

SORRAS II

Status of Recruitment  
Resources and Strategies  
2005-2006



State of Alaska  
Frank H. Murkowski, Governor

Department of Health and Social Services  
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Office of the Commissioner

## Acknowledgements

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This project is the result of interest and support generated from the SORRAS study of 2003-04. In 2003, the Alaska Department of Health and Social Services, Primary Care and Rural Health Unit, contracted with the Alaska Center for Rural Health, University of Alaska Anchorage, to conduct a statewide assessment of rural recruitment resources, strategies, and costs. The Primary Care and Rural Health Unit initiated the project due to its work with primary care and hospital sites that indicated that sites were using a wide variety of strategies to recruit employees, often duplicating efforts and expending considerable resources on recruitment. This project was needed to further document what was occurring. The project was consistent with the goals and funding of the Primary Care and Rural Health Unit, specifically their Alaska Primary Care Office, Alaska Office of Rural Health, and Rural Hospital Flexibility programs.

In 2005, the Alaska Department of Health and Social Services (DHSS), Office of the Commissioner's Health Planning and Systems Development Unit (previously called the "Primary Care and Rural Health Unit"), funded the Alaska Center for Rural Health (ACRH) to repeat the study, adding select urban facilities. ACRH collected data on strategies used by 80 hospitals, community health centers, and rural mental health centers to recruit physical, behavioral, and oral health providers. ACRH also documented the costs associated with recruiting these professionals. The analyzed information will allow the Department of Health and Human Resources and other Alaskan entities to identify strategies for better coordination and integration of rural recruitment practices.

### Key findings on recruitment costs:

- Surveyed sites **spent over \$24 million** in the last year on the combined recruitment of the following professions: physicians, pharmacists, midlevels, nurses, dentists, hygienists, psychiatrists, clinical psychologists, masters-level therapists, and LCSWs. Nearly **\$15 million** is attributed to rural facilities and over **\$9 million** is attributed to urban facilities.
- Of the recruitment expenditures, \$12,914,085 (54%) is attributed to the cost of locums (temporary traveling practitioners). For rural facilities, it was \$8,987,205 (60%) and for urban facilities it was \$3,926,880 (42.5%).
- For rural facilities, the investment in locums increased \$4 million between the two studies.
- Including the cost of locums and training for new recruits, the average cost-per-hire was \$34,413, with a slightly higher number for rural Alaska of \$36,074 and a lower number for urban Alaska of \$25,004.

### Key findings on recruitment strategies:

- As in the 2003-04 study, word of mouth was emphasized as the most commonly used, as well as the most effective, recruitment tool.
- As in the 2003-04 study, websites and other internet resources, and word of mouth, were highly rated as “most effective” method of recruitment. Interestingly, websites and other internet resources, as well as newspaper advertising, were highly rated as both the “most effective” and “least effective” method of recruitment. This contradiction can, in part, be attributed to the fact that these mediums are not appropriate for all organizations. For example, “Other Rural” organizations most frequently rated websites as most effective (22%), while Regional Tribal Health Organizations and Community Health Centers rated them least effective (27% and 18% respectively).
- Nearly three quarters (74%) of all respondents were interested in collaborating with other organizations to recruit providers. Another 14% responded “Maybe.” Only 4% of respondents specifically indicated “no,” that they are not interested in collaborating to recruit providers.
- Funding is perceived as a significant barrier to effective recruitment. When asked what factors would make recruitment efforts more effective, the top two factors were the ability to offer higher salaries/benefit package and a bigger recruitment budget/more money. This corresponds with findings in the 2003-04 study, in which these factors were ranked #1 and #3 respectively.
- The four biggest barriers to recruitment in this study are identical to those reported in the 2003-04 study. They are: locating qualified candidates, geographic isolation/harsh living conditions, spousal compatibility/job availability, and lack of urban amenities. In fact, the only change in the top nine barriers is that housing availability was found to be a slightly larger barrier to recruitment in 2005-06.

Recommendations from surveyed health care employers are similar to suggestions from the rural health care employers in the 2003-04 study. Distilling comments from the questions on how to make recruitment efforts more effective and what respondents want to see happen as a result of this study, organizations would like:

1. Information on how other organizations conduct recruitment towards the formulation of new ideas and more efficient recruiting practices;
2. Increased funding to a) allow them to offer a more attractive salary and benefits package and b) increase their overall recruitment budget;
3. Increased collaboration with other organizations to target individuals interested in rural living and exploring the concept of a candidate pool, a network of organizations that pool providers;
4. Increased awareness at the local, state, and federal level that recruitment is extremely challenging and expensive, and worthy of more support;

5. More information on good recruitment practices. Suggestions varied from a recruiter's workshop and concrete ideas to technical assistance; and
6. More/improved in-state training programs towards a larger local candidate pool.

### **Summary of Study Limitations**

The quality and consistency of these data is affected by consistency of data collection, consistency of staffing for the respondent organizations and ACRH, and consistency of internal processes for tracking recruitment expenditures.

- **Data Collection** - ACRH did not conduct telephone interviews with all respondents, as was done in the 2003-04 study. Organizations that did not complete a survey in the previous year were asked to complete the survey via telephone with an ACRH interviewer.
- **Staffing** - ACRH did not employ the same telephone interviewers as in 2003-04. Several organizations that did participate in 2003-04 have experienced turnover in their recruitment staff, such that a new person completed the survey this year.
- **Internal Processes** - Organizations track expenditure information differently. Some organizations do not track recruitment expenditures by provider type and others may not track their expenditures according to the survey tool's budget categories. These factors resulted in "best guesses" or exclusion from the data set altogether.

On a related note, several organizations indicated that they had changed/improved their internal accounting processes since the 2003-04 study. Presumably, this has resulted in more accurate data for the 2005-06 study. Nevertheless, it also points to inconsistency in data collection and reduces comparability between the two study periods.

## I. Background

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This project is an update of the 2003-04 Status of Recruitment Resources and Strategies (SORRAS) study commissioned by the Alaska Department of Health and Social Services, Primary Care and Rural Health Unit to describe and document current recruitment strategies, effectiveness, costs, and resources used by rural primary care clinics and small hospitals. This “SORRAS Update” collected the same data points from the original study, which surveyed all rural Alaskan health care facilities, but also included select urban facilities, including all the large hospitals and community health centers in Anchorage, Fairbanks, and Juneau. Similar to the previous study, recruitment strategies and costs were collected for the following provider types:

- Physician
- Pharmacist
- Midlevel providers (Nurse practitioner, physician assistant, certified nurse midwife)
- Registered nurse
- Dentist
- Dental hygienist
- Psychiatrist
- Clinical psychologist
- Licensed clinical social worker
- Master’s level therapist/counselor

The 2003-04 SORRAS study systematically compiled data on rural Alaskan health professional recruitment. It was the first known project to comprehensively survey the specific strategies used and to quantify the precise cost of recruiting health care professionals in rural Alaska.

Several agencies and organizations currently assist with the recruitment of health care professionals in Alaska. These include governmental agencies, statewide non-profit organizations, health professional organizations, and educational institutions. The extent of their recruitment corresponds with the members their organizations serve and funding requirements. Job candidates and rural health organizations can use recruitment websites managed by the Alaska Department of Labor and Workforce Development; Alaska Native Tribal Health Consortium; Alaska Primary Care Association; Indian Health Service; National Health Service Corps; Northwest Regional Primary Care Association; Rural Recruitment and Retention Network (3R Net); and others. All of these entities work together on several workforce development initiatives.

Results from this study are intended to help health care facilities and policy makers better understand the range of recruitment strategies available to them, identify the costs that health care facilities and other organizations invest in this arena, and form a background for strategizing new collaborations and initiatives on a statewide level.

## II. Literature Review

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### A. Published Literature

A comprehensive literature review was performed to identify publications released between January 1998 and December 2005 relevant to rural health professional recruitment. Findings from the literature review were incorporated in the development of the survey instrument.

Two health sciences databases were utilized: PubMed and HealthSTAR. The PubMed database provides access to MEDLINE citations and international journals focusing on clinical medicine and other health fields. The HealthSTAR database focuses on health planning and administration publications. In addition, a bibliography of health recruitment resources developed by the National Library of Medicine (NLM) was used.<sup>1</sup> Using the search keywords “**personnel selection-methods,**” “**rural health or rural health services,**” and “**cost or costs**” resulted in over 79 relevant citations. Research relating to a wide number of health providers such as physicians, nurses, mental health providers, and mid-level providers was included.

Seventy-nine publications met inclusion criteria for the literature review, with a fairly consistent number of publications appearing in each year.

In general, the relevant publications can be categorized into six major topic categories. Articles focusing on community and organizational strategies for health professional recruitment accounted for nearly one-third (33%) of all citations. Other publications focused on health professional training issues, the costs of recruitment, large scale strategies (generally national or state policies aimed at increasing rural providers), and employment selection behaviors.

<b>Figure 1. Publication Topic</b>	<b># Citations</b>	<b>% Citations</b>
Community/Organizational strategies for health profession recruitment and retention	26	33%
Cost of recruitment/turnover	7	9%
Health profession training issues	20	25%
Health professional employment selection behaviors	10	13%
Large scale strategies	15	19%
Multiple topics	1	1%
<b>TOTAL</b>	<b>79</b>	<b>100%</b>

The majority of citations were for descriptive papers (56%) and papers reporting survey results (35%). Descriptive papers generally reported on specific programs used by communities, universities, or rural hospitals and clinics to improve the recruitment of rural providers. Surveys were generally assessments of providers to determine practice patterns and factors impacting rural practice.

Nearly two-thirds of the publications focused on physician recruitment strategies (65%). Recruitment strategies aimed at nurses (14%) were the second most frequent provider type. Two manuscripts were identified for mental health providers, and another two manuscripts focused on mid-level providers.

<b>Figure 2. Profession Focus</b>	<b># Citations</b>	<b>% Citations</b>
Mental Health Providers	2	3%
Mid-level Providers	2	3%
More than one	3	4%
Not Specified	10	13%
Nurses	11	14%
Physicians	51	65%
<b>Total</b>	<b>79</b>	<b>100%</b>

Findings from the literature review can be generalized within the five main topic categories.

## **1. Community and Organizational Strategies for Health Professional Recruitment (32%)**

### ***a. Empowered communities can work together to make themselves more attractive to healthcare workers.***

Several researchers found that rural communities can be more successful recruiting and retaining providers when they take an active role in the process. Some specific methods cited to help communities become more “recruitable” include:

- Using a regional recruiter to guide the community through community development activities aimed at making communities more attractive to physicians;<sup>ii</sup>
- Empowering communities to be more active in community planning to define community health workforce needs, determine community barriers to achieving these goals, and build solutions to make communities more attractive to health workers;<sup>iii, iv</sup> and
- Developing lists of community and facility assets that will appeal to physicians.<sup>v</sup>

Communities with access to telemedicine, however, were not found to have an improved ability to recruit and retain rural providers.<sup>vi</sup>

### ***b. Rural recruitment and retention efforts should take into account the needs of the entire family.***

The needs of spouses and children of health care professionals are often neglected when health organizations partake in recruitment and retention efforts. However, a provider is unlikely to stay long-term if the needs of the whole family are not met.<sup>vii</sup> Organizations are wise to think about “recruiting” the entire family.<sup>viii</sup> One survey of rural

physicians found that the biggest barriers to practicing in a rural location were family related, including spousal employment and children's schooling.<sup>ix</sup> One solution suggested is the creation of a Spousal Network to address the needs and concerns of rural physician spouses, including spousal employment help, mentoring, stress management, and spouse getaways.<sup>x</sup>

***c. Organizations can improve recruitment and retention by finding creative ways to provide clinical, professional and financial support.***

Several authors mentioned the provision of generous financial support to rural providers as an important recruitment tool. Bold and innovative recruitment methods that include liberal compensation packages may help.<sup>xi</sup> Creative types of compensation include local loan repayment programs, repayment of relocation expenses, car allowances, percentage of gross revenue bonus structures, and retention bonuses. One program offers bonuses to clinical providers who recruit their colleagues to practice in the community.

Practicing rural physicians were also surveyed to solicit their ideas on possible solutions for recruiting and sustaining physicians in rural practice. A wide variety of clinical support solutions were identified, with the top four solutions including:

- Better planning and compensation for locums;
- Access to local/regional locums for rapid deployment when needed;
- Creation of on-call strategies to decrease physician call; and
- Greater access to specialty referral networks.<sup>xii</sup>

One program found success by providing professional support to rural physicians through strong ties with a university medical center. Support from a university was found to reduce professional isolation. Providing rural physicians with academic appointments also provides an attractive incentive for rural practitioners.<sup>xiii</sup>

Several suggestions for improving nurse recruitment and retention bear mention. Mentorship programs for nurses beginning practice in rural locations have been found to positively influence nurse retention.<sup>xiv</sup> Another program has looked at recruiting short-term providers to fill gaps. The program found that keys for such recruitment included providing necessary personal support, flexible work schedules, links to community leaders, and opportunities to discuss potential fears of working in rural northern climates.<sup>xv</sup>

## **2. Health Profession Training Issues (26%)**

***a. Rural training programs are successful tools for recruiting and retaining providers and should be focused at all aspects of the training continuum.***

Interdisciplinary health training programs with a rural rotation are an integral factor in recruiting health workers to practice in rural locations.<sup>xvi</sup> In fact, exposure to rural training curriculum and rotations are the factors most strongly correlated to provider

retention.<sup>xvii</sup> Fellows who complete a rural health fellowship have a higher tendency to locate in rural settings<sup>xviii</sup> and rural primary care clerkships positively impact students' perceptions towards rural practice.<sup>xix</sup>

Much research has been done over the past 20 years to document and analyze rural training programs. The research shows that strategies should encompass the entire educational pipeline, although there are still many opportunities for attrition at each point along the educational pathway.<sup>xx</sup> Training programs focusing on high school students,<sup>xxi</sup> undergraduates from rural locations,<sup>xxii</sup> prevocational physicians,<sup>xxiii</sup> undergraduate and graduate mental health providers,<sup>xxiv</sup> and nurse practitioners<sup>xxv</sup> have all been found to be successful. Training preceptors to guide nursing undergraduates towards rural careers also have an impact on the willingness of new nursing graduates to become rural mental health nurses.<sup>xxvi</sup>

***b. Strategies can be developed to minimize provider concerns regarding rural training tracks and encourage participation.***

Barriers to providers participating in rural training tracks have been identified through surveys. Top barriers cited include:

- Low number of patients in rural communities;
- Lack of exposure to large training conferences;
- Lack of exposure to peer residents;
- Rural hospital politics;
- Not enough attending teaching time; and
- Heavy call schedules.<sup>xxvii</sup>

However, strategies have been implemented to encourage rural training by minimizing some of the problems associated with rural training. These strategies have included the creation of flexible joint rural-metropolitan positions, the creation of rural physician conferences, and the introduction of individualized management consultant support to rural physicians.<sup>xxviii</sup>

***c. Rural training programs should emphasize recruiting those with a rural background and preparing candidates to become rural community leaders when designing family medicine rural practice curricula.***

Two non-clinical predictive factors for employment in rural practice include preparedness to be a rural community leader within a rural culture and being from a rural background. These issues should be considered when designing curriculum for training rural providers.<sup>xxix</sup>

### **3. Large Scale Strategies – (19%)**

***a. National and state financial incentive programs aimed at encouraging practice in underserved areas are effective but funded too modestly.***

Financial incentives have been successful in recruiting physicians to medically underserved areas in the United States.<sup>xxx</sup> National Health Service Corps is one such example.<sup>xxxi</sup> A literature review of return-of-service commitment programs found most to be generally effective. However, such efforts should have greater funding and more marketing in order to fully meet the vast needs of underserved communities.<sup>xxxii</sup>

Physicians serving obligations to state programs have been found to practice in demonstrably needier communities and care for more uninsured and underinsured patients. State managed return-of-service programs are effective at bringing physicians to places where they are most needed and physicians tend to stay within those rural communities for lengthy periods.<sup>xxxiii</sup>

Government sanctioned financial incentives have also been used to recruit physicians to rural British Columbia,<sup>xxxiv</sup> military physicians in Canada,<sup>xxxv</sup> and both nurses<sup>xxxvi</sup> and physicians<sup>xxxvii</sup> to rural areas in the United Kingdom.

#### ***b. States and counties who implement tort reform may have an easier time recruiting physicians***

One study reviewed counties with per-capita increases in physicians. The authors found that rural counties with malpractice caps on non-economic damages had larger increases in physician numbers than any other counties. However, the article acknowledges that the finding contrasts with those of another similar study recently performed by the GAO.<sup>xxxviii</sup>

### **4. Health Professional Employment Selection Behaviors (15%)**

#### ***a. Healthcare workers who grow up in a rural location are more likely to be recruited to rural practice.***

One citation reported the factor correlating strongest to rural practice is growing up in a rural location. The strong association has been found for a wide variety of healthcare workers including physical therapists and occupational therapists,<sup>xxxix</sup> nurses,<sup>xl</sup> and primary care physicians.<sup>xli</sup>

#### ***b. Many issues affect healthcare workers' decisions to practice in a rural location, so training, recruitment, and retention efforts should be multi-faceted.***

Although growing up in a rural location was most strongly correlated to recruitment, a wide variety of issues are cited by healthcare workers explaining why they were recruited to a rural practice and what they like about their rural location. Many of the same issues are cited by several health professions, including physical therapists, occupational therapists, nurses, and physicians. They include:

- Proximity to leisure and recreational activities;
- Proximity to extended family;

- Rural lifestyle (less stress, less hurried);
- Professional autonomy;
- Influence of spouse; and
- Financial compensation.

Physicians, nurses, and allied health workers also cite similar dislikes that may lead to low retention in rural practice. The most heavily cited dislikes include isolation, long hours, lack of locums, low pay, and lack of specialists.<sup>xlii.xliii</sup> Solutions, therefore, must look at a variety of factors.

## 5. Cost of Recruitment and Turnover (9%)

### ***a. The cost of turnover is large, so recruiting and retaining the right person is important.***

Provider turnover is expensive to organizations, although specific estimates of cost per hire vary greatly and are influenced by geography, profession, and assumptions used in financial calculations.

The largest study found on the subject looked at the cost of turnover of primary care physicians in both rural and urban settings. The authors found that recruitment and replacement costs for individual Primary Care Providers (PCP) were around \$236,383 for general/family practice, \$245,128 for internal medicine, and \$264,645 for pediatrics, based on costs of interviewing, relocation, search firms, sign-on bonuses, and loss of productivity (gross production minus starting salary).<sup>xliv</sup> Another author estimated the average turnover cost was \$33,000 for an RN earning \$47,000 per year. This figure included the entire spectrum of turnover costs, from separation and replacement, to training a new RN.<sup>xlv</sup> Physicians' costs were estimated at \$20,000-\$26,000 per hire, just for recruitment.<sup>xlvi</sup>

Although the cited costs per hire vary greatly, the authors agree that the cost of turnover is high and that a variety of different costs should be taken into consideration when calculating these costs, including:

- Separation costs;
- Replacement costs; and
- Training costs, as well as
- Lost revenue as a result of the open vacancy<sup>xlvii</sup>.

Tracking recruitment costs can help an organization develop better methodologies for recruitment.<sup>xlviii</sup> Hiring the right person can help decrease turnover and save an organization from incurring high turnover costs.

## **B. Alaskan Workforce Studies**

Several Alaskan health workforce studies conducted within the past five years bear mention. Because Alaska lacks funding for longitudinal monitoring of changes in the health workforce to support program planning, these individually funded studies provide a useful glimpse into specific components of the health workforce.

### **1. Colleagues in Caring**

Funded by the Robert Wood Johnson Foundation, Alaska State Board of Nursing, and the UAA School of Nursing, this study tracked the characteristics and work-related intentions of Alaska Registered Nurses in 1996, 1998, 2000 and 2002. Survey instruments were included in their licensure packets. Response rates varied between 43% and 80%. Key findings include:

- The average age of respondents in 2002 was 46 and the percentage reported to be American Indian/Alaska Native has grown to 2.4%;
- Alaskan nurses are, on average, more educated than their colleagues nationally;
- The biggest reason for deciding to stay in nursing was “salary/financial security” (54%); and
- Annual hourly salaries increased incrementally by age and level of nursing degree, but the average was \$28.55/hour.

Website: [http://www.dced.state.ak.us/occ/pub/RN\\_finalreport.pdf](http://www.dced.state.ak.us/occ/pub/RN_finalreport.pdf)

### **2. CHA/P Retention Study**

Funded by the Office of Rural Health Policy, Health Resources and Services Administration (HRSA), the purpose of this 2003 study was to identify factors contributing to retention in Alaska’s Community Health Aide/Practitioners program.

Key informant interviews were conducted with 41 community health aides/practitioners (CHA/Ps) in 15 villages statewide. Efforts were made to ensure the sample included a mix of villages with high retention of health aides and villages with lower retention. Geographic and ethnic diversity were also considered. Transcripts were coded using NUD\*IST software and data analyzed for differences between high retention and low retention villages, and between more experienced and less experienced CHA/Ps.

Five fundamental needs of health aides were identified as critical for retention of personnel. These needs include strong co-worker support, access to basic training, a fully staffed clinic, good community support, and supportive families.

Website: [http://www.ichs.uaa.alaska.edu/acrh/projects/report\\_chap-retention.pdf](http://www.ichs.uaa.alaska.edu/acrh/projects/report_chap-retention.pdf)

### **3. Alaska's Allied Health Workforce: A Statewide Assessment**

Funded by University of Alaska President Mark Hamilton, the purpose of this assessment was to determine the current and projected allied health workforce needs of Alaska by surveying employers of the allied health workforce, with results that include projections for 3-5 years into the future. The study covered 78 allied health professions, organized by academic requirements, in 369 organizations.

The project relied heavily on collaboration with many key agencies: the Alaska State Hospital and Nursing Home Association, the Alaska Primary Care Association, the Alaska Native Health Board, the Alaska Native Tribal Health Consortium, the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Governor's Council on Disabilities and Special Education, the Substance Abuse Director's Association, the Alaska Community Mental Health Services Association, AK Dept of Health and Social Services, Division of Senior and Disability Services, and the Alaska Department of Labor. This team assisted in the development of the assessment instrument, conducting phone interviews, reviewing results, and making recommendations to the University of Alaska.

Website: [http://www.ichs.uaa.alaska.edu/acrh/projects/archives/report\\_allied.pdf](http://www.ichs.uaa.alaska.edu/acrh/projects/archives/report_allied.pdf)

### **4. Physician Workforce 2000**

Funded with Alaska's Area Health Education Center grant, this study assessed the demographic characteristics and professional behavior of the Alaska physician workforce. Variables were selected based on their interest to health care employers and planning agencies statewide. The Alaska Division of Occupational Licensing mailed 2,020 surveys with license application materials (biannual licensing cycle). For the 960 (44.7%) returned, Alaska learned about the age, gender, ethnicity, location of primary practice, months worked during the year, and hours worked per week. In addition, the study identified how respondents access CME, provision of itinerant services, residency training, and ABMS certification.

Website: [http://www.ichs.uaa.alaska.edu/acrh/projects/archives/report\\_phys.pdf](http://www.ichs.uaa.alaska.edu/acrh/projects/archives/report_phys.pdf)

### **5. Attrition Among Alaska Emergency Medical Technicians**

This study surveyed former Emergency Medical Technicians whose certifications expired between 1995 and 2000 to determine why they failed to recertify. Two-hundred and forty-nine (249) of the 2,968 surveys were returned, for an 8% response rate. Nearly half were returned as undeliverable. Key findings included:

- attrition in moderate-sized communities hinder efforts by local EMS programs or by the State EMS program;
- sufficient efforts are being made to deliver EMT courses in communities with populations greater than 1,000;
- EMTs in the smallest communities drop their certifications due to the lack of opportunity to practice their skills, lack of local recertification classes, and family/personal reasons; and

- EMTs in larger communities drop their certifications due to health, stress, and expectations that differ from reality.

## **6. Alaska Economic Trends: Health Care Industry**

Funded by the State of Alaska and conducted by the Department of Labor and Workforce Development, Research and Analysis Section, this report documents the size of the health workforce, employment type, location, and contribution to the economy. It also assesses growth and projections for the sector as a whole as well as changes in demand for many of the health professions. The April issue provides extensive information on the health care industry and workforce.

Website: <http://labor.state.ak.us/trends/apr06.pdf>

## **7. Status of Recruitment Resources and Strategies 2003-2004**

Funded by the State of Alaska DHSS Primary Care and Rural Health Unit, and conducted by the Alaska Center for Rural Health, UAA, the project was a predecessor to SORRAS 2005-2006. ACRH conducted telephone surveys to collect data on strategies used by 76 small hospitals, rural clinics, and rural mental health centers to recruit 13 different provider types in physical, behavioral, and oral health.

Website: <http://hss.state.ak.us/commissioner/Healthplanning/publications> and [http://www.ichs.uaa.alaska.edu/acrh/projects/sorras\\_report.htm](http://www.ichs.uaa.alaska.edu/acrh/projects/sorras_report.htm)

### III. Methodology

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#### A. Project Advisory Committee

The original SORRAS project advisory committee reconvened to oversee this update. As in the original study, membership included a wide spectrum of health provider constituents, yet was small enough to convene and advise research staff throughout the project. Committee membership included:

- Alaska DHSS Health Planning and Systems Development – Nancy Barros, Facilitator; Pat Carr
- Alaska Mental Health Trust Authority – Erika Wolter
- Alaska Native Tribal Health Consortium – Tim Gilbert and Carrie Agibinik
- Alaska Primary Care Association – Marilyn Kasmar and Pat Fedrick
- Alaska State Hospital and Nursing Home Association – Randall Burns (ASHPIN)

This group convened three times throughout the project period. The first meeting was in September 2005 to discuss the project scope and review the original survey instrument. In addition, committee members reviewed and edited a list of respondent agencies and offered to include letters of introduction in the survey mailing to their membership. The Project Advisory Committee convened in January 2006 to review data and make recommendations for cross-tabulations and additional analyses. This input ensured appropriate data was shared at the Alaska Rural Health Conference in February. The group reconvened again in April 2006 to discuss results of the study and make recommendations for the final manuscript.

#### B. Survey Development

As stated earlier, this study used the 2003-04 study survey instrument to improve comparability across study periods. Some very slight modifications were incorporated based on the experiences from the first study. For example, the categories of “Nurse Practitioner” and “Physicians Assistant” were combined as “Midlevel,” as most facilities recruited for either provider type, and costs and strategies for these categories could not be disentangled.

Development of the initial survey instrument involved a comprehensive process including:

- A literature review to identify variables for inclusion in the instrument;
- Input from Alaska Department of Labor and Workforce Development, Research and Analysis Section (DoL) staff on content and format;
- Review from the Project Advisory Committee; and
- Field test of the instrument with pilot sites.

## **C. Respondents**

ACRH created the respondent database from the 2003-04 study's respondent list, adding several urban facilities. The Project Advisory Committee provided input and updates to the database as well. Through this process, an attempt was made to include in the database all Alaskan:

- Large hospitals, including the Alaska Psychiatric Institute;
- Small hospitals;
- Rural health clinics and community health centers; and
- Rural mental health centers.

Respondents were medical directors, human resource directors, and other representatives of small hospitals, rural clinics, community health centers, and rural mental health centers in Alaska.

## **D. Data Collection**

First, ACRH called all facilities in the database to confirm that the respondent from the previous study was still employed at the facility. If the original respondent was no longer there, another appropriate respondent was identified. In early October 2005, ACRH mailed a survey packet to all proposed respondents. The packet included:

- A letter from an appropriate organization explaining the purpose of the study and asking for participation. Depending on their relationship with the respondent, the Alaska DHSS Office of the Commissioner, APCA, ANTHC, AMHTA, and ASHNHA each wrote and signed letters to their constituents;
- A project background sheet;
- The facility's completed survey from the 2003-04 study;
- A blank hardcopy of the new survey; and
- Survey instructions

ACRH asked respondents to mail, fax, or email their completed survey forms. ACRH did not conduct telephone interviews with all respondents, as was done in the 2003-04 study, because most respondents were presumably still familiar with the instrument from the previous data collection. Respondents that did not complete a survey in the previous year were asked to complete the survey via telephone with an ACRH interviewer. Respondents were then contacted by phone to ensure receipt of the packet and answer any questions. In most cases, the call was followed up by an email with attachments of "soft copies" of previously mailed project information. Each facility was repeatedly contacted through the final data collection date, unless they refused participation.

Surveys were collected between October 14 – January 4, 2005. Eighty (80) of the 85 organizations participated, resulting in a response rate of 94%.

## **E. Limitations of the Data**

The quality and consistency of these data is affected by two spheres of factors. One relates to ACRH capacity and its selected methodology. The other centers on how organizations track information. Both may have affected the quality of data collected for this study and the comparability to the 2003-04 study.

First, organizations that did not complete a survey in the previous year were asked to complete the survey via telephone with an ACRH interviewer. Several organizations that did participate in 2003-04 experienced turnover in their recruitment staff, such that a different person received the survey for this year's study. Also, ACRH did not employ the same telephone interviewers as in 2003-04. The inconsistency of staff at the respondent level and at ACRH may have affected the data collected, as well as comparability between the two studies.

Second, organizations track expenditure information differently. For example, in the 2003-04 study, some organizations had to be excluded from the financial component, because they did not track recruitment expenditures by provider type. Other organizations may not track their expenditures according to the survey tool's budget categories. These factors resulted in "best guesses" or exclusion from the data set altogether.

On a related note, several organizations indicated that they had changed/improved their internal accounting processes since the 2003-04 study. Presumably, this has resulted in more accurate data for the 2005-06 study. Nevertheless, it also points to inconsistency in data collection and reduces comparability between the two study periods.

## IV. Analysis & Findings



Returned surveys were entered into an MS Access database. Doucette Information Systems Management designed the MS Access database in 2003. ACRH used Statistical Package for the Social Sciences (SPSS) to analyze all data.

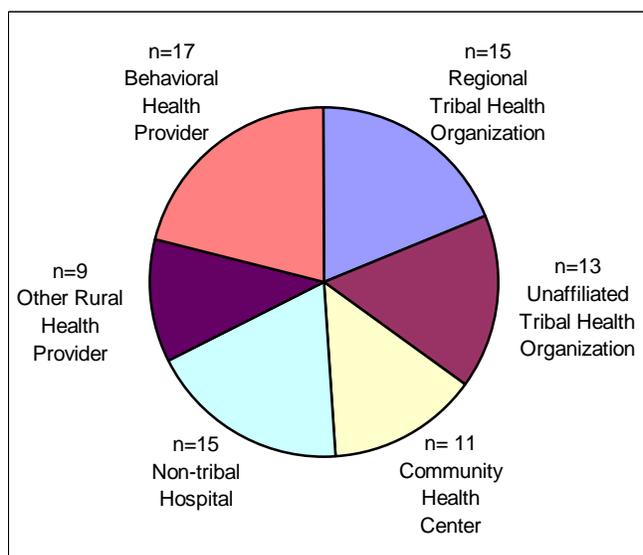
ACRH initially ran simple frequencies, statistics (mean, median, and mode), and several cross-tabulations. In January 2006, the Project Advisory Committee reviewed the preliminary data analysis and recommended additional analyses and report structure changes.

This section depicts key findings, analyzed with simple frequencies and cross-tabulations, from the survey data. Intentionally, all figures in this report correspond with figures in the 2003-04 report. That is, “Figure 3” in this report depicts the same information as “Figure 3” from the 2003-04 report. This will allow readers to easily compare findings between the two studies. All quotes in this report are indented, italicized, and within quotation marks.

### A. Study Participants

ACRH collected surveys from human resource directors and other staff self-identified to be knowledgeable about their organizations’ recruitment practices and costs. Only facilities that were directly involved in the recruitment of the providers listed above were surveyed. For example, if clinic X was a satellite site of clinic Z, and clinic Z handled recruitment for the entire alphabet, only clinic Z was surveyed. ACRH asked clinic Z to submit data regarding their entire operation, including staffing for their satellite facilities.

**Figure 3: Facility Type Breakdown of Study Participants**



**Regional Tribal Health Organization (n=15):** This refers to tribal health organizations operating multiple clinics across multiple communities. Regional tribal health organizations conduct recruitment for their affiliated hospitals, sub-regional clinics, and village clinics. Therefore, this category encompasses tribal hospitals and tribal Community Health Centers. The Alaska Native Medical Center and Southcentral Foundation were new additions for this 2005-06 study. The Barrow Service Unit included two facilities, Samuel Simmonds Hospital and the North Slope Borough Health Department.

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**Unaffiliated Tribal Health Organization (n=13):** These refer to the small, independently-operated tribal health organizations. These entities are single tribes running the operation of health for their individual village.

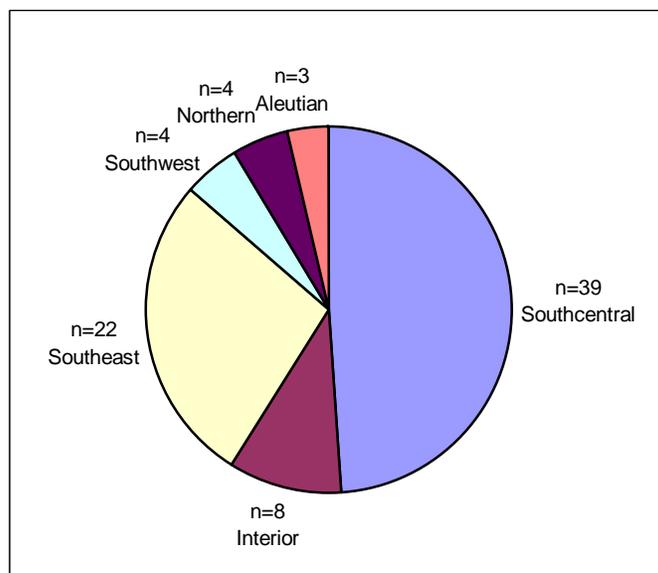
**Community Health Center (n=11):** The community health centers included in this category were non-tribally-affiliated 330 clinics. Since tribal community health centers do not typically finance and recruit providers independent of their larger organization, they were considered “satellite clinics” of regional tribal health organizations.

**Non-tribal Hospital (n=15):** Non-tribal hospitals in this report refer to rural Alaskan hospitals as well as four large hospitals located in Anchorage, Fairbanks, and Juneau.

**Other Rural Health Provider (n=9):** These refer to privately owned and operated clinics located in rural Alaska.

**Behavioral Health Providers (n=17):** These refer to mental health or substance abuse treatment facilities that operate independently and recruit and employ their own providers. This category also included Alaska Psychiatric Institute and North Star Behavioral Health systems. Data of behavioral health departments incorporated within larger organizations were collected from the larger organization.

**Figure 4: Regional Breakdown of Study Participants**

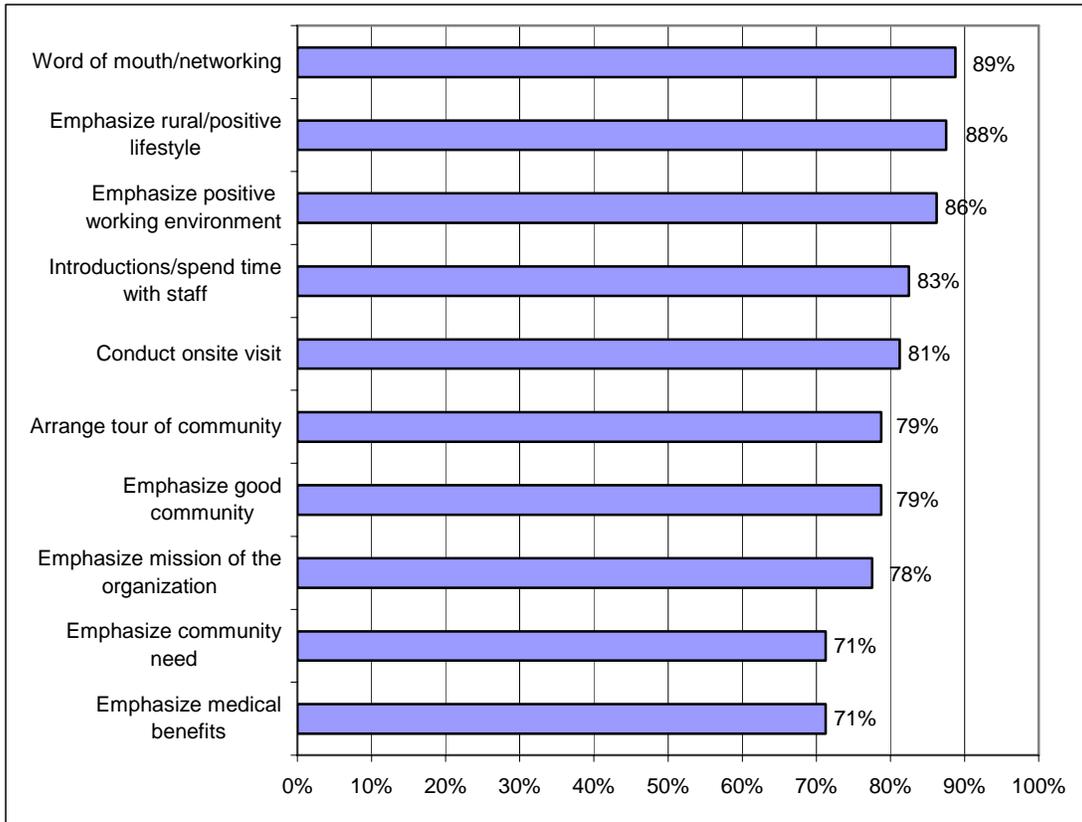


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## **B. Strategies Used to Recruit Providers**

Subsections B – F describe key findings on recruitment strategies. More detail, especially cross-tabulations by organization type, organization size, and provider type, are included in the separate Appendices.

**Figure 5: Top 10 Most Common Strategies Used to Recruit Providers\***



\*Respondents could check more than one strategy.  
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**Figure 6: Onsite Visits**

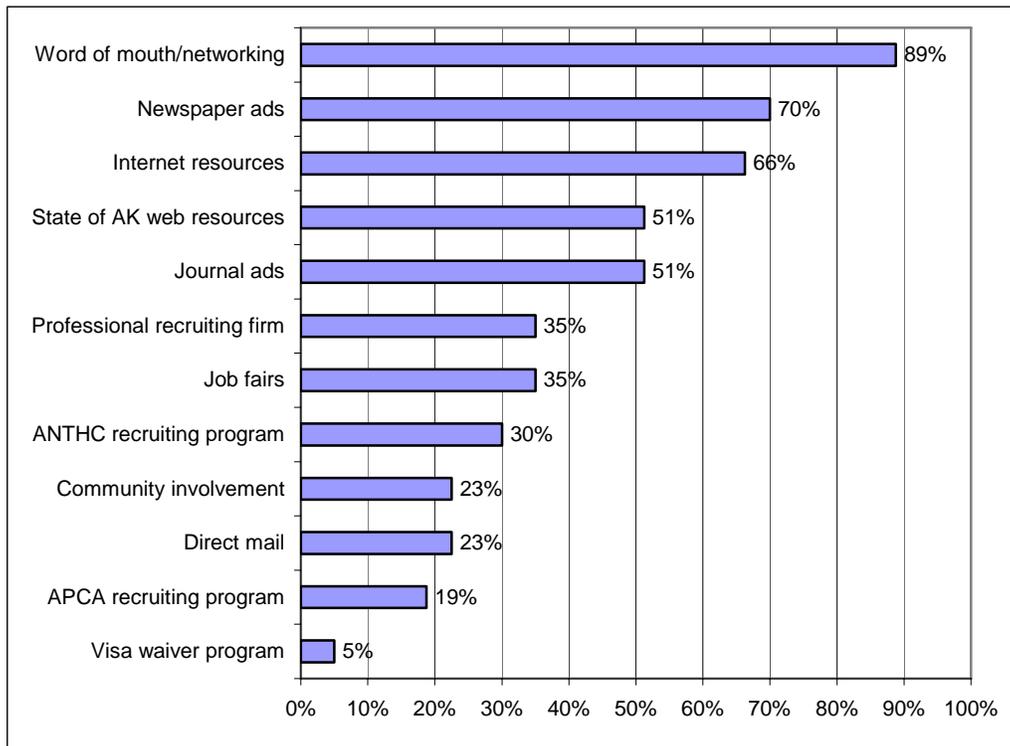
Onsite Visits	
Introductions/spend time with staff	83%
Conduct onsite visit	81%
Arrange tour of community	79%
Accommodation/travel arrangements	70%
Arrange recreational activities*	54%
Introductions to community members	53%
Invite family to onsite interview	49%

\*Examples include fishing, boat ride, drive, potluck or other gatherings, etc.

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Respondents were asked to select any strategies they used among a list of 43 different recruitment strategies. The list included various family/community-related approaches, financial incentives, interview-related strategies, job marketing tactics, and practice benefits. The most commonly used recruitment strategies selected are depicted in Figure 5. The results were found to be consistent with the previous findings in the 2003-04 data. Eighty-one (81%) of facilities invited candidates to their community/facility for an “onsite visit” (Figure 6). In many cases, families were also invited.

**Figure 7: Most Common Strategies Used To Market Vacant Positions**



*\* Internet resources includes the State of AK web resources (51%)  
Respondents could mention more than one answer.  
SORRAS, June 2006*

Figure 7 compares the frequency of methods used to actively market an open position. Word of mouth and advertising in the newspaper appeared to be the most common methods. The majority of facilities also used internet resources, and many advertised in journals.

The top four strategies identified in this study are the same as the strategies identified in the 2003-04 study. Rankings of subsequent strategies do not differ substantively.

Note that only a subset of facilities are eligible to participate in the Alaska Native Tribal Health Consortium (ANTHC) recruiting program, the Alaska Primary Care Association (APCA) recruiting program, or the Visa Waiver program.

**Figure 8. Job Marketing Strategies Used For Specific Professions**

Job Marketing Strategies											
	Total	Physician	Pharmacist	Midlevel	RN	Dentist	Dental Hygienist	Psychiatrist	Clinical Psychologist	LCSW	MLT
	n=80	n=44	n=28	n=47	n=49	n=22	n=17	n=17	n=18	n=40	n=42
Word of mouth/networking	89%	89%	75%	89%	88%	86%	77%	65%	89%	85%	84%
Newspaper ads	70%	48%	64%	64%	74%	59%	77%	47%	72%	61%	71%
Internet resources	66%	61%	71%	55%	59%	67%	53%	65%	67%	61%	61%
State of AK web resources	51%	54%	39%	47%	45%	55%	53%	35%	50%	58%	57%
Journal ads	51%	43%	64%	32%	63%	41%	24%	35%	39%	42%	33%
Job fairs	35%	25%	43%	23%	47%	32%	24%	29%	28%	34%	27%
Professional recruiting firm	35%	39%	43%	13%	29%	14%	6%	18%	17%	15%	12%
ANTHC recruiting program	30%	27%	18%	40%	33%	44%	35%	29%	33%	20%	30%
Direct mail	23%	23%	25%	9%	16%	18%	12%	6%	11%	7%	7%
Community involvement	23%	23%	19%	16%	22%	14%	6%	6%	0%	7%	9%
APCA recruiting program	19%	21%	0%	26%	10%	19%	6%	6%	0%	7%	5%
Visa waiver program	5%	9%	0%	2%	4%	5%	0%	6%	6%	2%	2%

*Respondents could select more than one answer.*

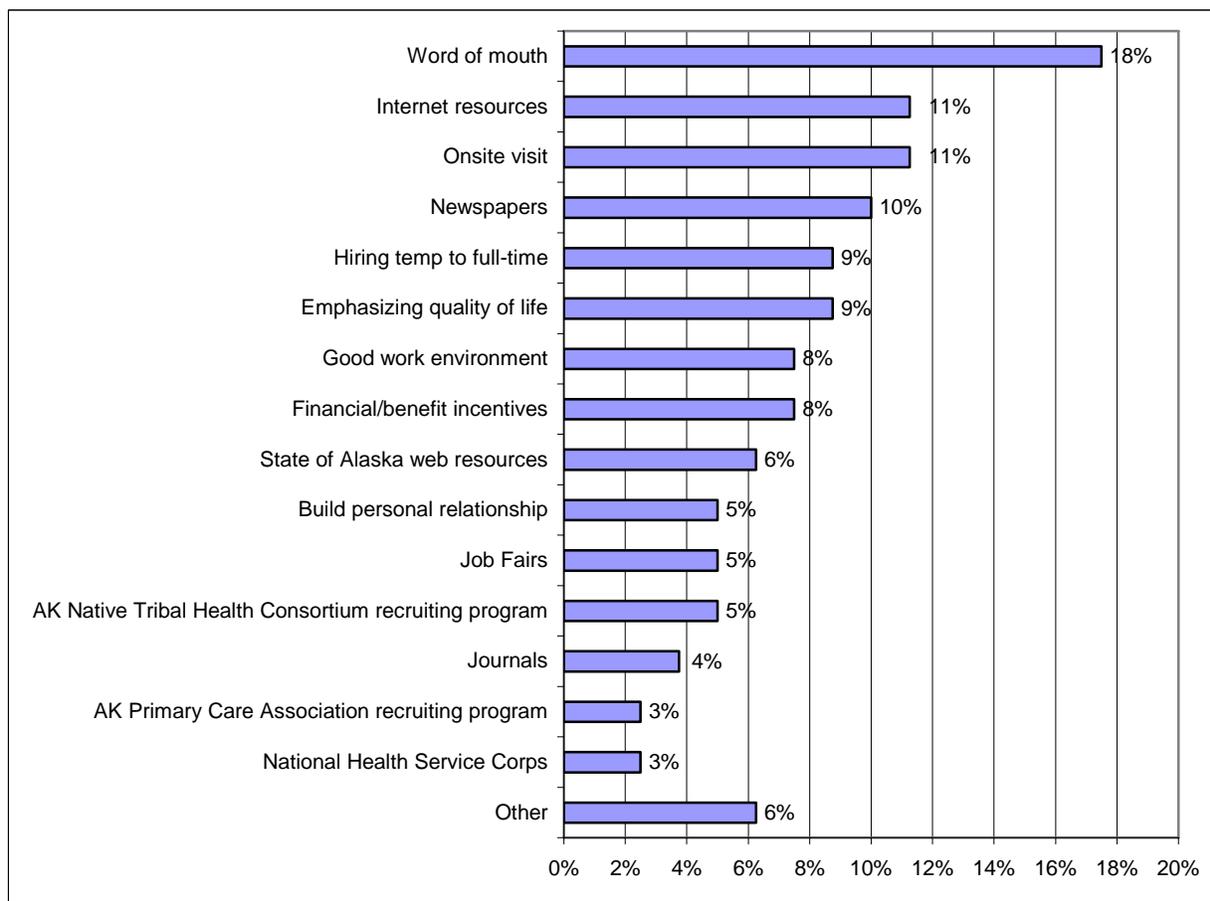
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Different recruitment methods were used for different types of providers:

- Word of mouth/networking as a strategy was used most commonly across professions (89%) and used least with psychiatrists (65%).
- Journal ads were most commonly used to recruit pharmacists (64%) and nurses (63%).
- Newspaper advertising was used commonly across professions, but was used most frequently in the recruitment of dental hygienists (77%) and RNs (74%).
- Professional recruiting firms were used most in the recruitment of pharmacists (43%) and physicians (39%).
- Direct mail was used most often in the recruitment of pharmacists (25%) and physicians (23%).
- Job fairs were used most often in the recruitment of RNs (47%) and pharmacists (43%).
- The Alaska Primary Care Association (APCA) recruiting program was used most often in the recruitment of midlevels (26%), physicians (21%), and dentists (19%).

## C. Most Effective Recruitment Strategies

Figure 9: Most Effective Recruitment Strategies



Categories above were created from verbatim responses to the open-ended question, "Which strategies have you found to be most effective for recruiting providers into your organization?"

Respondents could mention more than one answer.

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### 1. Internet Resources

Respondents were asked in an "open answer" format what recruitment methods were most effective. As was the case in the 2003-04 data collection, websites and other internet resources were most commonly mentioned.

### 2. Word of Mouth

Word of mouth and informal networking was mentioned as an important recruitment resource. Often, current staff was the best resource for recruiting other providers.

### 3. Hiring Temporary to Full Time

Another frequently used strategy was to recruit temporarily-placed individuals to full-time positions. Selected quotes:

*“Recruiting personnel as temporary contract employees and then recruiting to full-time positions.”*

*“Hosting students and residents is also very effective.”*

**Figure 10: Most Effective Strategies by Organization Type**

Most Effective Strategies: by Organization Type														
	All facilities		Non-tribal Hospital		Regional THO*		Unaffiliated THO*		CHC		Other Rural		Mental Health	
	n=80	%	n=15	%	n=15	%	n=13	%	n=11	%	n=9	%	n=17	%
Word of mouth	14	18%	2	13%	2	13%	1	8%	2	18%	4	44%	3	18%
Internet resources	9	11%	1	7%	2	13%	1	8%	1	9%	2	22%	2	12%
Newspapers	8	10%	1	7%	1	7%	2	15%	1	9%	1	11%	2	12%
Onsite visit	9	11%	2	13%	2	13%	1	8%	2	18%	0	0%	3	18%
Emphasizing quality of life	7	9%	2	13%	0	0%	2	15%	0	0%	1	11%	2	12%
Hiring temp to full-time	7	9%	1	7%	1	7%	1	8%	2	18%	2	22%	0	0%
Financial/benefit incentives	6	8%	3	20%	0	0%	0	0%	0	0%	1	11%	2	12%
Good work environment	6	8%	1	7%	0	0%	2	15%	1	9%	0	0%	2	12%
State of AK web resources	5	6%	1	7%	0	0%	1	8%	1	9%	0	0%	12	71%
Alaska Native Tribal Health Consortium recruiting program	4	5%	0	0%	4	27%	0	0%	0	0%	0	0%	0	0%
Build personal relationship	4	5%	0	0%	2	13%	0	0%	2	18%	0	0%	0	0%
Job Fairs	4	5%	1	7%	2	13%	1	8%	0	0%	0	0%	0	0%
Journals	3	4%	0	0%	2	13%	0	0%	3	27%	0	0%	1	6%
National Health Service Corps	2	3%	0	0%	0	0%	0	0%	2	18%	0	0%	0	0%
Alaska Primary Care Association recruiting program	2	3%	0	0%	0	0%	0	0%	1	9%	1	11%	0	0%
Emphasize loan repayment	1	1%	0	0%	0	0%	0	0%	1	9%	0	0%	0	0%
Emphasizing need	1	1%	0	0%	0	0%	1	8%	0	0%	0	0%	0	0%
Recruiter	1	1%	0	0%	0	0%	0	0%	1	9%	0	0%	0	0%
Other	5	6%	1	7%	2	13%	1	8%	0	0%	1	11%	0	0%
Don't know/no answer	15	19%	6	40%	0	0%	3	23%	0	0%	1	11%	5	29%

\*Tribal Health Organization

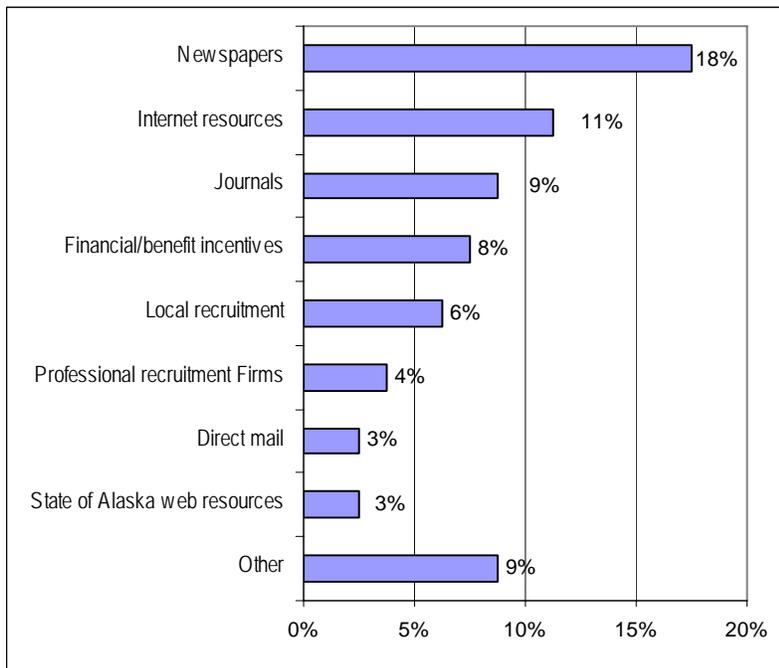
Respondents could mention more than one answer.

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The table above describes how different organizations viewed what strategies were effective. These were entirely open-answer, so respondents did not have a list from which to choose. Interestingly, the top three “most effective” strategies for “all facilities” in the 2003-04 study are the same in this year’s study, in a slightly different order. The next five items are also identical, in a different order. This suggests consistency between the study periods and a lack of remarkable changes in this area.

## D. Least Effective Recruitment Strategies

Figure 11: Least Effective Recruitment Strategies



Categories above were created from verbatim responses to the open-ended question, "Which strategies have you found to be least effective for recruiting providers into your organization?"

Respondents could mention more than one answer.

SORRAS, June 2006

### 1. Newspaper advertising

Respondents were asked in an "open answer" format what recruitment methods were least effective. As was the case in 2003-04, newspaper advertising topped the list. Respondents emphasized the importance of clearly targeting the intended audience in 2003-04. Respondents provided fewer details on paper surveys in 2005-06, but the issues are likely to be similar to the previous year.

### 2. Internet Resources

As with the previous year's report, internet resources were ineffective when they were not appropriately targeted. Most of the websites found to be ineffective were large, general recruitment clearinghouses. Selected quotes:

*"Huge recruitment websites, such as career building."*

*"Some internet advertising (i.e. Monster.com) for physicians."*

**Figure 12: Least Effective Recruitment Strategies by Organization Type**

Least Effective Strategies: by Organization Type														
	All facilities		Non-tribal Hospital		Regional THO		Unaffiliated THO		CHC		Other Rural		Mental Health	
	n=80	%	n=15	%	n=15	%	n=13	%	n=11	%	n=9	%	n=17	%
Newspapers	14	18%	4	27%	2	13%	1	8%	2	18%	0	0%	5	29%
Internet resources	9	11%	1	7%	4	27%	0	0%	2	18%	1	11%	1	6%
Journals	7	9%	1	7%	3	20%	0	0%	1	9%	1	11%	1	6%
Financial/benefit incentives	6	8%	2	13%	0	0%	0	0%	1	9%	0	0%	3	18%
Local recruitment	5	6%	0	0%	2	13%	1	8%	1	9%	0	0%	1	6%
Recruitment Firms	3	4%	1	7%	0	0%	0	0%	1	9%	1	11%	0	0%
State of Alaska web resources	2	3%	0	0%	0	0%	0	0%	0	0%	1	11%	1	6%
Direct mail	2	3%	1	7%	1	7%	0	0%	0	0%	0	0%	0	0%
Onsite visits	1	1%	0	0%	0	0%	0	0%	1	9%	0	0%	0	0%
Other	7	9%	1	7%	2	13%	1	8%	1	9%	2	22%	0	0%
Don't know/no answer	29	36%	5	33%	3	20%	10	77%	2	18%	3	33%	6	35%

*Respondents could mention more than one answer.*

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Looking at the least effective recruitment strategies by organization type shows clear differences.

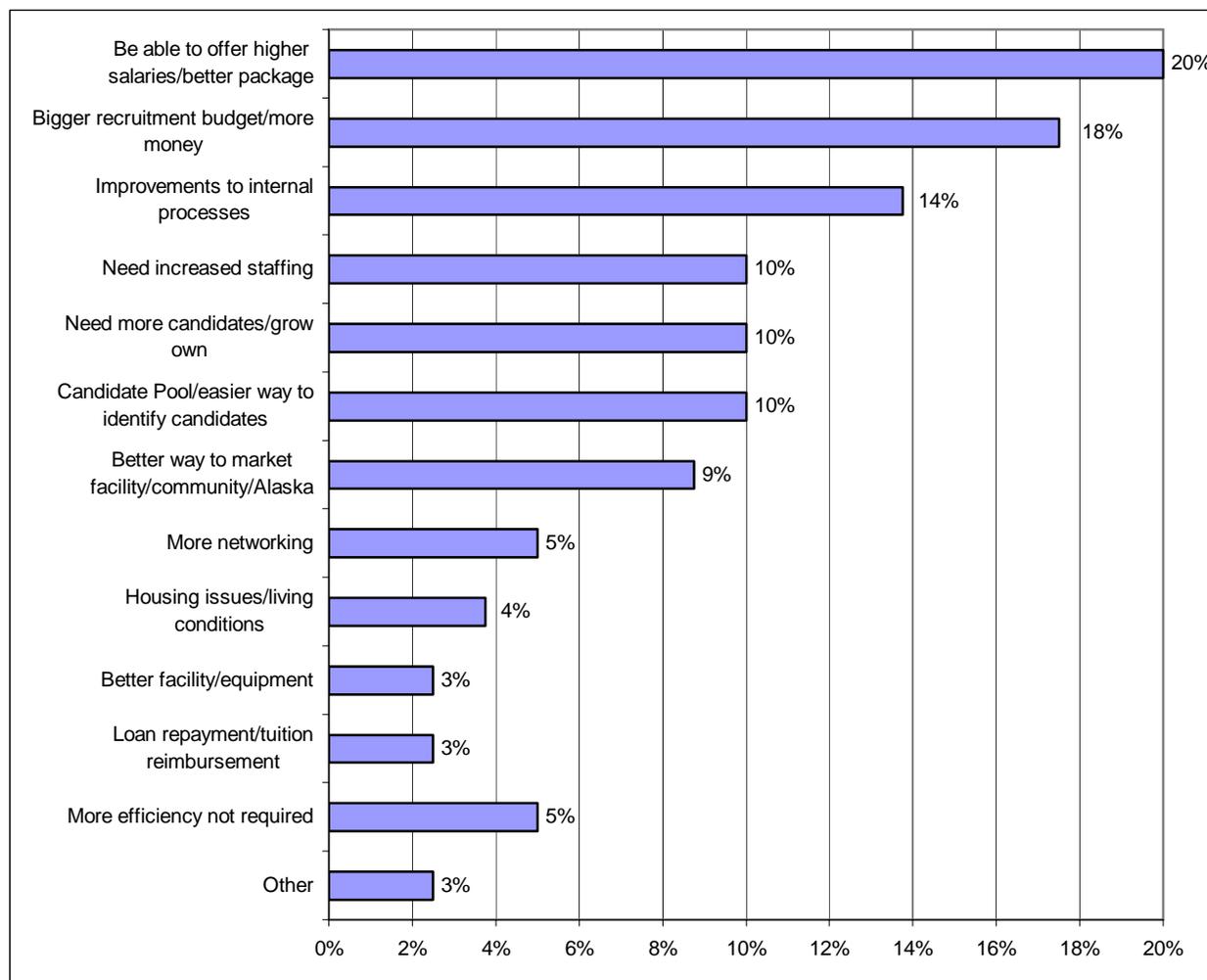
Newspapers, which ranked as the 4th most effective recruitment strategy in Figure 9, were considered the least effective recruitment method by mental health centers (29%) and non-tribal hospitals (27%).

Websites ranked #2 as the most effective and least effective recruitment method. “Other Rural” organizations most frequently rated websites as most effective (22%), while Regional Tribal Health Organizations and Community Health Centers rated them least effective (27% and 18% respectively).

Responses to Journals as a recruitment strategy proved easier to understand. They ranked quite low in the most effective strategy question and third in the least effective question, with a spike in the Regional Tribal Health Organization (20%) group.

## E. Making Recruitment Efforts More Effective

**Figure 13: Factors That Would Make Recruitment Efforts More Effective**



*\*Categories above were created from verbatim responses to the open-ended question, "What would make your recruitment efforts more effective?"*

*Respondents could mention more than one answer.*

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### 1. Higher Salaries/Benefit Package

The capacity to offer better wages and benefits rang out most frequently as the best mechanism for improving recruitment. Selected quotes:

*"If we could provide a higher salary to make them want to work here. Offering 3% COLA helped in the past."*

*"Next time need to offer more money – higher initial salary."*

## **2. Bigger Recruitment Budget**

The second most frequently mentioned factor was the recruitment budget. The proposed use of funding varied, reflecting the broad need. Selected quotes:

*“Don’t have enough money to fly people up.”*

*“Having time and money to invest in recruiting. Hiring a fulltime HR person. Too small to do that. Only need to recruit for the summer. Can handle winter with a smaller staff.”*

*“Increasing grant funding to help with salary benefits.”*

## **3. Improvements to Internal Processes**

Third, the following quotes demonstrate potential recruitment process improvements:

*“Establish a new system for contractual employees for new medical clinic.”*

*“Faster turnaround time; more specialists dedicated to recruiting; dedicated budgets to recruiting.”*

*“Polished resources. Continuing education benefits. Best practices in recruiting.”*

## **4. Need for Increased Staffing**

Fourth, the following quotes demonstrate the need for recruitment staff:

*“A fulltime HR person with ideas, experience and professionalism.”*

*“Additional staff involvement; conference visit; university agreements (in process)”*

## **5. Need More Candidates/ Grow Our Own/ Candidate Pool**

Fifth and sixth, the following quotes reflect the need to develop more candidates:

*“Better pool of applicants to draw from. Working with UAA to hire graduates.”*

*“Increased number of local graduates at UAA/APU.”*

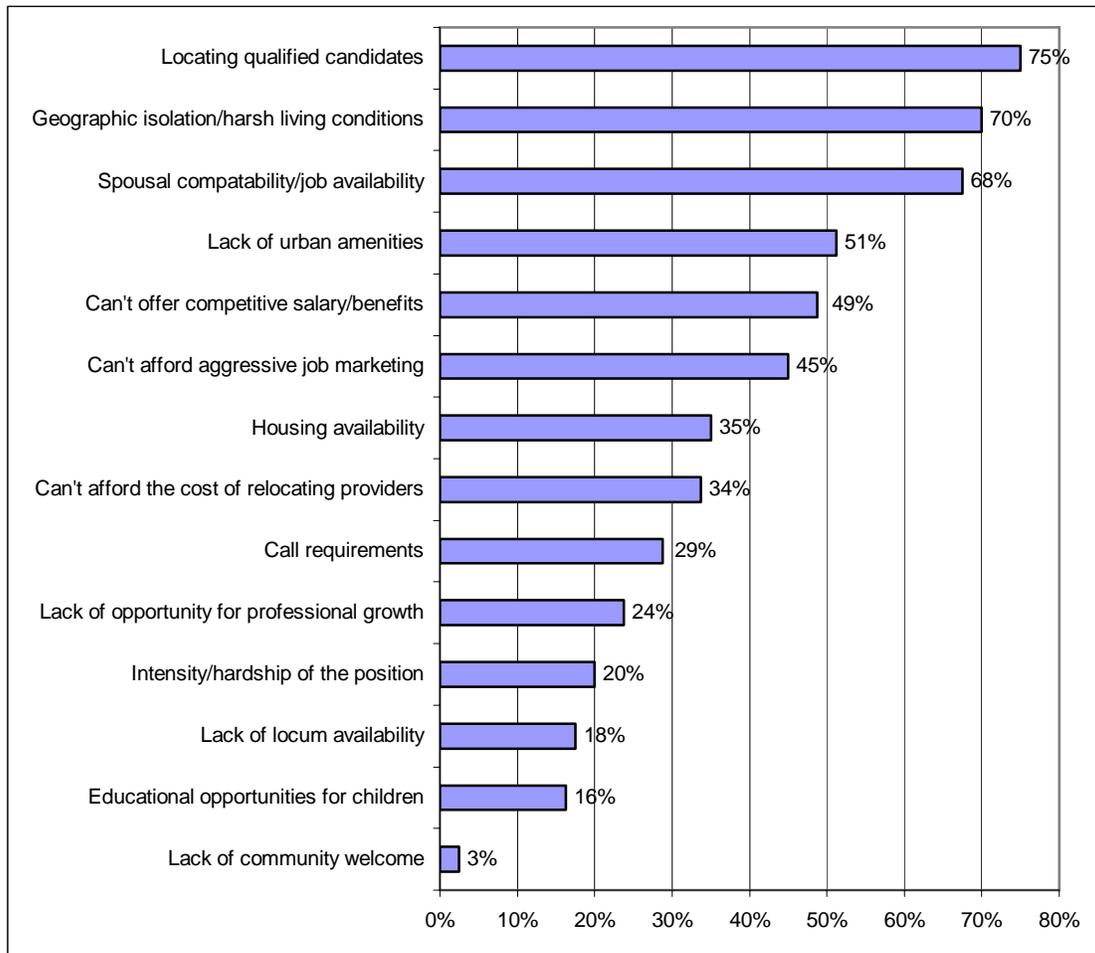
*“Alaska global pool serving as agency for rural Alaska to fill critical need.”*

*“Pool of applicants.”*

*“Brochures or materials that would give potential candidates information on the State of Alaska (realistic and broad enough to be used to recruit different professionals.) Budget increases.”*

## F. Barriers to Recruitment

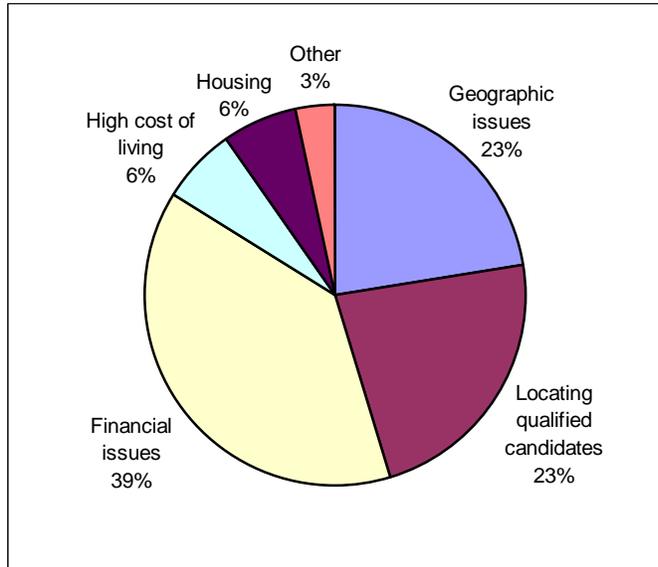
Figure 14: Barriers to Recruitment Overall



Respondents could select more than one answer.  
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Interestingly, the four biggest barriers to recruitment in this study are identical to those reported in the 2003-04 study. In fact, the only change in the top nine barriers is that housing availability was found to be a slightly larger barrier to recruitment in 2005-06. The top three barriers include: locating qualified candidates, geographic isolation/ harsh living conditions, and spousal compatibility/ job availability.

**Figure 15: Biggest Single Barrier to Recruitment**

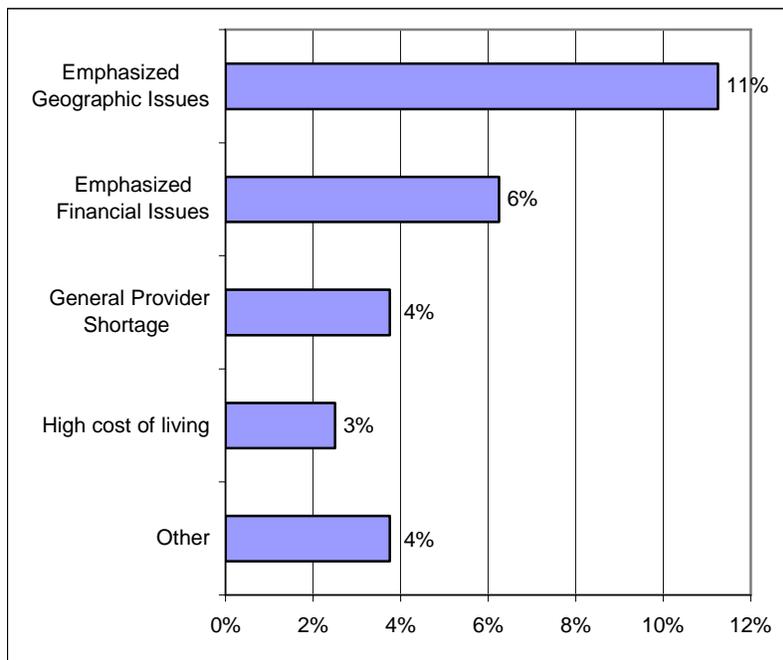


This figure differs from Figure 14 in that respondents were asked to identify the single factor that was the greatest barrier to recruitment. As shown in the graph above, when probed about their biggest barrier, financial issues topped the list.

*N=31 for this question. The shown percentages are based on that total.*

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**Figure 16: Other Barriers to Recruitment**



Respondents had the opportunity to tell interviewers “other issues” not listed on the survey that were barriers to recruitment. Similar to the 2003-04 study, many re-emphasized difficulty recruiting due to geographic and isolation issues. Other issues include internal financial issues, general provider shortage problems, and the high cost of living in rural areas. These are the same top four issues as the 2003-04 study, with geographic issues topping the list in both studies.

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## G. Cost of Recruitment

As with sub-sections A-F, this sub-section is intentionally organized so that figures correspond numerically with the 2003-04 report. In order to provide a breakdown of the data by geography, most of the figures have three parts: "All Facilities," "Urban Facilities," and "Rural Facilities." Only the rural facilities section can be compared with the 2003-04 data, which only surveyed rural facilities.

Surveyed sites **spent over \$24 million** in the last year on the combined recruitment of the following professions: physicians, pharmacists, midlevels, nurses, dentists, hygienists, psychiatrists, clinical psychologists, masters-level therapists, and LCSWs. Nearly **\$15 million** is attributed to rural facilities and over **\$9 million** is attributed to urban facilities (hospitals/CHCs).

The following table, Figure 17, depicts the breakdown of recruitment costs for each type of organization surveyed. Urban non-tribal hospitals and the (predominantly) rural regional tribal health organizations are larger and recruit more providers. Thus, their recruitment expenses are shown here to be considerably higher than other facility types.

### *Interpretation of Changes*

Comparing rural recruitment expenditures between 2003-04 and 2005-06, expenditures reportedly increased \$2.8 million overall. The cost of locums is particularly intriguing, increasing \$4 million between the two studies. In 2005-06, rural facilities invested nearly \$9 million in temporary traveling practitioners of the total \$14.8 million, or 60.3%. In 2003-04, those rural facilities (all respondents for that year) invested \$4.9 million in temporary traveling practitioners of the total \$12 million in recruitment, or 41%.

Three factors warrant caution in interpreting the data. Different people in the organizations responded from the first year, the data collection technique changed slightly (more phone assistance in first year), and there were changes in recruitment needs and capacity. Nevertheless, ACRH did note the changes and conducted follow-up calls with several organizations, specifically those organizations reporting the greatest changes in expenditures. The eight organizations contacted reflect a blend of tribal and non-tribal, community health centers, and regional tribal health organizations.

Organizations attributed the differences to multiple factors, and responses largely fell into two categories. First, six respondents felt changes in recruitment expenditures between the 2003-04 study and the 2005-06 study corresponded accurately with changes in recruitment needs – attrition. Second, four respondents felt that the 2005-06 data was more accurate than the 2003-04 data due to reporting errors and problems with internal processes within each organization. Of those four respondents, two mentioned improved internal systems for recruitment processes. It is worth mentioning that four of the respondents had accepted their positions since the 2003-04 study, and either used available historical records to advise us or were not comfortable commenting on the responses of their predecessors.

**Figure 17: Breakdown of Recruitment Costs by Organization Type**

Breakdown of Recruitment Costs by Organization Type							
	Total	Non-tribal hospital	Regional THO	Unaffiliated THO	CHC	Other Rural Health Provider	Behavioral Health Provider
<i>All Facilities</i>							
Recruiting firms	\$1,434,248	\$1,041,500	\$314,948	\$0	\$27,000	\$20,000	\$30,800
Advertising	\$1,234,945	\$753,300	\$372,794	\$5,400	\$31,250	\$5,200	\$67,001
Website management	\$91,499	\$6,100	\$83,419	\$300	\$500	\$180	\$1,000
Membership Organization	\$22,900	\$7,500	\$4,600	\$700	\$3,700	\$0	\$6,400
Recruitment related staff travel	\$242,616	\$33,000	\$111,116	\$0	\$94,000	\$3,000	\$1,500
Travel/accommodations for on-site interview	\$474,705	\$173,570	\$212,885	\$11,850	\$26,200	\$6,000	\$44,200
Moving expenses (inc. travel)	\$2,751,820	\$820,320	\$1,643,500	\$62,000	\$107,500	\$29,000	\$89,500
Cost of locums	\$12,914,085	\$3,629,297	\$8,495,729	\$152,500	\$266,500	\$45,059	\$325,000
Training and orientation	\$837,166	\$324,300	\$341,021	\$6,000	\$69,548	\$10,420	\$85,877
Other costs*	\$118,000	\$32,700	\$68,800	\$0	\$9,500	\$2,000	\$5,000
Staff time	\$3,997,481	\$1,453,230	\$1,511,627	\$83,366	\$385,737	\$60,967	\$502,554
<b>Total</b>	<b>\$24,119,465</b>	<b>\$8,274,817</b>	<b>\$13,160,439</b>	<b>\$322,116</b>	<b>\$1,021,435</b>	<b>\$181,826</b>	<b>\$1,158,832</b>
<i>Urban Facilities</i>							
Recruiting firms	\$1,060,000	\$1,030,000	\$0	\$0	\$0	\$0	\$30,000
Advertising	\$713,864	\$602,000	\$86,864	\$0	\$22,000	\$0	\$3,000
Website management	\$5,000	\$5,000	\$0	\$0	\$0	\$0	\$0
Membership Organization	\$7,600	\$7,500	\$100	\$0	\$0	\$0	\$0
Recruitment related staff travel	\$91,000	\$31,000	\$60,000	\$0	\$0	\$0	\$0
Travel/accommodations for on-site interview	\$205,615	\$140,800	\$43,315	\$0	\$1,000	\$0	\$20,500
Moving expenses (inc. travel)	\$1,506,500	\$536,500	\$890,000	\$0	\$5,000	\$0	\$75,000
Cost of locums	\$3,926,880	\$1,520,000	\$2,106,880	\$0	\$0	\$0	\$300,000
Training and orientation	\$466,077	\$254,000	\$120,000	\$0	\$50,000	\$0	\$42,077
Other costs*	\$8,000	\$0	\$0	\$0	\$8,000	\$0	\$0
Staff time	\$1,247,444	\$772,750	\$338,510	\$0	\$47,000	\$0	\$89,184
<b>Total</b>	<b>\$9,237,980</b>	<b>\$4,899,550</b>	<b>\$3,645,669</b>	<b>\$0</b>	<b>\$133,000</b>	<b>\$0</b>	<b>\$559,761</b>
<i>Rural Facilities</i>							
Recruiting firms	\$374,248	\$11,500	\$314,948	\$0	\$27,000	\$20,000	\$800
Advertising	\$521,081	\$151,300	\$285,930	\$5,400	\$9,250	\$5,200	\$64,001
Website management	\$86,499	\$1,100	\$83,419	\$300	\$500	\$180	\$1,000
Membership Organization	\$15,300	\$0	\$4,500	\$700	\$3,700	\$0	\$6,400
Recruitment related staff travel	\$151,616	\$2,000	\$51,116	\$0	\$94,000	\$3,000	\$1,500
Travel/accommodations for on-site interview	\$269,090	\$32,770	\$169,570	\$11,850	\$25,200	\$6,000	\$23,700
Moving expenses (inc. travel)	\$1,245,320	\$283,820	\$753,500	\$62,000	\$102,500	\$29,000	\$14,500
Cost of locums	\$8,987,205	\$2,109,297	\$6,388,849	\$152,500	\$266,500	\$45,059	\$25,000
Training and orientation	\$371,089	\$70,300	\$221,021	\$6,000	\$19,548	\$10,420	\$43,800
Other costs*	\$110,000	\$32,700	\$68,800	\$0	\$1,500	\$2,000	\$5,000
Staff time	\$2,750,037	\$680,480	\$1,173,117	\$83,366	\$338,737	\$60,967	\$413,370
<b>Total</b>	<b>\$14,881,485</b>	<b>\$3,375,267</b>	<b>\$9,514,770</b>	<b>\$322,116</b>	<b>\$888,435</b>	<b>\$181,826</b>	<b>\$599,071</b>

\*Other costs include: background checks, consulting fees, licensure fees, legal fees, contract buyouts, salary guarantees, website management, membership organization fees, and other miscellaneous costs.

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**Figure 18: Breakdown of Recruitment Costs by Provider Type**

<b>Total Cost Breakdown: by Provider Type</b>											
	Total	Physician	Pharmacist	Midlevel	Registered Nurse	Dentist	Dental Hygienist	Psychiatrist	Clinical Psychologist	LCSW	Masters Level Therapist
<i>All Facilities</i>											
Recruiting firms	\$1,434,248	\$139,590	\$112,636	\$32,090	\$1,076,406	\$19,454	\$0	\$30,000	\$0	\$5,818	\$18,254
Advertising	\$1,234,945	\$145,901	\$120,160	\$58,860	\$691,960	\$47,964	\$4,760	\$39,604	\$22,019	\$51,556	\$52,161
Website management	\$91,499	\$10,191	\$9,891	\$8,991	\$10,791	\$8,691	\$0	\$8,691	\$11,191	\$9,781	\$13,281
Membership organization	\$22,900	\$4,800	\$1,500	\$2,100	\$5,500	\$550	\$0	\$500	\$500	\$1,550	\$5,900
Recruitment related staff travel	\$242,616	\$100,274	\$14,274	\$19,724	\$60,924	\$14,774	\$0	\$10,774	\$2,774	\$5,424	\$13,674
Travel/accommodations for on-site interview	\$474,705	\$109,940	\$31,625	\$62,450	\$177,020	\$34,020	\$500	\$16,600	\$0	\$20,850	\$21,700
Moving expenses (inc. travel)	\$2,751,820	\$799,910	\$212,000	\$177,500	\$1,141,410	\$181,000	\$13,000	\$119,000	\$1,000	\$40,750	\$66,250
Cost of locums	\$12,914,085	\$4,905,750	\$790,948	\$486,206	\$5,005,119	\$304,474	\$0	\$761,647	\$211,647	\$211,647	\$236,647
Training and orientation	\$837,166	\$139,500	\$29,689	\$50,089	\$490,481	\$22,435	\$2,900	\$17,308	\$0	\$26,354	\$58,410
Other costs*	\$118,000	\$12,000	\$9,500	\$13,500	\$40,200	\$14,500	\$0	\$4,500	\$4,500	\$6,500	\$12,800
Staff time	\$3,997,481	\$605,177	\$165,537	\$499,518	\$1,594,402	\$134,066	\$40,115	\$158,663	\$121,356	\$366,256	\$312,384
<b>Total</b>	<b>\$24,119,465</b>	<b>\$6,973,033</b>	<b>\$1,497,760</b>	<b>\$1,411,028</b>	<b>\$10,294,213</b>	<b>\$781,928</b>	<b>\$61,275</b>	<b>\$1,167,287</b>	<b>\$374,987</b>	<b>\$746,486</b>	<b>\$811,461</b>
<i>Urban Facilities</i>											
Recruiting firms	\$1,060,000	\$14,000	\$48,000	\$0	\$968,000	\$0	\$0	\$30,000	\$0	\$0	\$0
Advertising	\$713,864	\$75,610	\$73,250	\$3,300	\$513,500	\$22,000	\$2,000	\$16,204	\$2,000	\$3,000	\$3,000
Website management	\$5,000	\$1,000	\$1,000	\$0	\$1,000	\$0	\$0	\$0	\$0	\$1,000	\$1,000
Membership organization	\$7,600	\$1,600	\$1,000	\$0	\$3,000	\$0	\$0	\$0	\$0	\$1,000	\$1,000
Recruitment related staff travel	\$91,000	\$55,000	\$0	\$0	\$28,000	\$0	\$0	\$8,000	\$0	\$0	\$0
Travel/accommodations for on-site interview	\$205,615	\$52,690	\$21,825	\$7,500	\$103,200	\$3,300	\$0	\$13,100	\$0	\$4,000	\$0
Moving expenses (inc. travel)	\$1,506,500	\$540,000	\$144,500	\$45,000	\$590,000	\$88,000	\$0	\$99,000	\$0	\$0	\$0
Cost of locums	\$3,926,880	\$2,556,880	\$60,000	\$0	\$1,160,000	\$0	\$0	\$150,000	\$0	\$0	\$0
Training and orientation	\$466,077	\$83,000	\$20,000	\$26,000	\$311,154	\$0	\$0	\$17,308	\$0	\$1,846	\$6,769
Other costs*	\$8,000	\$4,000	\$0	\$4,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Staff time	\$1,247,444	\$195,442	\$68,798	\$42,608	\$732,788	\$20,608	\$9,365	\$123,492	\$15,608	\$17,127	\$21,608
<b>Total</b>	<b>\$9,237,980</b>	<b>\$3,579,222</b>	<b>\$438,373</b>	<b>\$128,408</b>	<b>\$4,410,642</b>	<b>\$133,908</b>	<b>\$11,365</b>	<b>\$457,104</b>	<b>\$17,608</b>	<b>\$27,973</b>	<b>\$33,377</b>

<i>Rural Facilities</i>											
Recruiting firms	\$374,248	\$125,590	\$64,636	\$32,090	\$108,406	\$19,454	\$0	\$0	\$0	\$5,818	\$18,254
Advertising	\$521,081	\$70,291	\$46,910	\$55,560	\$178,460	\$25,964	\$2,760	\$23,400	\$20,019	\$48,556	\$49,161
Website management	\$86,499	\$9,191	\$8,891	\$8,991	\$9,791	\$8,691	\$0	\$8,691	\$11,191	\$8,781	\$12,281
Membership organization	\$15,300	\$3,200	\$500	\$2,100	\$2,500	\$550	\$0	\$500	\$500	\$550	\$4,900
Recruitment related staff travel	\$151,616	\$45,274	\$14,274	\$19,724	\$32,924	\$14,774	\$0	\$2,774	\$2,774	\$5,424	\$13,674
Travel/accommodations for on-site interview	\$269,090	\$57,250	\$9,800	\$54,950	\$73,820	\$30,720	\$500	\$3,500	\$0	\$16,850	\$21,700
Moving expenses (inc. travel)	\$1,245,320	\$259,910	\$67,500	\$132,500	\$551,410	\$93,000	\$13,000	\$20,000	\$1,000	\$40,750	\$66,250
Cost of locums	\$8,987,205	\$2,348,870	\$730,948	\$486,206	\$3,845,119	\$304,474	\$0	\$611,647	\$211,647	\$211,647	\$236,647
Training and orientation	\$371,089	\$56,500	\$9,689	\$24,089	\$179,327	\$22,435	\$2,900	\$0	\$0	\$24,508	\$51,641
Other costs*	\$110,000	\$8,000	\$9,500	\$9,500	\$40,200	\$14,500	\$0	\$4,500	\$4,500	\$6,500	\$12,800
Staff time	\$2,750,037	\$409,736	\$96,740	\$456,912	\$861,614	\$113,460	\$30,750	\$35,171	\$105,748	\$349,130	\$290,776
<b>Total</b>	<b>\$14,881,485</b>	<b>\$3,393,812</b>	<b>\$1,059,388</b>	<b>\$1,282,622</b>	<b>\$5,883,571</b>	<b>\$648,022</b>	<b>\$49,910</b>	<b>\$710,183</b>	<b>\$357,379</b>	<b>\$718,514</b>	<b>\$778,084</b>

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Figure 18 depicts the breakdown of recruitment costs associated with each provider type included in this study.

**Figure 19a: Average Recruitment Cost by Provider Type**

<b>Average Cost Breakdown: by Provider Type</b>											
	All providers	Physician	Pharmacist	Midlevel	Registered Nurse	Dentist	Dental Hygienist	Psychiatrist	Clinical Psychologist	LCSW	Masters Level Therapist
<i>Year 2 All Facilities</i>											
Average recruitment activity costs	\$304,879	\$219,581	\$74,012	\$35,058	\$248,566	\$43,191	\$3,527	\$126,078	\$36,233	\$20,012	\$23,766
Average recruitment related staff time	\$62,461	\$23,276	\$11,036	\$20,813	\$41,958	\$9,576	\$6,686	\$17,629	\$20,226	\$19,277	\$14,199
Average number hired	10.30	1.96	1.05	1.72	14.92	1.29	2.11	1.10	0.17	1.10	1.44
Total number hired	824	55	21	55	582	22	19	11	1	22	36
Average number recruited	13.71	3.36	2.05	2.68	17.82	1.82	2.44	1.80	1.17	1.50	2.48
Total number recruited	1083	94	41	83	695	31	22	18	7	30	62
Average cost per hire	\$34,413	\$126,782	\$71,322	\$25,655	\$17,688	\$35,542	\$3,225	\$106,117	\$374,987	\$33,931	\$22,541
Average cost per recruit	\$27,927	\$74,181	\$36,531	\$17,000	\$14,812	\$25,223	\$2,785	\$64,849	\$53,570	\$24,883	\$13,088
<i>Year 2 Urban</i>											
Average recruitment activity costs	\$887,837	\$563,963	\$73,915	\$21,450	\$459,732	\$56,650	\$2,000	\$83,403	\$2,000	\$3,615	\$3,923
Average recruitment related staff time	\$138,605	\$39,088	\$13,760	\$14,203	\$81,421	\$10,304	\$9,365	\$30,873	\$15,608	\$5,709	\$10,804
Average number hired	57.22	5.00	2.20	4.20	46.56	2.00	12.00	1.75	0.00	1.00	3.00
Total number hired	515	30	11	21	419	4	12	7	0	2	9
Average number recruited	72.33	7.67	3.60	6.60	56.44	3.50	12.00	2.50	0.00	1.00	5.00
Total number recruited	651	46	18	33	508	7	12	10	0	2	15
Average cost per hire	\$25,004	\$119,307	\$39,852	\$6,115	\$10,527	\$33,477	\$947	\$65,301	\$0	\$13,986	\$3,709
Average cost per recruit	\$20,514	\$77,809	\$24,354	\$3,891	\$8,682	\$19,130	\$947	\$45,710	\$0	\$13,986	\$2,225

Average cost per hire was determined by dividing total cost/total hired for accuracy.

These figures include the cost of locums and new recruit training

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**Figure 19b: Average Recruitment Cost by Provider Type (continued)**

Average Cost Breakdown: by Provider Type cont.											
	All providers	Physician	Pharmacist	Midlevel	Registered Nurse	Dentist	Dental Hygienist	Psychiatrist	Clinical Psychologist	LCSW	Masters Level Therapist
<i>Year 2 Rural</i>											
Average recruitment activity costs	\$212,832	\$129,742	\$74,050	\$37,532	\$185,998	\$41,120	\$3,832	\$168,753	\$41,939	\$23,087	\$27,073
Average recruitment related staff time	\$50,001	\$19,511	\$9,674	\$21,758	\$29,711	\$9,455	\$6,150	\$7,034	\$21,150	\$21,821	\$14,539
Average number hired	4.35	1.14	0.67	1.26	5.43	1.20	0.88	0.67	0.17	1.11	1.23
Total number hired	309	25	10	34	163	18	7	4	1	20	27
Average number recruited	6.17	2.18	1.53	1.92	6.23	1.60	1.25	1.33	1.17	1.56	2.14
Total number recruited	432	48	23	50	187	24	10	8	7	28	47
Average cost per hire	\$36,074	\$135,752	\$105,939	\$37,724	\$36,096	\$36,001	\$7,130	\$177,546	\$357,379	\$35,926	\$28,818
Average cost per recruit	\$29,162	\$70,704	\$46,060	\$25,652	\$31,463	\$27,001	\$4,991	\$88,773	\$51,054	\$25,661	\$16,555
<i>Year 1 All Facilities</i>											
Average recruitment activity costs	\$148,172	\$86,390	\$51,747	\$34,660	\$232,050	\$30,791	\$20,089	\$126,025	\$13,819	\$10,305	\$12,737
Average recruitment related staff time	\$48,714	\$33,255	\$31,305	\$19,564	\$71,241	\$11,051	\$16,308	\$20,728	\$16,137	\$13,199	\$15,374
Average number hired	4.45	1.39	1.18	1.66	5.59	1.00	1.00	0.60	0.75	1.33	1.32
Total number hired	285	32	13	53	119	10	3	3	3	16	33
Average number recruited	4.83	1.68	1.64	2.10	7.16	1.43	1.33	1.20	1.50	1.58	1.48
Total number recruited	338	37	18	65	136	10	4	6	6	19	37
Average cost per hire	\$38,018	\$73,739	\$63,886	\$32,201	\$42,575	\$27,315	\$40,572	\$237,678	\$34,563	\$20,566	\$16,571
Average cost per recruit	\$31,353	\$63,774	\$46,140	\$26,256	\$37,253	\$27,315	\$30,429	\$118,839	\$17,281	\$17,319	\$14,779

Average cost per hire was determined by dividing total cost/total hired for accuracy.

These figures include the cost of locums and new recruit training

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Figure 19 depicts the average number of each provider type hired and average cost per hire, for facilities recruiting specific providers. For example, in Year 2, facilities that recruited new physicians the past year hired an average of 1.96 of them, and it cost an average of \$74,181 per successful hire. The cost of hiring a psychologist was found to be disproportionately high. Much of the expense was due to the high cost of temporary psychologists filling in for vacancies. Without this cost, the average cost per hire was closer to \$163,340. Also note that 7 psychologists were recruited, and only one was hired. As a percentage of recruitment effort to successful hire, this is much lower than other provider types.

The data presented in the remainder of this section compares the cost of recruitment in Alaska with a study titled, “2004 Recruiting Metrics and Performance Benchmark Report,” conducted by Staffing.org<sup>1</sup>. Staffing.org is an independent nonprofit corporation and leading proponent and provider of standard human resources performance metrics.

Cost-Per-Hire data is a commonly used method of reviewing recruitment costs among organizations. The major limitation of this method is that Cost-Per-Hire data is not comparable among different locations, industries, and job levels since staffing costs vary widely depending on these different factors.

Cost-Per-Hire is:

$$\frac{\text{Total staffing costs}}{\text{Total \# of hires}}$$

As shown in Figure 19, The average Cost-Per-Hire for all Alaskan providers included in this study was **\$34,413**. The average Cost-Per-Hire for rural providers was **\$36,074** and for urban providers was **\$25,004**

*These figures include the cost of locums and new recruit training*

Comparison data with the contiguous U.S. are only available for hospitals and clinics. For this reason, Figure 20 only shows data for Alaskan hospitals and clinics.

**Figure 20: Cost Per Hire**

<b>Cost Per Hire: Alaska Versus Continental U.S.</b>				
	Rural Alaska Hospitals	Continental U.S. Hospitals (staffing.org study)	All Other Rural Alaska Facilities (Clinics, Mental Health Centers)	Continental U.S. Clinics (Nursing and Specialty Services) (staffing.org study)
Total cost*	\$3,709,869	\$224,835,814	\$2,184,411	\$127,310,190
Total hires	204	61,397	105	27,174
<b>Cost Per Hire</b>	<b>\$18,186</b>	<b>\$3,662</b>	<b>\$20,804</b>	<b>\$4,685</b>

*These figures exclude the cost of locums and new recruit training*  
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Data in Figure 20 suggest that Alaska spends considerably more per health professional hired than facilities in the continental U.S. Additional clarification is necessary concerning possible bias in the study sample. The agency has suggested that a disproportionate volume of their respondents are located in Chicago. The sheer number of health professions schools in greater Chicago and other urban centers is likely to reduce their recruitment effort. Secondly, respondents in the staffing.org study

<sup>1</sup> [www.staffing.org](http://www.staffing.org) “2004 Recruiting Metrics and Performance Benchmark Report, Version 2.0”

self-selected. Thus organizations that knew they spent a great deal of resources on recruitment were possibly less likely to participate, effectively deflating the overall numbers.

Nevertheless, rural Alaskan health facilities often compete with these continental U.S. agencies to recruit health professionals. The data suggest that facilities outside Alaska invest less in the recruitment process, retaining more internal resources to spend on other programs.

Cost of recruitment in this report is also gauged using the Recruiting Efficiency Index, developed by Staffing.org and the Human Capital Metric Consortium. The Recruiting Efficiency Index takes differences of geography, industry, and job level into account by using the compensation of recruits, instead of total number of recruits. This method assumes that compensation of hires is greater in labor markets with higher costs of living, as well as for positions that are more difficult to fill.

The Recruiting Efficiency Index equation is:

$$\frac{\text{Total staffing costs}}{\text{Total compensation recruited}}$$

**Figure 21: Recruiting Efficiency Index (REI)**

Recruitment Efficiency Index: Alaska and Continental U.S.					
	Rural Alaska Hospitals	Urban Alaska Hospitals	Continental U.S. Hospitals (staffing.org study)	All Other Alaska Facilities (Clinics, Mental Health Centers)	Continental U.S. Clinics (Nursing and Specialty Services) (staffing.org study)
Total staffing cost	\$3,709,869	\$4,266,711	\$224,835,814	\$3,228,800	\$127,310,190
Total recruits compensation	\$15,116,309	\$30,480,540	\$1,888,523,000	\$13,628,852	\$1,051,773,000
<b>REI</b>	<b>25%</b>	<b>14%</b>	<b>11.9%</b>	<b>24%</b>	<b>12.1%</b>

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With the Recruiting Efficiency Index, the lower the index, the more “efficient” the recruiting processes. Findings for the REI correspond with the cost-per-hire data. The REI for rural Alaska hospitals was almost double the index for hospitals in the continental U.S. In other words, rural Alaska hospitals experienced almost double the difficulties of recruitment of continental U.S. hospitals. The REI for Alaskan clinics and other services were almost three times that of the continental U.S. This suggests that rural Alaskan facilities face more difficulties in recruitment and must invest more in the process.

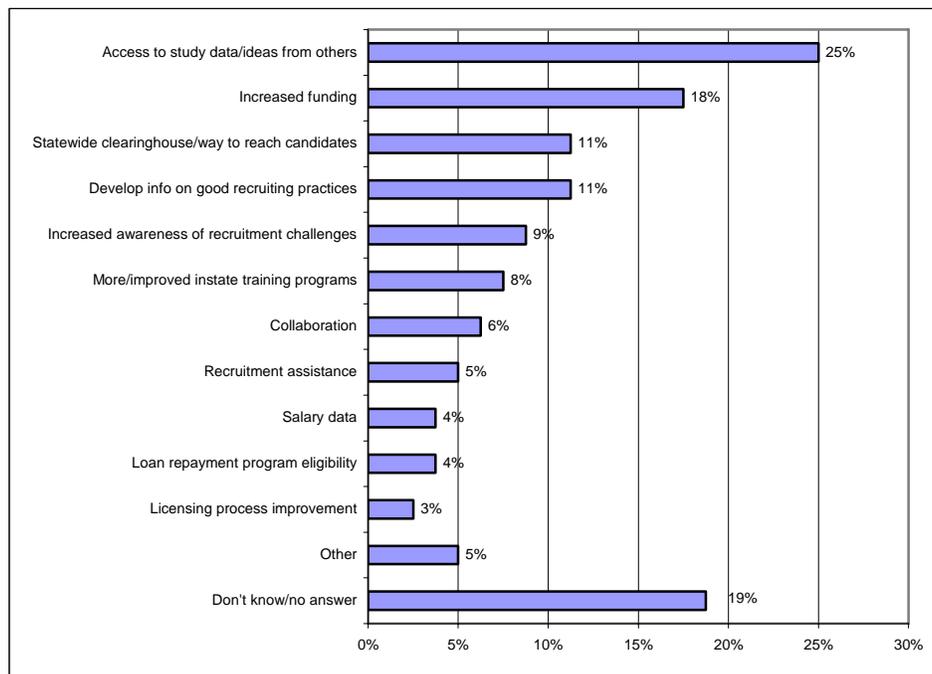
### What do these figures include?

Regardless of the way in which these costs are depicted, the business of recruiting providers in rural Alaska is staggeringly expensive. It is important to note that the figures presented here are limited in the following ways:

- Rural Alaska is staffed with many more provider types than is covered in this report. The figures in this study represent the recruitment costs of these provider types only: physicians, midlevel providers (PA/NP/CNM), RNs, pharmacists, dentists, dental hygienists, psychiatrists, psychologists, masters-level therapists, and LCSWs. Thus, support staff, non-clinical management staff, paraprofessionals, and many other positions critical to the function of rural health facilities are not included.
- The cost data is an underestimate of true costs, as it was collected only when facilities could directly attribute costs to the provider types described above. For example, if a rural hospital reported to have spent \$150,000 in advertising for all positions within the last year, but could not break the cost down to specific providers, this information was not included in the final analysis.
- One study in the literature review noted, "80% of corporate America does not track recruiting costs, and most do not keep records of cost, length of time per hire, acceptance ratios, and other measures to help organizations understand the price of recruiting" <sup>xlviii</sup>. Similarly, a large percentage of Alaskan health facilities did not systematically track recruitment costs. These facilities were asked to make an estimate based on their typical recruitment practices.

### H. Outcome of This Study

Figure 22: Desired Outcome of This Study



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Respondents were asked in an open-ended format, “What would you like to see happen as a result of this study.” Very little has changed since the 2003-04 study. The same themes emerged. First, respondents asked for access to the study results towards formulating new ideas for their own recruitment. Respondents see value in learning from each other to become more efficient in their own recruitment endeavors. Next, facilities need more money for the recruitment process. They also want a statewide clearinghouse to reach candidates and more information on good recruiting practices. Suggestions ranged from a recruiter’s conference to a list of what’s most effective for others. Respondents also sought for the local public, state, and federal government to become more aware of the enormity of the challenges they face in recruiting health care providers. These comments centered on awareness and understanding more so than any specific response or policy change. Other comments included: access to salary data, recruitment assistance, more/improved in-state training programs, loan repayment, and licensing improvement.

The following are verbatim responses to illustrate the data. See Appendix B for a complete list of the responses. Selected quotes:

**Access to study data**

*“Would like to see what other people are doing to recruit.”*

**Increased funding**

*“The results and a grant to aid rural-located clinics to recruit.”*

**Statewide clearinghouse of job seekers**

*“Pool funds to recruit for global pool with selected applicants going to area with critical need.”*

*“Less costly ways of recruiting – shared recruiting. “*

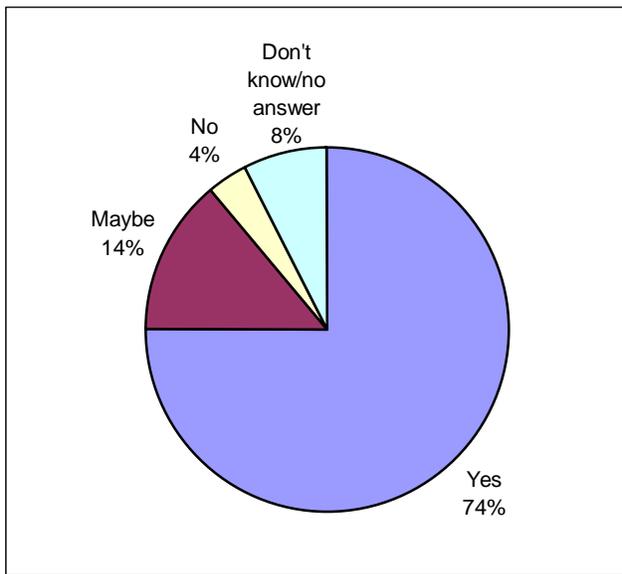
**Increased awareness of recruitment challenges**

*“Hope that the State sees the massive amount of need for medical professionals in this state and focus educational opportunities on grow your own and health career choices. Rural needs are much more important than metro needs.”*

**Collaboration**

*“More resources and partnerships.”*

**Figure 23: Interest in Collaboration**



Nearly three quarters of all respondents were interested in collaborating with other organizations to recruit providers. Those that answered “Maybe” (14%) or “No” (4%) were cautious about losing potential candidates to collaborative partners. The following verbatim comments describe the various sentiments regarding collaboration. Selected quotes:

**Yes**

*“Yes, Perhaps ideas could be generated to do an ad campaign to recruit healthcare workers to Alaska.”*

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**Maybe**

*“In spirit, yes, but don’t want to compete.”*

**No**

*“It would be good if we were a larger community. Wouldn’t want to lose applicants to others.”*

## V. Discussion and Recommendations

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Recruitment of health professionals is an enormous issue in Alaska, the United States, and abroad. A review of this project's open and closed question responses, beside a review of the literature, provides relevant insights to rural Alaska's recruitment process and how it compares to the rest of the country and elsewhere.

### A. Barriers to Recruitment

Before addressing recruitment strategies, it is important to address the question, "What makes recruitment difficult for rural Alaskan facilities?" This study confirmed two major factors posing a barrier to recruitment in rural Alaska. First of all, the dearth of qualified candidates available to fill positions made recruitment extremely difficult. It was the most frequently mentioned barrier. Working in Alaska, especially rural Alaska, requires a unique skill set. In the rural areas, strong clinical skills are often required, as an individual must have the capacity to work in an unpredictable environment, often with no direct supervision, no colleagues for support, and no specialists to refer special cases. The second most frequently mentioned barrier, as with last year, is geographic isolation/harsh living conditions. It is noteworthy that this issue continues to be second, even though the survey included urban respondents. Spousal compatibility/job availability, lack of urban amenities, difficulty in offering competitive salary/benefit packages, and housing availability are all related to the difficulties of attracting workers to Alaska.

### B. Recruitment Strategies

In many cases, Alaskan hospitals, community health centers, clinics, and mental health facilities reported using recruitment strategies that correspond with recommendations from the literature. According to the literature, some of the issues affecting a provider's decision to practice in a rural location include: proximity to recreation; proximity to family; affinity to a rural lifestyle; professional autonomy; influence of spouse; and financial compensation.

In this study, 88% emphasized the "rural/positive lifestyle" and 86% talked about "positive working environment." "Good community" was ranked seventh. Thus, there is some overlap with strategies that are well-regarded in the literature.

The literature also emphasized the need to include the needs of the entire family in recruitment efforts. Spousal employment and schools for children are a significant factor in recruitment and retention. Respondents echoed this finding. Spousal compatibility/job availability was the third most frequently mentioned barrier to recruitment (68%).

As demonstrated in the closed question responses, "word of mouth" is the most common, and one of the most effective, recruitment strategies. In this study, 89% of

respondents reported use of this method. In reviewing open ended responses in this category, “word of mouth” can refer to informal networking, networking during conferences, and contacting former employees for leads. Interestingly, strategies around effectively using networking and word of mouth are not frequently mentioned in the literature.

Respondents’ use and reported efficacy of websites and newspapers for recruitment displayed some apparent contradictions. “Websites” (18%), “on-site visits” (18%), and newspaper ads (10%) were listed as the most effective recruitment strategies, after word of mouth. However, newspapers were also listed as the least effective recruitment strategy (18%), followed by websites (14%). As with the 2003-04 study, advertising in national newspapers and internet clearinghouses was found to be ineffective. Respondents may have received a high volume of inquiries from these advertising venues, but candidates were largely inappropriate. Further research may help explain this in detail.

Extrapolation from open ended comments can help us understand how advertising can be more effective. Advertising on websites and in newspapers that attract providers with a rural orientation could be a far more useful investment of resources. Respondents repeatedly emphasized the need for employing recruitment tools that targeted the intended audience.

### **C. Recruitment Costs**

This study confirmed what many have hypothesized – that it is costly to recruit primary providers in Alaska. As shown in the Appendix, on average, Alaska invests \$34,413 for each successful primary care hire, with rural Alaska investing \$36,074 and urban Alaska investing \$25,004. Alaska’s cost-per-hire data continues to be significantly higher than data collected by staffing.org, despite including the same variables in the calculation. As cost-per-hire numbers vary considerably for different markets, regions, and jobs, this study also examined recruitment cost in terms of a Recruitment Efficiency Index, developed by staffing.org. Even then, rural recruitment is significantly more expensive than the recruitment of providers in the contiguous United States.

It is worth noting that if the cost of temporary traveling providers is excluded, the cost-per-hire decreased relative to the 2003-04 study. Expenditures by rural Alaska hospitals decreased slightly, from \$19,543 per hire to \$18,186 per hire. And expenditures by other rural facilities decreased much more, from \$27,304 per hire in 2003-04 to \$20,804 per hire in 2005-06. Looking at budget categories, the exclusion of locums from this figure is the primary causal factor. As described in the **Interpretation of Changes** (page 27), expenditures for temporary traveling providers increased significantly relative to other recruitment expenditures.

Finally, the methodology for data collection in the 2005-06 study was closer to the staffing.org approach, with less technical assistance from the phone interviewer.

## **D. Collaborations**

Of the 80 organizations that participated in this study, 39 (49%) currently reported some level of partnering with other organizations in recruitment efforts. Of the 80 participating organizations, 60 (74%) responded positively to an inquiry for further collaboration and another 11 (14%) said “maybe.” Respondents’ biggest concern with collaboration was the fear of losing potential employees to partners. Respondents were evenly distributed across the state, organization type, and organization size. This suggests that 74-88% of respondent organizations are interested in some level of collaboration to improve recruitment.

The types of collaboration were not specifically discussed. However, suggestions can be found in the reported “desired outcomes” and “what would make recruitment more effective” suggestions in this study. Several of the most frequently requested outcomes that correspond with a new level of partnership are:

- Access to the study towards comparing with other organizations and formulating more efficient recruitment techniques;
- Shared recruiting, a pool of applicants/candidates/providers, more sharing of information and resources;
- Information on good recruitment practices, possibly via a recruiter’s workshop or list of tips and techniques; and
- More and improved in-state training programs.

Responses for how to make recruitment more effective were categorized, and several categories suggest a mechanism for collaborating in recruitment, such as:

- A pool of applicants gathered in one place;
- A statewide campaign to attract professional level staff to Alaska; and
- More networking, such as with other HR departments statewide to share recruiting ideas and things that have worked.

## **E. Recommendations**

Recommendations from surveyed health care employers are similar to suggestions from the rural health care employers in the 2003-04 study. Distilling comments from the questions on how to make recruitment efforts more effective and what respondents want to see happen as a result of this study, organizations would like:

1. Information on how other organizations conduct recruitment towards the formulation of new ideas and more efficient recruiting practices;
2. Increased funding to a) allow them to offer a more attractive salary and benefits package and b) increase their overall recruitment budget;
3. Increased collaboration with other organizations to target individuals interested in rural living and exploring the concept of a candidate pool, a network of organizations that pool providers;

4. Increased awareness at the local, state, and federal level that recruitment is extremely challenging and expensive, and worthy of more support;
5. More information on good recruitment practices. Suggestions varied from a recruiter's workshop and concrete ideas to technical assistance; and
6. More/improved in-state training programs towards a larger local candidate pool.

## Endnotes

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