Recruitment and Retention/Workforce Development

Introduction

Carmen Clelland, Pharm.D., M.P.A.
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Carmen Clelland, Pharm.D., M.P.A
Captain, USPHS

- Chief Executive Officer
- Clinton Service Unit, Clinton, OK
- Previous positions include Director, Division of Health Professions Support at Indian Health Service Headquarters.
- Has worked in multiple Indian Health Service Areas including Oklahoma, Phoenix, Navajo, Portland and Headquarters.
- Recently completed certificate program in Healthcare Corporate Compliance from George Washington University.
Jerry N. Harrison, Ph.D.

- Executive Director, New Mexico Health Resources and Acting Director and Chair of the New Mexico Health Policy Commission.
- Past President of the National Rural Recruitment and Retention Network (3RNet).
- Long term participant with the National Health Service Corps (NHSC) and recruited his first NHSC Scholar in 1988.
- Worked extensively in the Southwest with IHS, NHSC and Veterans Affairs to place healthcare professionals and improve regional recruitment.
Jennifer Fry, M.A.

- Compensation Specialist
- Indian Health Service Headquarters
- Has worked in human resources for over 15 years.
- Earned a Master’s degree in human resource development at the George Washington University.
Learning Objectives

• Identify the need for increased awareness and actions for recruitment and retention along with human resources

• Implement strategies for effective position management

• Identify best practices and tools to support clinicians
Recruitment

The recruitment and retention of highly qualified health care professionals to serve Indian health communities is of critical importance and presents tremendous challenges, including:

- Cost to recruit
- Time to recruit
- Shortages
- Low competition
Strengthening Recruitment Infrastructure

- Establish a “regionalized” approach
- Establish increased use of Direct Hire Authority
- Offer more robust financial incentives
- Alignment of stakeholders, incentives, contracts, candidate parameters and candidate sourcing
- Incorporate IHS staff clinicians into the Recruitment plan
- Strengthen our ability to respond nimbly throughout recruitment process
CEO Perspective

• HR is here to support but the managers determine the needs (duties and responsibilities)

• Managers need to have clear idea of staffing types, mix, and types of training
Identifying and Sharing Best Practices

• Recruitment and Retention Best Practices are posted on the IHS Retention Website at www.ihs.gov/retention

• Corresponding “toolkits,” sample emails are under revision

• Best Practices in Action:
  • Chinle - HR part of the strategic plan for primary care clinics
  • Chinle – Cross-functional department “huddles” with CEO, senior leadership and HR.
  • PIMC – PIMC Interview Guide in making the right fit
Recruitment and Retention are Driven and Defined by Employers

- Administrators and directors are responsible for adopting recruitment and retention programs at the local level in concert with organizational policies and procedures.
- Absence of recruitment and retention plans eventuate in poor results.
- Few organizations develop actionable recruitment and retention plans.
- Few organizations employ professionally educated recruitment specialists.
Recruitment, Retention, and Recruitention

• Recruitment is the process of identifying the best qualified candidates (from within or outside) for a job vacancy in a cost effective and timely manner.

• Retention is made up of the clinic or system practices that meet the needs of employees and encourage them to remain employed in place.

• “Recruitention” is the process of recruiting to retain.
High Tech, High Touch

- Recruitment and tracking software
- Smart phones
- Skype or Facetime
- Access to Job Boards or referrals from such: 3RNET, Practice Link, Practice Match
- Practice Sights, Doc in a Box
- “First to Contact, First to Contract” – someone must act quickly
- [http://www.3rnet.org](http://www.3rnet.org)
- [http://www.nmhr.org](http://www.nmhr.org)
Who Recruits and Who Should Do It?

- Sourcing agencies
- “In-House” recruiters
- Administrators
- Clinical Directors
- Human Resource Personnel
- Administrative Assistants
- Self-Generated via Electronic means
Keys to Successful Recruitment

• Preparation – is a physician, pharmacists or dentist really needed? Can another health professional or new model of care delivery fill the need?
• Action Plan – is a formal study required?
• Timely response and Persistence.
• Adequate Budget for recruitment and compensation.
• Community support and involvement – is a recruitment team needed?
• Adequate human resources (people), not departments.
• Optimism; and,
• Realistic expectations in terms of time and competition.
What is a Recruiter?

• Leads the recruitment effort;
• Makes appropriate assignments;
• May be the Contact Person and First Interviewer and the first to answer questions;
• May be assigned to any number of positions in an organization – do what is best for the process;
• Identifies who will work with the significant other or family members.
Most Common Barriers to Successful Recruitment and Retention

• Too much call frequency;
• Lack of attention to or job opportunities for significant other;
• Lack of communication among parties;
• Low compensation guarantee;
• Limited benefits;
• School choice;
• Limited housing options;
• Cultural misalignment.
Recruitment Strategies

• Local, regional, national in least expense order;
• Provider networking;
• Classified advertising versus Internet;
• National Rural Recruitment and Retention Network;
• State 3RNET member;
• National Health Service Corps;
• Coordinated internet advertising;
• Residency and training visits; and,
• Recruitment firms.
The Best Recruit

- Is someone already employed in your organization.
- Costs of replacement recruitment processes are expensive and or contribute to declines in revenue.
- New graduates often cost more than keeping someone in place.
Questions Frequently Asked About Practice Related Issues by Applicants

- Can I get Loan Repayment in this site?
- How much call is required or must I work after regular business hours?
- Why is there a need for a new provider?
- Is there anyone else there?
- What is the status of the EHR?
- What are the major health issues in the community?
- Do people work well with one another?
- How hard is it to get licensed?
Questions Frequently Asked About Community Related Issues by Applicants

- Is the clinic successful financially?
- Can my significant other find a satisfying job?
- What educational opportunities are there for my family?
- What is the local school, public and private, situation?
- What religious institutions are there?
- What are the recreational, social and cultural opportunities?
- Will I fit in culturally and how may I learn about it?
- Where can we shop?
Significant Others Want Answers

• Is there loan repayment available? If so, what kind?
• Will my _____ earn what was promised?
• What housing is available?
• What are the other providers like?
• Are there good schools?
• Can I work locally?
• Can I practice my religion freely?
• Where is the closest place to shop?
• Can I get a good “feel” for the community while my _____ interviews?
Retention is Becoming a Larger Issue as Our Workforce Ages

• 50% of physicians leave within three years;
• 12% of physicians leave within one year;
• Some health professionals do not appear after being hired and contracts signed;
• Scholarships have the least impact upon long term retention;
• New hires, especially those with loan obligations almost immediately begin looking for other positions: two year cycle of obligation contracts.
Retention is a Continuous Process

• Evaluate whether a community recruitment and retention committee should be organized;
• Follow guidelines and boundaries about interactions with employees;
• New hires should be welcomed into the community;
• Providers and their significant others should receive orientations to the community;
• Anticipate questions that might lead them to leave for which answers will encourage them to stay;
• Integrate them, if they want, into local cultural life; and,
• Help to reduce isolation.
Important Issues in Retention, Ranked Highest to Lowest

- Availability of relief coverage;
- Quality of local schools;
- Compatibility with professional colleagues;
- Housing availability;
- Telephone consultation;
- Availability of peers within the clinic or practice;
- Income potential;
- Local consultation;
- Continuing education opportunities; and,
- Local cultural and social participation.
Roadblocks to Recruitment and Retention

• Primary care providers are in short supply;
• Unrealistic expectations may exist about the ability to recruit or retain providers;
• Lack of attention to family issues;
• Seeking the perfect candidate;
• Lack of planning and recruiter employment;
• No contact with candidates within 24 hours;
• No formal offer letters or contract documents;
• Lack of community need for the type of provider.
Overview of Pay Flexibilities at the Indian Health Service

IHS National Combined Councils Meeting

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Human resource
Compensation Specialist
Division of human resources
June 26, 2014
Topics

• **Individual Pay Flexibilities:**
  1. Superior Qualifications/Special Need Appointment
  2. Maximum Payable Rate/Highest Previous Rate
  3. Service Credit for Annual Leave
  4. Recruitment, Relocation, and Retention Incentives

• **Occupational Pay Flexibilities:**
  1. Title 5 Special Salary Rates
  2. Title 38 Special Salary Rates

• **Special Topic:** Title 38 Physician and Dentist Pay
What is this overview about?

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.. and IHS’s ability to recruit and retain successfully.
Superior Qualifications/Special Needs
Pay Setting Authority

✓ Pay set at advanced rate (step).
✓ Candidate “new” to the Federal government (break of at least 90 days).
✓ Justification: employee’s superior qualifications or a special need of the agency.
✓ Justification must also supply rationale for the specific step proposed (e.g. salary in current job).
Maximum Payable Rate/
Highest Previous Rate

• Applies to employees with past or current Federal experience - reemployed, transferred, reassigned, promoted, demoted, or with an appointment change. Not an entitlement.

• Takes into consideration rate of basic pay previously received in another related Federal position.
Service Credit for Annual Leave Scenario

I am eligible for only 4 hours of annual leave a pay period????！！！！！

“But I am an experienced Nurse and often work overtime!! I will also be working in an isolated community!! VA Nurses get 8 hours why don’t we?”

“No thanks!!!”
Service Credit for Annual Leave

✓ Recruitment tool for “new” Federal employees.
✓ Gives employee a calculated service computation date for leave purposes that moves them closer to, or places them in, the 6 or 8 hour annual leave category.
✓ Previous experience (private sector/uniformed service) directly related to position is creditable.
✓ One year service agreement required.
✓ Authorization by Director, DHR, before start date.
Service Credit for Annual Leave Question

How often do Area Offices offer this hiring incentive to Nurses being recruited from outside the Federal government?
Recruitment, Relocation and Retention Incentives (3Rs)

• **Recruitment** - for an employee “new” to the Federal government.

• **Relocation** – for a current employee relocating. This is different from paying relocation expenses.

• **Retention** – for a current employee in their current position.
• Up to 25% of an employee’s annual salary. Not creditable for retirement, life insurance, etc.
• Recruitment/Relocation incentives require service agreements. Multi-year payments and service agreements possible. Paid in a lump sum(s).
• Retention incentives are paid biweekly. No service agreement.
• Proof of new residence for relocation authorization.
• Succession planning for retention incentives.
Justification for 3Rs

• **Recruitment**: position is difficult to fill, the individual is unlikely to accept the position without incentive.

• **Relocation**: the position is difficult to fill, PMAP is “fully successful” or higher.

• **Retention**: employee has unusually high/unique qualifications and/or there is a special agency need for their services. The employee is likely to leave IHS without the incentive. PMAP is “fully successful” or higher.
Amount of Proposed 3Rs Incentive

• Justification must also provide a rationale for the proposed amount, e.g., a compensation survey citing higher salaries.

• Aggregate limitation on pay applies. GS salary + incentive cannot exceed Executive Level I: $201,700 (most positions)

• Government-wide cap on incentives continues. IHS limited to 2010 expenditure level.

Trending now: fewer Doctors, more Nurses, receiving retention incentives.
Title 5 and Title 38 Special Salary Rates

• Special Salary Rates (SSRs): appropriate when there are proven recruitment/retention problems based on compensation levels.

• **Title 5 SSRs:** any occupation. Approved by OPM.

• **Title 38 SSRs:** positions performing patient care or services incident to patient care. Approved by HHS.
Title 5 Special Salary Rates

• Current IHS Title 5 Special Salary Rates: Diagnostic Radiologic Technologist, Medical Instrument Technician, Medical Technologist, Nursing Assistant (AK), Dental Assistant (AK), Practical Nurse (AK).

• In some locations the locality pay rate might be higher than these SSRs.

• As health care positions these should probably be brought under Title 38 authority.
Title 38 Special Salary Rates

• Currently we have 8 Title 38 SSR pay tables: Nurses (AK and nationwide), CRNA, Physicians Assistants (AK and nationwide), Dentists, Optometrists, Pharmacists.

• Looking ahead:
  1. Possible increase to CRNA pay table.
  2. Possible termination of Dentist pay table.
  3. Reviewing compensation concerns of additional occupations.
Title 38 Physician and Dentist Pay (PDP)

- PDP has two components: GS base pay (Title 5) and market pay (Title 38).
- Market pay: the VA develops ranges through analysis of national salary surveys. Pay tables have not been increased since 2009.
- Title 38 pay tables: by specialty and tier level indicating level of responsibility.
- HHS policy: compensate physicians at levels comparable to Federal sector physicians in the local area.
- PDP is fully creditable for retirement calculation, life insurance, and other purposes.
Recruitment for Title 38 Physicians/Dentists

- Use Title 38 pay ranges on your vacancy announcements.

  • Bring candidate on at the step one – allowing them to receive increases during a pay freeze and to be in a shorter waiting period.

  • Use recruitment incentives judiciously and be advised that they should not morph into a retention incentive.
PDP Review & Approval

• Area Director authority: PDP approval for amounts within the applicable pay range and <$250K.

• IHS Director authority: approval for PDP amounts exceeding the pay range and <$250K.

• HHS authority: all PDP amounts > $250K. (HHS rejected recent request for IHS approval if within pay range but over $250k).

• Incentive payments are included when determining whether compensation is above the pay range.
PDP Review & Approval

• Area CMO signs PDP requests approved in Area as the compensation panel chair. Regional HR Directors also review.

• Title 38 requests above the established pay range should be rare and well justified. Follow the criteria in HHS Instruction 590-1 when writing an exception request.
Title 38 PDP with Incentives

• Pay ranges are developed with recruitment and retention issues in mind. Incentive payments should be rare.

• Additional justification criteria beyond Title 38 criteria are required when adding an incentive (e.g. PMAP).

• Ongoing retention incentives: consider carefully.
Upcoming Biennial Review

- Required every two years.
- Review by specialty and Area Office.
- Areas will gather/submit information and then the Division of Human Resources will compile.
- A compensation review at HQ will analyze the information and certify that the use of Title 38 PDP at IHS is equitable, consistent, and follows regulations.
Questions?

• Utilize your on-site and/or regional HR staff but feel free to call or e-mail Jennifer Fry or Lisa Reyes.