

## Recruitment and Retention

Recruitment and retention of health care professionals is a mixture of complex and time consuming activities that occur constantly. Lack of retention efforts could possibly result in the risk of losing current providers and the services they provide. Communities with happy well integrated providers know the need for additional providers and will help create an environment for new and existing providers. They are usually involved in planning that is visionary, regional in scope and integrative in nature. The planning addresses the economic, educational, social, and health care perspectives of the region. The planning process will help ensure the development of realistic goals, objectives and implementation strategies.

Rural communities working together holds the promise for guaranteeing regional, high quality health services for citizens while creating an environment attractive to new and existing rural health care professionals. Critical is determining how many and what types of professionals will be ideal for service delivery and service consolidation in more efficient delivery systems. The sharing of resources between providers will contribute to a more effective health care delivery system.

### Recruitment

Multiple barriers are faced when recruiting primary healthcare providers. The most basic is the continued shortage of primary care physicians. This has been caused by the demand due to physician retirement (many physicians are over 55 years of age), changing practice patterns of young physicians, the increase use of physicians in managed care health plans, and provider mal-distribution.

The typical medical student is tens of thousands of dollars in debt upon graduation. Many residents seek loan repayment as part of their practice opportunity. Mid-level practitioners also face high education costs and lost wages while in training programs.

A significant number of residents are women. They have unique practice needs such as job sharing, part time schedules, family leave, and child care. They are also less likely to select a rural practice. Half of female physicians are married to a physician also.

New and established program will likely impact the number of primary care providers. However, many factors affect the specialty and practice location choices of primary health care providers that can not be addressed through program admissions policies or curriculum. These include reimbursement and salary inequities, lifestyle issues, and perceived lower status within health care professions. These factors work against an individual with an interest in providing primary care in a small community.

The practice styles have changed. The new provider seeks the same balance we value in our careers: job security, compatibility with colleagues and staff, respect from

the community, professional and educational support, reasonable time away from work, and fair compensation. Today providers desire more free time to spend with their family and pursue personal and professional development. They want to spend more time providing direct patient care and less time on paperwork.

Communities may find the supply of providers falls short of demand and changing healthcare provider expectations will reflect changing values and lifestyles. These will challenge communities to create practice environments that will attract providers.

Are access or provider shortages your community problem?

Perform an assessment of your local health care system. Include the following factors:

- Geographic, economic, social or other boundaries of the local health service area.
- Local community providers
- Provider roles and available services
- Economic resources available to support existing providers
- Equality of life for local health care providers
- Understanding the role of local healthcare providers
- Unmet community healthcare needs
- Access to providers (travel and waiting periods)
- The community use of existing services

Contacts within the community with access to this information include: Administrators, healthcare providers, economic development councils and employers, clergy, and other civic groups and community representatives. Provider shortages are easy to demonstrate when a provider has retired or relocated from a practice setting. Communities can recruit based on patient growth (waiting times, population increase, new businesses or contracts, or service area expansion). One way to calculate the need for a physician is by using the population-to-physician ratio. The community needs to demonstrate to a prospective physician that a full practice is available.

Universities, hospitals, state organizations or other specialized groups often gather information necessary to assess the local healthcare setting. Outside assistance can make your job easier and potentially more accurate, but information gathered by the local community is often the best and most familiar. Rural communities often face challenges related to insufficient financial support for services or facilities, a limited number of health care providers to recruit, and provider maldistribution.

[http://www1.cms.gov/NationalHealthExpendData/25\\_NHE\\_Fact\\_Sheet.asp](http://www1.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp) provides information on national health expenditures for consideration. See also <http://www.practicesupport.com/Merritt%20Hawkins%20Physician%20to%20Population%20ratios.doc> for a discussion on specialist physician to population ratios. Ratios for primary care scenarios are:

**PHYSICIANS REQUIRED PER  
100,000 POPULATION**

Following are suggested estimates for the number of physicians required per 100,000 population by advisory group.

<b>Primary Care</b>	<b>GMENAC</b>	<b>HICKS &amp; GLENN</b>	<b>SOLUCIENT</b>
Family Practice	25.2	16.2	22.53
Internal Medicine	28.8	11.3	19.01
Pediatrics	12.8	7.6	13.90

Rural communities and health care organizations should work together to create a vision statement, conduct strategic planning and develop action steps for local healthcare systems. These written statements should be developed by a broad based community coalition consisting of community and healthcare leaders. They should reflect a common understanding of the future direction for the local health care system.

The involvement and support of local people is essential to developing and sustaining health care systems. A good first step in creating community involvement is the development of a community health care coalition. A variety of community groups should be involved including key representatives from the following:

Business leaders'	Health care providers'	Church officials
School districts	Senior citizens	Civic leaders
Local Government	Tourism office	Social services Public
Health	Health care administrators	Local government
Local Farming/Mining/Ranching/Industry		

Avoid overrepresentation by any single group. Health care professionals should be involved at the very early stages. It is important that all members understand the commitment involved for the development of this committee. Once the coalition is formed, the process of defining health care services of today and the development of tomorrow's vision can begin.

The community health planning process means that you:

- Educate local citizens about healthcare trends and provider roles
- Conduct health care needs assessments, internal and external
- Provide leadership training
- Develop a vision statement
- Develop action plans and timetables to achieve goals
- Prepare process evaluation methods

Often times a facilitator, skilled in group process development, would help with this process. The vision and strategic plan is shared with the entire community and used

for fund raising and resource development. The plan can also be used as a tool for recruitment and retention by indicating to candidates that the community understands the present system, has a common commitment, and a vision for the future.

Often the success of provider recruitment efforts has a major impact on economic and quality of life issues for the entire community. The community can also support and influence the outcome of the recruiting initiative.

In most cases the success of provider recruitment must be conducted and coordinated by one organization, normally a hospital or clinic. The determination of health care provider recruitment is necessary. The delineation of the details of the opportunity, and the responsibility for negotiating provider salaries and benefits rests with the hiring agent. The hiring agent and organization must be free to initiate and facilitate recruitment process decisions.

Several key elements need to be in place before recruiting begins – they are:

- Documentation of providers needed
- A position description including specialty, call schedule, practice scope, and working hours
- A contract or employment agreement
- Marketing and informational material about the opportunity and the community
- A recruitment committee

The time to successfully recruit a physician is often twelve months or longer. The search time for a nurse practitioner or physician assistant is often two to six months. These times could be longer in a rural environment. The largest pools of candidates are providers in training.

### Recruitment Process Steps

If possible, an in house recruiting position should be established. This individual would ensure all phases of the recruitment process are carried out in a professional timely manner. When appointing a recruitment coordinator consider: strong organizational skills, marketing experience, flexible work hours, ability to work autonomously, good communication skills, aware of the healthcare systems and community.

Potential recruiter activities include: workforce planning, developing opportunity and community profiles, coordinating fundraising, loan repayment applications, organization marketing material, sourcing candidates, conducting initial telephone interviews, candidate screening, facilitating relationships, coordinating site visits, scheduling locum tenens providers, negotiating employment agreements and facilitating retention efforts including orientation.

The recruiter works with the recruitment committee to ensure each component of the plan is carried out. The recruiter established rapport and can quickly address candidate concerns and answer questions during the recruiting effort.

The cost of recruiting varies. Often stated is that a community could possibly spend one-half of the yearly salary for the position being filled. It is possible to spend less or more. Influencing factors include the specialty and number of providers, the availability of the recruitment coordinator, and use of outside recruitment firms. The recruitment budget should include the development of promotional materials and advertising (includes brochures, exhibits, videos, web sites, journal or classified ads, and a toll free number), sourcing materials(provider lists, subscriptions, mailing services, postage, telephone calls, etc) and participation in recruiting fairs and events, salary and benefits for the recruitment coordinator, site visit expenses (mileage an airfare reimbursement, hotel accommodations, and meals), recruitment incentives (loan repayment, signing bonuses, relocation costs) and recruitment firm fees and expenses.

Recruitment expenses are a community investment leading to the overall improvement of the community's economy and the well being of its members. Awareness of the economic importance and the need for community cooperation is essential. When provider recruitment becomes a priority, raising recruitment funds can be developed. Clinic, hospital board members, chamber of commerce, and the economic development office can assist with promotional material development or capital improvements. Larger health systems can offer support in the form of advertising, sourcing, and exhibiting. Recruitment firms can provide additional recruitment assistance. For profit firms have resources and expertise often not available in rural communities. Services can be costly. Use recruitment firms when a provider is needed quickly, above average financial resources are available, providers are needed in several different specialties, and in house recruitment is not available. Rural placements can be difficult.

Contingency firms work for the candidate with payment made after the candidate is placed. Retained firms contract to search for physicians. Fees vary depending on the services provided. There may be a substantial non-refundable down payment required even if search does not result in a placement. An exclusivity agreement may also be required. Database or sourcing firms provide clients with lists of provider names. The more specific, the higher the price. Locum tenens provide temporary coverage due to vacation, illness, continuing education, etc.

There are also not for profit resources available to communities. These groups provide evaluation of a community's recruitment environment, recruitment technical assistance, and candidate sourcing. Investigate all options. Compare fees and check a firm's success.

Candidate sources include:

- Medical and nursing training programs and residencies
- Military providers

- Academic setting providers
- Public health
- Practicing providers and community members
- Rural health offices and associations
- Exhibits at opportunity fairs
- National Health Services Corps

Lists of names can be obtained from:

- National, state, local professional associations
- Medical and nursing licensing authorities
- The World Wide Web
- Medical and nursing education programs and
- Database and mailing list firms.

Communities are starting to recruit providers earlier in their training and educational process. Identify students who have an interest in rural medicine. Communities can sponsor students through their training in exchange for a practice commitment. The length of time, specialty and practice location decision can affect when candidates are ready. "Growing your own" could be appropriate for mid-level providers due to a shorter training program and lower educational cost.

Recruiting is primarily marketing your opportunity to prospective providers. Providers may consider many opportunities in a week or a month. Successful communities emphasize the unique advantages of the opportunity and the community. Some possibilities for marketing your opportunity include:

- Personal contacts
- World Wide Web
- Journal advertisements
- Direct mail and telephone
- Exhibits at continuing education conferences and recruitment fairs

When candidates first consider your opportunity from a mailing, advertisement or exhibit, they want to know the:

- Geographic location and community size
- Type of clinic and medical group
- Number of providers and specialty

Essential to the recruiting effort is good recruitment materials. Materials are the provider's first look at your community. They should be attractive, professional, and targeted to the provider. Generally the information should be about 40% on the practice opportunity and 60% on community advantages. Include information from the chamber of commerce and other area agencies. Do not overwhelm a candidate with information. Send a well written letter and one or two high quality brochures. Follow up information should focus on economic conditions of community, schools, churches, and housing is

helpful. Potential providers want to know who else is in the community. A short bio and photograph helps this interest. A typical response rate from a purchased list is 1%.

When using direct mailings, the following is suggested:

- Customize the message to your audience, providers looking for a change or students/residents interested in loan repayment
- When designing the mailing, keep in mind the cost of postage
- A 3 phase mailing consists of
  - 1 a postcard
  - 2 a brochure and letter
  - 3 a folder of information or video
- Coordinate with community advertisements and telemarketing efforts
- Use color pictures if possible
- Track the effectiveness of mailings

Recruitment videos can be an extremely effective tool when done properly. Keep it brief, focused, maintain quality, and package it effectively. There can be high production costs with video development.

Once a provider has responded to a mailing, it is imperative to contact them quickly. Be sensitive to when and where you call. A lot of recruitment time is spent on the phone. It is typically better to call them at home between 7 – 9pm.

Expect to talk to answering machines and leave voice mail. Develop a targeted message and telephone number (800#) for return calls. Differentiation is a must. Listen and be sincere. Introduce yourself and explain why you are calling. A quick screening can consist of the geographic interest, the type of practice, and if a match, keep talking about the opportunity. Send promotional materials the same day or next.

Factors that are considered and influence a practice location decision include:

- |                                 |                             |
|---------------------------------|-----------------------------|
| Partners in practice            | Clinic's economic situation |
| Salary                          | Geographic location         |
| Size of community               | Recreational activity       |
| Case load                       | Call schedule               |
| Access to referrals             | Opportunities for children  |
| Economic situation of community | Opportunities for spouse    |
| Vacation time                   |                             |

## Interviewing

Conduct telephone interviews by the recruiter or a provider before the site visit. This is a time to gather information about each other and identify a potential match. The standard job interview questions, past experience, special interests, strengths and weaknesses, and long term goals, can be used in addition to practice specifics. You

may also discuss employment, educational or recreational interests for the spouse of significant other and questions about the community.

You will need to check references. This is an important step and should be done before a visit is made and a final contract offered. This will determine if a provider is qualified to practice and identify potential problems or issues. Providers should have a Curriculum Vitae (CV) and or Resume) and three professional and three personal references. Before doing a reference check, ask for an authorization to release information to avoid any potential legal liability.

You will need to verify the following information:

- State licensure (in all state where practiced)
- Location and graduation dates for undergraduate and graduate training
- Location and graduates for medical/nursing school training
- Location and graduation date of residency training
- Board certification
- Facilities where candidate has privileges
- Legal action take or pending against the candidate
- Credit report
- Driving record

References should be asked for information on the provider's competency, personal style, problems encountered, and overall assessment of suitability to practice. Ask each reference to provide an additional individual to contact. People do not list bad references. Providers are more comfortable talking with colleagues. With positive outcomes from the reference check, invite the candidate for a site visit.

Providers often make a decision about a practice opportunity during a site visit. Discuss the following practice items during the visit:

- Patient demographics (service area, age distribution, and average number of patient visits/year, waiting time for new patients)
- Patient referral sources and systems
- Payer mix and reimbursement rates
- Outcome information
- Patient satisfaction information
- Systems integration within the region
- Reason for vacancy
- Retention rates for physicians, mid levels, other staff
- Practice considerations (Procedures, call, admissions, ER coverage)
- Midlevel Collaborative agreements
- Compensation and benefits (salary, production, buy-in, incentives)

Of equal or more interest is the community. Be ready to discuss the following items:

- Schools - Special education services, high school graduates going to college, higher

- education opportunities in the area
- Weather
- Housing - availability, homes for sale, rentals, buildable property, average cost to buy or build
- Recreational, social, and cultural opportunities (sports, library, pool, community center, area attractions)
- Religious worship opportunities
- Airline services
- Shopping
- Safety services (police, fire, and ambulance)
- Population and economic growth in community

Share the questions with your interviewers along with the applicants CV. Decide who will address the practice and community questions.

Visits are typically one and a half to two days long and often occur on weekends. The candidate's lodging and travel should be paid in advance or reimbursed soon after the visit. Candidates in training often will do a clinical rotation at the facility. This allows the candidate to work with your facility and staff to determine if there is a good match. Residents may also provide call or ER coverage on weekends.

Include information for the spouse and children. Tailor the itinerary for the provider and family interests. Ensure accommodations and rental car are available. Have your best people involved to sell the position and the community. Leave time for relaxation. Have a sample contract or agreement available. It appropriate, begin preliminary negotiations.

Lifestyle and practice issues are important as well as school debt. A community option to offer assistance and support in exchange for guaranteed future service is not out of line. Assist providers with financing debt during training, providing assistance in loan refinancing or purchasing the providers debt load in exchange for a guaranteed number of years of service. This may sound expensive but balance out the cost of recruitment, locum tenens support, and lost revenues. It is also best to wait until the member has entered a residency program before arranging loan assistance. An escrow account is one option that provides for fund safety for the community and the student. You can also "grow your own". The training required for a mid level is shorter and therefore less risky for the community.

Signing bonuses are also a possibility but the IRS regulatory requirements must be determined first. There are limits on what can be provided. Not inclusive but a starting point is Revenue Ruling 97-21. In it the Internal Revenue Service provides guidance on incentives that a tax-exempt hospital may offer to recruit private practice physicians to join its medical staff or provide medical services to the community. The Service presents five situations with different incentive packages, ruling on whether or not the recruiting incentives offered to the physician endangered the hospital's Section

501(c)(3) tax-exempt status. Have an understanding of the requirements and if necessary, seek legal counsel.

From the website, <http://www.mcguirewoods.com/news-resources/news/2720.asp>, in 2006, 81 percent of physicians received some type of financial incentive in addition to their base salary (Jackson and Coker, 2006 Physician Compensation Survey, 2006). Income guarantees, annual and signing bonuses, relocation allowances, CME expenses, and educational loan forgiveness are just some of the most popular incentives offered (Merritt, Hawkins & Associates, [2006 Review of Physician Incentives](#), 2006). Hospitals frequently consider the use of these recruitment options as a way to attract patients and solidify relationships with key physicians. This update provides a general overview of three key federal regulatory schemes that restrict the recruitment activities in which a hospital can engage: the Ethics in Patient Referrals Law set forth at 42 U.S.C. §1395nn (commonly referred to as the “Stark Law”) the Anti-Kickback Statute set forth at 42 U.S.C. §1320a-7b(b), and IRS tax-exempt regulations.

1. Stark Law. The Stark Law prohibits a physician from referring Medicare or Medicaid patients to receive “designated health services” from an entity, such as a hospital, with whom the physician has a financial relationship. Most hospital-physician financial recruitment incentives implicate this referral prohibition. As a result, such arrangements must be structured to fit within a Stark Law exception. The two primary applicable Stark Law exceptions permit incentive payments to a physician only if the physician is relocating his or her practice, or if the hospital is located in a Health Professional Shortage Area (“HPSA”). The Stark Law physician recruitment exception, which applies only to physicians who relocate their practice to the hospital’s geographic area, permits a hospital to give a relocating physician incentives only when certain requirements are satisfied, including: the physician must join the hospital’s medical staff; the arrangement may not be conditioned on the recruited physician’s referral of patients to the hospital; the recruited physician must be permitted to establish staff privileges at and refer patients to other entities; and incentive payments may not fluctuate according to the value or volume of referrals by the recruited physician. The Stark Law physician retention payment exception permits hospitals located in an HPSA to provide physicians with retention incentives. As with the physician recruitment exception, several other requirements must be met to qualify. If a hospital is not recruiting a physician who will relocate, or is not located in an HPSA, any physician incentive payments must be fit into other limited Stark Law exceptions such as the personal services exception.

2. Anti-Kickback Statute. The Anti-Kickback Statute prohibits a hospital from knowingly or willfully providing remuneration, including recruitment incentive payments, to a physician in order to reward or induce federal health care program business. The Anti-Kickback statute provides a practitioner recruitment safe harbor (the “Safe Harbor”), under which a hospital located in an HPSA is permitted to recruit a new physician or a physician willing to relocate his or her practice as long as certain criteria are met. Recruitment activity that falls outside of the Safe Harbor is not per se illegal, and will be evaluated on a case-by-case basis. As a hospital’s activity meets more of the attributes of Safe Harbor status, the likelihood that liability will attach diminishes.

Joint hospital-private practice recruitment efforts (for example, where a hospital works with, and makes incentive payments to, an existing physician group for the purpose of recruiting one or more physicians) attract particularly close scrutiny because such arrangements present a high potential for misuse, as demonstrated by the recent case *U.S. v. Barry Weinbaum, Tenet Health System Hospitals Inc.* In this case, the government alleged that Tenet was paying illegal kickbacks to existing private physician practices for patient referrals, and disguising such payments as new physician relocation expenses. After two mistrials, Tenet settled out of court for \$21 million (Office of the U.S. Attorney for the Southern District of California, News Release Summary, May 16, 2006).

3. The Tax-Exempt Regulations. A tax-exempt 501(c)(3) hospital that recruits physicians must also comply with IRS regulations that impact physician recruitment. Tax-exempt regulations require that a qualifying hospital be operated exclusively for the charitable purpose for which it was formed, and prohibit private inurement of net earnings to insiders. No definitive test exists to evaluate the propriety of a recruiting arrangement. Rather, inquiry will be conducted on a case-by-case basis. The IRS has outlined basic documentation requirements and approval processes that a tax-exempt hospital must undergo in connection with any recruiting arrangement. The propriety of a physician recruitment arrangement can turn on several factors, including whether the recruited physician will be a hospital employee, and whether the physician will be relocating from an outside area. Additionally, a tax-exempt hospital must document the community need for each physician recruiting arrangement.

These federal laws and the related regulations and agency guidance substantially restrict the physician recruitment incentives that a hospital can provide. In addition, state-specific restrictions may exist. This complex regulatory environment presents a significant challenge to hospitals that conduct physician recruiting efforts on an ad hoc basis. Ideally, a hospital that wishes to minimize potential liability will develop and implement a physician recruitment protocol. If a hospital instead chooses to evaluate recruiting arrangements on an ad-hoc basis, each arrangement must be closely scrutinized to ensure compliance with the Stark Law, Anti-Kickback Statute, and, if applicable, the IRS tax-exempt regulations.

If you would like assistance with structuring compliant physician recruitment arrangements, or have any questions regarding the information contained in this article, please contact us.

Rural communities may also be eligible for federal and state loan repayment programs if the community has a Health Professional Shortage Area (HPSA) designation.

After the site visit –

- Send a thank you letter to the candidate expressing appreciate for visit
- Follow up with a phone call to reiterate your offer and answer any

questions

- You may want to invite the candidate for a second visit
- Send an unsigned employment offer in writing within two weeks if not provided during the visit. This allows for negotiation and avoids committing the community to one provider at a time.
- Limit the duration of the offer to two or three weeks.
- If candidate bonded, have that community member call to answer questions or hear concerns.

If your candidate declines an employment offer, determine why, maybe you can remedy the situation for the next candidate. Typically only 1 in 5 visits results in a signed contract. Keep recruiting until you have dry ink on the paper.

## Retention

Getting the practitioner there is only half the battle. You must also keep them there. Understand that one of the stressful problems is the lack of professional support and backup for the rural physician. Covering call is disruptive to a personal life as it requires 24 hour availability. Most are looking for call no more frequent than 1 in 4. Mid-levels can take call but will require physician backup. Another issue is coverage for medical education and vacation. Generally, outside coverage is expensive or not available.

Other common issues are expensive malpractice insurance, excessive paperwork, long hours, insufficient access to technology and support services, limited access to hospital facilities and resources, lack of community support, limited spousal employment opportunities, inadequate reimbursement, etc. When faced with two or more of these difficulties, the provider may choose to leave the community. With the shortage of physicians, they could be getting job offers right not with great financial incentives and less problems. All providers need to feel supported and wanted. It is extremely important to retain your providers.

It is crucial to have an organized provider retention plan that starts with quality matching during recruitment and continues with regular communication with the providers to assess whether professional and personal expectations and goals are being met. Primary care specialists living in rural communities need opportunities for contact with professional peer groups, collegiality with the workplace, quality facilities and support personnel, acceptance from the community, adequate family support, and appropriate time for continuing education and recreation. The average stay of a physician after initial placement is less than two years and retention is often overlooked.

Retention should focus on assessing the needs of the healthcare provider and their families, Questions the retention group should ask include:

- Does the provider feel there is emotional support from the partners and community?
- Is the provider's family included in community events?
- Does the provider and family feel a sense of belonging to the community?

- Can the provider family time for family and recreation?
- Are there any unmet expectations and are the original contract terms being met?
- Are referral patterns established and appropriate?
- Does the community utilize the provider services fully?
- Are on call responsibilities realistic and reasonable?
- Is there opportunity for continuing education or teaching?
- Does the provider need additional professional support?

To ease the transition to the community

- Send the moving bill to hospital or clinic
- Provide local newspaper
- Provide contacts for spousal employment, business start-up funds, academic interests, etc.
- Provide family service information; daycare, community programs, educational programs, etc
- Facilitate credentialing for hospital privileges
- Place announcement and picture in newspaper and or newsletter

A written retention plan includes defined goals and objectives. It organizes a retention committee. The plan is evaluated on a periodic basis. The effort is organized, sincere, and involves community support and activities.

There are some essential components for retention. During orientation, there should be a tour of the clinic and hospital facilities. The procedures for scheduling, charting, payroll billing, expenses, call and referral policies should be discussed. Key people with whom they will interact, including other physicians, administrators, ancillary department personnel, county medical society should be addressed. Assist with office setup; furniture, filing, library, etc. Provide a resource guide of who to call for assistance in an area with their direct number.

Periodic feedback is expected and encouraged. This can happen at weekly lunches or other interactions. Interaction is more frequent initially and will taper off but will always be needed. You will be checking to see if the physician feels acceptance and camaraderie. Does the spouse feel satisfied with the community? Is there economic satisfaction? Are the physicians input and opinions appreciated and welcomed? Does the physician see their work environment as high quality with high quality equipment and personnel? Is the physician being medically challenged with interesting cases and satisfactory CME opportunities? Is remuneration, personal/professional support, and time schedules adequate?

Providers need to be integrated into the community. Make them and their family part of the social, cultural, or recreational activities. Involve the physician in community and clinic/hospital activities.

Recognition activities are important and need to begin early. Write articles on the provider's personal and professional activities to publish. Recognize provider at staff meetings. Provide for service recognition and present awards when appropriate.

A community has about 12 months to convey that they care about the physician and family. Retention is an emotional, psychological issue. Physicians and families will not stay in a community when they do not feel wanted.

Comments and suggestions gladly accepted to improve the information and focus of this important effort. Please send them via email to [marshall.kratz@uthct.edu](mailto:marshall.kratz@uthct.edu). Thank you.

Good luck and best wishes with your current and future recruitment and retention efforts!

Much of the information contained in this document was obtained from the "Recruitment Strategies Handbook" published at that time by the Minnesota Center for Rural Health.

The current name of the organization is the National Rural Health Resource Center and their web site address is <http://www.ruralcenter.org/>