community served. They do not specifically reflect the smaller markets

typically served by IHS facilities. However, in Merritt Hawkins' experience, physicians in smaller, rural areas generally do not receive smaller salary offers than those in larger areas. Sometimes the opposite is true. In smaller areas, lack of competition and a relatively large patient base may allow physicians to earn incomes comparable to or exceeding those of physicians in larger areas. Salary offers consistent with national averages also are often needed to attract physicians to rural areas and smaller communities.

It should be noted that salary data for a variety of specialty services, notably anesthesiology, otolaryngology, ophthalmology, orthopedic surgery, emergency medicine and radiology was limited. Many Indian health program facilities are engaged in the provision of primary care and do not have occasion to recruit full-time medical specialists. Data are more robust for obstetrics/gynecology, psychiatry, and general surgery. The comparatively low dollar amounts being offered to recruit in the specialty areas listed above may account for the generally long recruiting time-frames Indian health program facilities are experiencing in medical specialty searches.

Salaries for other clinicians were generally within industry parameters, with the exception of dentistry, as indicated by the chart below.

AVERAGE ANNUAL SALARIES/NON-PHYSICIAN CLINICIANS

	INDIAN HEALTH	NATIONAL AVERAGE
Dentists	$129,487	$153,290*
nurse practitioners	$92,911	$92,000**
Physician assistants	$84,582	$105,000***
Nurses	$65,103	$73,141****

Again, the comparatively low dollar amount being offered to dentists may be contributing to the recruiting challenges some Indian health program facilities are experiencing.

In addition to the dollar amount, the way income is structured typically is of importance to physicians more so than most other providers. Through revenue production bonuses physicians are usually able to earn income on top of a base salary. Indian health program administrators indicated that 65% of clinicians at their facilities are recruited on fixed salaries, with the remaining 35% hired on a salary plus bonus formula. By contrast, 88% of the physician recruiting assignments Merritt Hawkins conducted in 2010 featured an income structure (salary with bonus or income guarantee) by which physicians could realize additional income on top of the initial salary or guarantee. Only 12% featured a straight salary capping physician earning potential at a fixed amount.[6]

* www.healthcaresalaryonline.com/dentists

** Merritt Hawkins

*** Merritt Hawkins

**** www.allnursingschools.com

[6] Merritt Hawkins 2010 Review of Physician Recruiting Incentives

Those Indian health program facilities that are struggling with physician recruiting may wish to consider modifying income structure, particularly if they are seeing robust patient volumes and physicians have the capacity to increase their patient loads. Straight salaries may not offer sufficient incentive for physicians to be maximally productive, thereby creating the need for additional recruitment and its associated expense. However, a balance is needed in this area as the pressure to be productive and "churn" patients is a common complaint of many physicians in the private sector. IHS' 2011 Survey of Physician Practice Patterns and Career Satisfaction indicates that the ability to see a limited number of patients is one of the attractions of Indian health programs practice for physicians.

Other types of providers, such as nurses, do not have the opportunity to directly generate billings and revenue and typically receive fixed salaries without a bonus component. When these salaries are competitive there is no need, and often no opportunity, to add a production incentive.

Salaries and bonuses may be supplemented in other ways, including through educational loan forgiveness/repayment. The majority of administrators surveyed (62%) indicated they offer loan forgiveness/repayment as part of the recruiting package. By contrast, only 28% of the physician search assignments Merritt Hawkins conducted for acute care hospitals, medical groups and other facilities in 2010 featured educational loan forgiveness. Given the level of educational debt facing many clinicians (physicians in particular, whose average educational debt coming out of medical school is $155,000) loan forgiveness is a potent recruiting incentive frequently utilized by Indian health program facilities. However, the loan forgiveness amount offered by these facilities appears to be considerably less than industry standards, at least in regard to physicians.

Indian health program administrators indicated the average loan forgiveness amount offered at their facilities was $39,684 forgiven over an average of 22 months. This amount applies to all clinicians and presumably is higher for physicians than for nurses, PAs and others. This is close to the average amount of loan forgiveness Merritt Hawkins sees in the private sector, which is approximately $45,000. The average term of loan forgiveness Merritt Hawkins sees in the private sector is 30 months.

Balanced against the cost of recruiting physicians and other clinicians is the revenue they generate. Indian health service administrators were asked to indicate the average amount of revenue physicians in various specialties generate on behalf of their facilities in the course of a year. As noted above, data is more robust for primary care, obstetrics/gynecology, general surgery and psychiatry than for other specialties. Physicians in these specialties generally are generating hundreds of thousands of dollars in net revenue each year for their facilities, underscoring the importance of physician recruiting from a financial perspective.

In primary care, recruiting costs versus revenue generated can be compared as follows:

	INTERVIEW EXPENSES*	SALARY	REVENUE GENERATED	BALANCE
Family physicians	$11,400	$165,522	$387,263	$210,341
General intentions	$11,400	$174,423	$290,000	$101,527
Pediatricians	$11,400	$173,563	$411,000	$226,037

**An average of three interviews times $3,800 per interview. Other one-time expenses associated with recruiting, such as advertising, etc., are variable and are not included above.*

Other types of clinicians also are generating significant revenue streams through daily gross charges. Indian health program facility administrators were asked to indicate the average daily gross charges generated by physicians in various specialties, by NPs, PAs, pharmacists and dentists. It is noteworthy that NPs and PAs are generating more in daily gross charges, on average, than family physicians, as illustrated in the chart below:

GROSS DAILY CHARGES/FPS, NPS, PAS

Family physician	$2,100
Nurse practitioners	$2,570
Physician assistant	$2,348

These numbers suggest that primary care patient volume at Indian health service facilities is to a great extent handled by non-physician providers, a model toward which the general health care system is moving as primary care physicians become more difficult to find.

ADMINISTRATOR COMMENTS

Indian health program facility administrators were given an opportunity to comment about the recruiting challenges facing their facilities. Administrators were asked the following question:

"If you could make a statement to IHS administrators and clinical directors about recruitment challenges at your site or suggest ways in which we could help you meet these challenges, what would you say?"

In general, the comments focus on two central themes.

Administrative/human resources processes need to be streamlined or refined. There is particular concern about the efficiency of the HR process. Sample comments pertaining to these issues include:

1. "The difficulties in recruitment and retention are significantly affected by the difficulties experienced with HR, Acquisitions and Security."

2. "Improve Human Resources. It is the major impediment to recruitment."

3. "The application process is too complicated (sic). The length of time is so problematic people take other jobs because physicians and other professionals have choices."

4. "IHS Human Resources delays noted up to 2 months for vacancy announcements."

5. "I feel that I constantly let me staff down because I am powerless to make things happen in HR, Acquisitions, Finance and Security."

6. "There needs to be less red tape to add procedures and effect change at the local level."

Resources need to be expanded. Running through many of the comments is the need for additional resources to enhance recruiting effectiveness. Sample comments pertaining to this issue include:

1."More individuals should be in place to recruit professionals to areas thru out (sic) IHS."

2."We need more funds to hire more providers, make bigger facilities."

3."Additional funding for equipment, Staffing, Training."

4."We need to ensure an annual cost of living increase is built into the tribe's annual funding awards that are at least equivalent to the annual cost of living rate IHS personnel receive each year."

5."CPSU is in dire need of financial assistance to improve and provide for additional housing (to coincide with recruitment of providers)."

6."The small, isolated clinics need additional support due to lack of other existing resources."

7."Presently, financial resources are needed to successfully compete with local medical entities."

In addition to addressing these two themes, several comments were directed at the survey itself, with some administrators indicating they are in unique situations and therefore were not able to answer all the questions, i.e.

1."We are a 7-dentist facility with 21 operatories so I did not answer questions about non-dental providers."

Other administrators indicated they did not have the data to answers some questions, or the time to retrieve it, i.e.

2."I do not have ready access to some of the data and have chosen not to answer those questions because it would take me a little bit of time to analyze and calculate and I don't have the time."

All of the comments received are listed on page 38.

COMMENTS RECEIVED FROM INDIAN HEALTH SERVICE ADMINISTRATORS

Note: Comments are printed as received, without corrections to spelling, punctuation, etc.

1."Don't forget to ask about behavioral health...lcsw....I do not have the time to figure out money that MD create for the clinic..."

2."CRIHB is a technical assistance entity functioning like a tribally controlled Area Office of the IHS. We do not provide direct patient care. You should also be communicating directly with United Indian Health Services, Sonoma County Indian Health Project, Warner Mountain Indian Health Project, MACT Health Board Inc and Mathiesen Memorial Indian Clinic which do provide direct care services. You may want to take this response out of your survey. If you have any questions call me at (916) 929-9761"

3."Tribal clinics face different challenges then IHS facilities as the formula for funding them are different. Sharing of providers, provider interactions, would greatly assist smaller tribal facilities. The needs of the patients are the same, but access to the care differs. I believe that IHS facilities are less cognizant of the costs then are tribal and urban facilities (tribal and urban facilities on limited budgets must control their resources more tightly). The IHS has more at their disposal than tribal or urban facilities and even those between urban and tribal differ as the pool for resources differ. We are located in a remote area which differs from tribal programs located near more urban settings and recruitment is really a challenge."

4."We need help getting good providers in our area so we can provide quality care to the people in our community. A promise was made years ago to provide healthcare to Indian People and we need more scholarship monies and loan repayment in order to recruit qualified employees. Many people get denial letter after denial letter because of limited funding and they leave to go to another facility that has a higher score and we all need help. Improve Human Resources. It is the major impediment to recruitment. My site has been unable to announce vacant positions or make selections for new hires for 3 months due to HR processing problems. Improve local recreational facilities for health professionals - access to fields in the warm months, gyms in the winter. Improve housing and security."

5."The small, isolated clinics need additional support due to lack of other existing resources. The IHS loan repayment program is crucial to our existence and the physician comparability allowance as well. If not for these two financial incentives we may not be able to keep our doors open for services that are really needed in our isolated community. We need more support from area office and headquarters. We send paper work 3-4 times before it is taken care of or responded to. The rule of thumb is to get it in writing and make a paper trail to try and hold someone accountable. However when someone cannot get the job done they seem to get promoted or moved to another job. We need more funds to hire more providers, make bigger facilities. There needs to be less red-tape to add procedures and effect change at the local level. Tribal politics and the push to hire tribally enrolled members over more qualified candidates is not appropriate. At time Indian Preference rules seem to over ride basic job qualification requirements. HR needs to make sure that the candidates on a panel are qualified to do the job or they should not make the panel. To replace a leaving worker, the new hire should be found and start before the leaving individual leaves so that training can be done. Currently the job cannot be filled until the position is vacated. For example the leaving dentist should be able to hire in a new dentist and train him to the facility before he leaves. Most doctors just want to take care of the patients, but we have to deal with the many rules about how to prescribe, complete excess paper work (for travel, proof of annual certifications, time cards, formulary compliance etc.). There are good things here, but the bad things currently outweigh them."

6."More individuals should be in place to recruit professionals to areas thru out IHS."

7."CPSU has inadequate housing in terms of quality and quantity. CPSU is in dire need of financial assistance to improve and provide for additional housing (to coincide with recruitment of providers) All providers must have a commitment to Electronic Health Record by understanding process and their own role/responsibility with respective discipline and relationship to CPSU. All providers must have a commitment to the Improving Patient Care 3 Collaborative by understanding their own role/responsibility with respective discipline and relationship to CPSU."

8."The difficulties in recruitment and retention are significantly affected by the difficulties experienced with HR, Acquisitions and Security. Those things may be greater factors than any of the traditional recruitment and retention issues mentioned in this survey. It is virtually impossible to avoid selecting a poor IP or VA candidate; it is virtually impossible to hire for positions not covered by direct hire (Using Aberdeen Area for DEU hires is not working well--people give up before their applications are certified out); it is virtually impossible to get people fingerprinted/cleared because it requires an extra trip to a very remote location or remaining in this location without pay while waiting. Getting contractors has become just as bad. I think we are on the verge of having no medical staff at all because the difficulties are so great. I have been an IHS administrator for 25 years. I loved my job and was proud of my work until the last 2 years. Now the administrative barriers to doing a good job are vastly greater than the pleasure of the work. I feel that I constantly let my staff down because I am powerless to make things happen in HR, Acquisitions, Finance and Security."

9."Note: I am away on leave and don't have access to the info I left blank. Sorry for this. HR is clearly the rate limiting step. Classification takes forever, and things sit on HR desks endlessly, waiting for info or signatures that could be gotten in five minutes if they would just ask the right person for it."

10."We need to ensure an annual cost of living increase is built into the tribe's annual funding awards that are at least equivalent to the annual cost of living rate IHS personnel receive each year."

11."Sharing of the recruitment process and status for vacancy."

12."Presently, financial resources are needed to successfully compete with local medical entities; financial resources needed to establish a dental clinic to meet the basic preventive dental needs of the underserved and uninsured children, youth over 18 years of age and adult populations."

13.Remote locations and ancillary sites for larger service units do not have access to budget/costs specific to their location, which make it difficult to give accurate information. IHS Human Resources delays noted up to 2 months for vacancy announcements. Physician vacancies not covered properly with locums due to costs, leads to decreased availability and quality of services for our communities."

14."It is always difficult to recruit new physicians. If we could guarantee loan repayment, it would be easier. We usually get it for the doctors but it is not guaranteed."

15."The GPRA paperwork increases the time spent with patients. The electronic health records system slows the system. Gross charges generated by doctors and dentists do not equal actual revenue."

16."The Social Service and Outreach components greatly increase patient's access to outside services for unrelated needs that do affect their health, i.e.; housing, food, transportation, and legal aid."

17."Also, I could not answer your financial questions because I do not have direct information relating to those questions, sorry."

18.“We are a contract only site. We do not have any physicians, nurses, etc. on staff. We are currently seeking a nurse practitioner to conduct a once a month, half day (4 hours) diabetes clinic.”

19.“The challenge in recruitment has been the pay rate for the provider. It would be a straight pay situation and we would not hold out taxes, etc. and no benefits are included. The nurse practitioners I have spoken with are employees of the local hospitals and are worried about how this will affect their tax rates at the end of the year.”

20.“The application is too complicated, poor follow through, no checks to see if an application is complete! The length of time is so problematic people take other jobs becuase physicians and other professionals have choice.”

21.“Continue to offer loan repayment programs. Do not charge a $10,000 surcharge to place a IHS staff physician in our clinics.”

22.“I think the way the survey was worded made it difficult to answer some questions. For example, I answered yes to loan repayment but it didn’t give me the option to explain what we actually do - which was different than the selections offered - e.g. IHS loan repayment - which does not require employer match. As a smaller facility, I do not have ready access to some of the data and have chosen not to answer those questions because it would take me a little bit of time to analyze and calculate and I don’t have the time.”

23.“We are a 7-dentist facility with 21 operatories so I did not answer questions about non-dental providers. Because we are in an urban setting, recruitment is usually not an issue for us. However, the cumbersome, lengthy, ever-changing recruitment/hiring process is a challenge for applicants and for administrators.”

24.“You have not left us spaces to write narrative where numbers do not properly answer the questions - didn’t leave enough space for average salaries - couldn’t insert my numbers. Some of your questions were ambiguous - survey did not follow question...”

25. “We have had a great make up of providers (physician, nurse, pharmacist, dentist, lab and support staff). However I am losing 1.5 FTE medical providers due to retirement this year. We will really see how the process is to get RIGHT replacement for these two providers goes this year. With 2 FTE we topped off at 9200 primary care visit one Fiscal year. Mainly having the mixture of providers and support staff work together. Getting one in place that does not work because of power struggles, bad ethics and someone can spoil the whole group. We are small enough of a facility with high volume that if you do not work together then the days are long and hard to come back to the next day.”

26.“Your survey was two pages to long.”

27.“Additional Funding for equipment, Staffing, Training”

28.“I am not involved in the salaries or income sources of our facility.”

29.“Be as flexible as you can with any clinician. If this means offering more part time work we may have to do this.”

30.“We do not recruit for dr’s or PA’s or nurse. NSHC does all the providing of medical needs.”

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 administrators through the survey in part to *renew and strengthen our partnership with tribes*. Communication is a central to this effort. The survey provides insights from administrators 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 procedures*. This reform will be shaped by input from administrators and physicians 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 administrators and other Indian health program leaders in the policy making process. The survey puts on record administrators' current recruiting needs and practices and the ways in which administrators believe IHS can help improve their 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 AND RECOMMENDATIONS

Indian health program facilities are recruiting within the larger context of a rapidly evolving healthcare system and a medical staffing market characterized by clinician shortages. Many of these facilities express an urgent need for the same types of clinicians being sought by virtually all other types of medical facilities nationwide. Recruiting challenges are particularly acute in primary care medicine and dentistry.

While some facilities are enjoying recruiting success (64% have recruited one or more physicians in the last year) many reported that both access to care and quality of care in their service areas have been compromised due to a lack of clinicians. Vacancy rates at Indian health program facilities are comparatively high and staff attrition is an ongoing challenge, as Indian health program facilities are losing more clinicians than they are able to replace.

In general, the financial incentives being offered by Indian health program facilities are less robust than those found throughout the private sector. While the style of practice offered by Indian health program facilities is deemed to be attractive by administrators, many of the written comments submitted by administrators suggest that administrative and human resource inefficiencies and a lack of resources are eroding their recruiting efforts. In addition, like many other types of facilities, Indian health program facilities are hampered in their recruiting efforts by a lack of local strategic staff planning and recruiting resources. The majority of Indian health program administrators surveyed (67%) indicated their facilities do not have a clinician recruitment and retention plan.

Ongoing changes and escalating competition in the clinical recruiting market, particularly in the physician sector, require medical facilities of all types to closely consider their recruiting strategies and methods. It is Merritt Hawkins' recommendation that IHS promote the use of formal recruiting plans among Indian health program facilities, with a primary goal of establishing and leveraging the IHS practice "brand." The characteristics and strengths of this brand, from the physician's perspective, are more clearly defined in IHS' 2011 Survey of Physician Practice Patterns and Career Satisfaction. This survey establishes that IHS practice features many of the amenities physicians seek today, including a mission driven focus, a favorable malpractice posture, comparatively more time per patient than private sector practice typically affords, comparatively less non-clinical work, a reasonable income for primary care physicians and favorable work hours. The consistent promotion of the IHS brand throughout Indian health program facilities will both enhance the overall appeal of IHS practice and provide individual facilities with a compelling narrative around which to build recruiting campaigns.

In addition to establishing a recruiting theme or narrative, a formal staff plan will incorporate a projection of a facility's staffing needs, an evaluation of recruiting incentives and contracts relative to overall market benchmarks, an examination of candidate sourcing strategies, interviewing techniques, and a review of the search process: how it is structured, how it is led, and how results are measured. In Merritt Hawkins' experience, the key to successful recruiting begins with front-end preparation in which stakeholders, incentives, contracts, candidate parameters, and candidate sourcing methods are aligned.

For IHS facilities, it will be particularly important to identify the types of physicians to whom Indian health program practice is most likely to appeal and the platforms for contacting these physicians. Such platforms may include social media discussion groups for mission-driven physicians, email lists and more traditional data bases that allow for geographic targeting of candidates. A staff plan, and/or additional on-site training in the tenets of clinical recruiting, can be useful in tying together front end preparation and establishing a strong recruiting foundation.

Particular focus should be given to incorporating staff physicians into the recruiting plan. As noted above, many IHS facility physicians who responded to the Survey of Physician Practice Patterns and Career Satisfaction appear to be disengaged from the recruiting process. In the physician recruiting arena, staff physicians can be the best proponents of a practice opportunity, confirming to candidates that a need for their services exists, that the practice style is favorable, and that the financial and emotional rewards are robust. By contrast, staff physicians who are not involved in or not supportive of recruitment can be a serious impediment to recruiting success. One method for leveraging physician support is through individual facility web sites, which should have a strong recruiting component. This may include video testimonials from staff physicians extolling the benefits of a particular facility and its community and explaining why the opportunity provides a favorable practice setting.

An additional key is the ability to respond nimbly throughout the recruiting process, adjusting incentives, strategies, and schedules as needed to ensure consistent communication with candidates and the timely flow of information. This appears to be a particular challenge for IHS facility administrators, a number of whom identified IHS human resource (HR) procedures as a bottleneck. Specifically, once candidates have been identified, HR processing times become so extended that many candidates move on to other opportunities. In Merritt Hawkins' experience, this challenge is not confined to IHS. Private sector facilities frequently have difficulty approving contracts or otherwise vetting candidates in a timely manner – a critical drawback in today's highly competitive recruiting market in which candidates typically have a variety of opportunities from which to choose. Merritt Hawkins recommends that IHS reevaluate its HR

processes to achieve efficiencies where possible. The desirability of an efficient candidate review process and reasonable turnaround times cannot be over-emphasized.

A strong "brand narrative," front-end preparation (particularly stakeholder consensus on strategies and incentives) and responsiveness are three key components to the recruiting equation. Resources and regional knowledge are two others. IHS administrators voiced a need for additional recruiting resources, to increase provider salaries, enhance facilities, and to fund local recruiting personnel and local recruiting training. The survey indicates salary offers made by Indian health program facilities to primary care physicians, while below private sector averages, are within the range Merritt Hawkins observes in private sector settings. Salaries for medical specialists, however, generally are not. Indian health program facilities are unlikely to compete for candidates strictly on salary amounts. As noted above, they have a range of other amenities that may be attractive to many physicians. However, salaries must at least be "within the discussion" given the options that physicians have in today's market. Merritt Hawkins recommends that IHS facilities review the latest physician income data and evaluate their offers in the context of industry standards, adjusting incentives where appropriate and feasible.

Data also is a resource. If not already in place, Merritt Hawkins recommends that a candidate data-sharing program be initiated within Indian health programs, allowing for candidate "passes" to take place among facilities and building a national candidate pool of clinicians who have expressed an interest in IHS practice.

Just as all politics are said to be local, clinician recruiting also is largely driven by knowledge of local nuances and by knowledge of particular medical specialties. Merritt Hawkins recommends that any recruiting training focus on building recruiter knowledge of specific geographic areas and specific medical specialties or professions. Merritt Hawkins' recruiters are trained on this basis.

In summary, more consistent and uniform local strategic staff planning, IHS practice brand leverage, additional financial resources for recruiting incentives, training, and infrastructure, and more administrative efficiencies are required to address the clinician recruiting needs of Indian health program facilities.

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