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Are Background Checks Necessary?

Hospitals and medical groups may underestimate the importance of background checks and the referencing of candidates who are being considered for a position with their organization. A physician who trained at a well-respected residency/fellowship program will have impressive credentials. However, do you know if there is a gap in the candidate's training or work history? Is there history of malpractice suits or is a suit pending? Has the physician been involved in any civil actions? A completed application for employment may not tell the whole story regarding malpractice, licensing issues or sanctions. The review of information should not stop here. Conducting a background check before you invite a candidate for a site visit or make an offer may prevent you from wasting time, money and effort on someone who might not meet your criteria.

Perhaps using the services of a reputable, professional background check company should be part of your credentialing process, and depending on what information you want to cover, this will likely begin with a release form from the candidate. William Loughrige of WJL Investigations, Inc. notes not only is it important to request a completed application from the candidate, but obtaining a signed authorization is mandatory to release certain information. The signed authorization must be in strict compliance with all provisions of the Fair Credit Reporting Act (FCRA), the American Disabilities Act and all other applicable federal and state laws. If a candidate refuses to provide the release form, perhaps this is not a candidate you will want to pursue. Your hospital or medical practice needs to be assured your medical providers are high quality professionals and will uphold the positive image the organization wants to maintain.

A detailed background screening and credentialing verification investigation may include:

- Education Verification
- License and Privilege Verification
- Professional References
- Social Security Trace
- Criminal and Civil Records Search
- Nationwide Background Check
- Sex Offender Search
- HHS/Office of Inspector General's (OIG) Exclusion List Check

You may also want to verify the physician through the National Practitioner Data Bank (NPDB). Only healthcare facilities can access the NPDB, or a physician may provide you a self-inquiry report from the NPDB. Take advantage of this important resource prior to a site visit or contract offer.

When or if items do surface during credentialing and investigations, don't arbitrarily reject a candidate without further review, as there may be legitimate reasons that something has occurred that would not automatically disqualify them from further consideration. Look into the matter and make the appropriate decision.

Background checks are indeed necessary, so be sure to investigate prior to inviting the candidate to interview. Or, at a minimum, make your contract offer contingent upon a satisfactory background investigation.

WJL Investigations, Inc. located in Tempe, Arizona provides background investigations for healthcare facilities throughout the nation. As an expert in his field, Mr. Loughrige's history includes employment with the Fraud/Trade Enforcement, Phoenix Police Department, Anti-Terrorism Task Force and Equal Employment (EEO).

Top 10 Reasons Candidates Decline Your Offer... And What to Do About It!

You've interviewed and made an offer to a candidate and are surprised to learn that he or she has declined your offer. This can happen for a variety of reasons. Here are the top 10 reasons candidates may turn down an offer:

- 1. Compensation offered was too low or differed from what was discussed.**
Solution: Never discuss or present a salary or income potential that cannot be achieved. Make your compensation plan as attractive and competitive as possible within the means of the practice potential. If you are uncertain, investigate available compensation surveys or other possible data. It is also wise to discuss the candidate's expectations before making an offer to avoid this problem.
- 2. Contract or employment offer was too slow in coming.**
Solution: The best time to review your contract and or employment agreement is before you begin your search. The recruitment environment is competitive and candidates usually interview with several potential employers, making it likely they are holding offers in hand at the time of their visit. Many candidates will not wait if your offer is too slow in coming. If your contract is not ready, consider offering a candidate a letter of intent to let them know the formal offer is in process. Better yet, be ready before you bring the candidate out for a visit.
- 3. Practice did not seem busy enough; no solid evidence of growth potential.**
Solution: Ensure that your medical staff plan supports the addition of the specialty or position based on solid data and fully share this information in detail with the candidate. If the business or growth simply isn't there you should not be recruiting. Adding a physician or provider simply to expand the call schedule will be costly and counterproductive in the long run if there is not enough business to support the decision.
- 4. Practice buy-in was too high or length to partnership was too long.**
Solution: Competition in the recruitment marketplace mandates that your offer for partnership match the market conditions in your area. Do your homework to see what your competition is offering to their new hires. Partnership is generally offered after one or two years, anything longer is unusual. Buy-in also needs to be reasonable, explainable and structured or financed over a few years. Remember, this needs to be a win-win for both the new hire and the existing partners. Keep in mind that partnership agreements that were crafted years ago may no longer reflect current market conditions.
- 5. Candidate got a better offer or another location was a better fit.**
Solution: Learn in advance what it will take to attract the candidate to your practice. If the other location is truly a better fit, learn what makes it so. If nothing can be changed to accommodate the need, probe to see if an alternative may sway the decision, e.g., a stipend during final training year, signing bonus, possibly earlier partnership or some creative solution to meet or exceed the other offer. Caution – do not get into a bidding war. But if you believe the candidate genuinely prefers your location and practice, explore what you can do to make it happen.
- 6. Candidate received and accepted a counter offer to stay.**
Solution: Call your candidate to learn if the decision is truly final. The best strategy for this situation is not to let it happen! Discuss this option with the candidate during the recruitment process. Learn what the motivating factors are in his/her decision making process and try to anticipate those. If the decision is final, remember to conduct an "exit" interview. Find out what you could have done differently and learn from the experience.
- 7. Candidate could not proceed because house wouldn't sell.**
Solution: Much can depend on how serious your interest is in hiring the candidate and how

intense the need. If it is possible, delay the planned start date for a few months. Align yourself with a creative realtor who can assist the candidate in setting the house up for lease or rent, hopefully with an option to buy. See if a local bank might be able to offer a relatively short-term low-interest loan to accommodate the candidate's needs until the property sells. Look into the possibility of renting a house in your community and help underwrite that cost until the candidate's house sells. Be creative.

8. **Candidate did not feel welcomed by or comfortable with the group or hospital physicians or management/administration.**

Solution: Consider assigning a peer liaison to act as a host before, during and after the site visit. If your candidate is coming with his/her significant other, be sure to find out about their interests, professional plans and family needs. The courtesy you show will be noted and appreciated. Similarly, ensure all group physicians and executive administration knows the background and interests of the visiting candidate and spouse so they can communicate on a friendly basis that shows genuine interest. Don't leave this to chance – brief all who they will be meeting and share what is important to know about them.

9. **The practice/community did not seem like the right "fit" to the physician/candidate.**

Solution: If a candidate tells you this it could be a blanket excuse for any number of other problems or concerns. Probe to learn what the candidate specifically means by this and be prepared to research and offer additional information that might change the candidate's mind. Extend an invitation to make a second site visit if you believe it may be beneficial. However, if the candidate expresses a general malaise about everything and offers up no specific objections or reasons they feel this way, they probably truly are not interested and it is best to move on.

10. **Location, location, location. The spouse/family disliked the community/did not fit their needs.**

Solution: Again, the best time to address community concerns is at the very beginning of the recruitment process. Skillful interviewing and good listening skills will help screen out candidates who will not be comfortable in your community. Know what they need and whether you have it! Good screening in the beginning of the search process will help eliminate bringing the wrong candidates to interview and visit. Conducting good, in-depth telephone interviews will save money, time and frustration later in the process.

Please contact us to further discuss offers that you have extended that have been declined or share your success story with us and we may publish your solution soon!

Cost Effective Physician Assistants – History and Facts

The Chair of the Department of Medicine at Duke University Medical Center established a program in 1965 to educate ex-military corpsmen to practice medicine (with physician supervision). The purpose was to serve North Carolina communities with limited access to medical care. The program was based in part on his experience with the fast-track training of doctors during World War II. There were 3 graduates from the first program in 1967.

Today there are 140 programs training 12,000 students with 4,600 graduating each year. More than 85,000 Physician Assistants (PAs) are eligible to practice in the United States. In the early years, PAs were predominantly male but currently 65% are female and 35% are male.

Where do PAs Work?

Over 43% of PAs work in group or solo physician practices, 38% work in hospitals, 8% work in rural clinics or community health centers, and 10% work in other settings.

Most PAs work in primary care medicine (26% in Family/General Medicine, 16% in General Internal Medicine and subspecialties, and 4% in General Pediatrics and pediatric subspecialties). However, 25% of PAs work in General Surgery and surgical subspecialties and 11% work in Emergency Medicine. A small percentage of PAs work in OB/GYN (2%) and Occupational Medicine (2%).

Is it Cost Effective to Hire a PA?

Yes! On average, PAs generate revenues 80% greater than what their compensation costs employers. Recent compensation surveys reveal that for every dollar of charges a PA generates for the practice, the employer pays, on average, just 30 cents to employ a PA!

Boosting Patient Satisfaction and Easing Physician Workloads

With a PA on staff, patient waiting times decrease, improving patient satisfaction through increased access to healthcare. PAs improve patient flow by freeing up physicians to manage more complex or demanding cases. An American Medical Association (AMA) survey found that PAs enhance practice efficiency and solo physicians who employ PAs experience expanded practices, greater efficiency and greater access to care for their patients.

For more information regarding PAs and PA recruitment, please contact us.

Compensation Corner:

Pulmonary Critical Care Medicine

2009 National Median \$293,411

By Geographic Region:

East	\$280,582
West	\$304,360
South	\$281,132
Midwest	\$303,583

Pathology (Anatomical and Clinical)

2009 National Median \$342,601

By Geographic Region:

East	\$279,410
West	\$359,070
South	\$306,899
Midwest	\$330,525

Physical Therapist

2009 National Median \$ 66,481

Occupational Therapist

2009 National Median \$ 62,235

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