CLINICAL RECRUITMENT AND RETENTION TOOLKIT

Adapted with permission from the

Recruitment & Retention Best Practices Model 2005

Published in 2005, the *Recruitment & Retention Best Practices Model* was produced by a quad-state partnership of the Arizona, Illinois, Mississippi, and Virginia State Primary Care Associations, with financial support from HRSA's Bureau of Primary Health Care. The complete document can be accessed by clicking on the following link: http://www.nachc.com/client/documents/Recruitment%20%20Retention%20Best%20Practices%20Model.pdf.

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RECRUITMENT AND RETENTION TOOLKIT
Recruiting to Retain Primary Care Providers

Introduction

With the recent American Recovery and Reinvestment Act ("Stimulus Package") infusing millions of dollars into community health centers (CHCs) and the recent passage of the Affordable Care Act ("Health Care Reform") with the Community Health Center Trust Fund adding $11 billion, the need for qualified, mission-driven primary care providers is a significant challenge. Prior to the passage of Health Care Reform, according to ACCESS Transformed: Building a Primary Care Workforce for the 21st Century, health centers needed up to 19,500 primary care providers and up to 14,400 nurses to reach 30 million patients by 2015. With the goal of developing the capacity to serve 40 million patients by the end of 2015, the current clinical workforce will need to double.

This Toolkit has been developed to assist community health centers to support the existing clinical workforce and attain, groom, and retain compassionate healers who provide excellent clinical care and feel professionally at home in a CHC. For purposes of this document, "primary care providers" includes: physicians, nurse practitioners, physician assistants, certified nurse midwives, dentists, dental hygienists, and behavioral health specialists.

The first section of the Toolkit focuses on recruitment – hiring the right person for the right position for the right community is the critical first step in developing a quality clinical workforce <u>and</u> also the first step in retention. The second section focuses on retention – a critical strategic priority if health centers wish to retain quality staff and thus maintain quality services and financial stability.

Recruitment

STEP 1: Assess the need

a. Determine the number of additional clinical staff needed

Given the time and cost related to provider recruitment, it is essential that a CHC determine their exact clinical staffing needs. Determining the number of primary care providers required to serve a specific population can be a complicated process. Often when a primary care provider ("provider") leaves, the first impulse is to replace the provider with one of the same type and specialty. Whether replacing a provider or adding a provider due to growth of the community health center, analysis should be conducted to consider the true need and necessary response. As the result of the research, you may find that a nurse practitioner or physician assistant is more appropriate than a physician or that the local demand for primary care cannot justify the addition of another provider. Following are steps that can be taken to determine need for additional providers.

Determine your service area

What population will the proposed provider serve?

- Determine where most of the current patients live by zip code, census tract, community or other defined service area. Ideally, utilize the UDS reporting (or practice management system) to determine patient origin using zip codes and associated patient data fields of age, sex, payer source, and diagnosis.
- Utilize census-breakdown information by age and sex for all residents in your service area. This information can be collected through state health departments or going on-line to http://factfinder.census.gov/home/saff/main.html?lang=en. The information should be collected for each zip code in your service area.
- Identify by FTE (full-time equivalent) other primary care providers in the service area. Lists of providers can be obtained from the state's primary care office (PCO).

> **Note:** All data from external sources requires a second review by the CHC for accuracy.

Calculate primary care provider supply

The simplest method for determining the primary care provider need is to take the service area's population and divide it by the number of primary care providers serving that population, and then comparing the resulting ratio to standard benchmarks and/or ratios from other areas with similar demographic markers (e.g., age and population density). A separate analysis will need to be made for medical, dental, and behavioral health. Although this process is fairly straight forward, it could be misleading because the formula does not take into account primary care utilization rates of different population groups within the service area. Nor does it take into account a myriad of other factors, such as:

- A local population may have grown significantly during the last few years or rapid growth is forecasted, possibly due to industry growth or other changes in demographics.
- Local practices may draw patients from contingent areas.
- The current primary care professionals are overworked and their patient load is at a maximum capacity.
- Primary care professionals are of retirement age or near retirement.
- There may be a recent loss of provider(s) due to relocation, death or disability.
- Providers may have or plan to scale back practice in terms of clinic hours, patient load or scope of services.
- Providers may also begin to limit which patients they see based on insurance coverage. – do they take Medicaid recipients and/or the uninsured?

- Actual clinical hours available may be influenced by on-call schedules in relation to increased number of mid-levels and/or lack of hospitalists.
- Distance and travel time to the admitting hospital can limit clinical hours available.
- Service to special populations (for example, migrant farmworkers, homeless, HIV, people with limited English proficiency) can be a contributing factor.
- A growing obstetrics and gynecology practice may be enhanced by selecting a female provider.

Note: CHCs should use established methodologies. Data from local HPSA and MUA designations may provide assistance. Contact your Primary Care Association and/or State-based Primary Care Office for information.

Calculate primary care demand

National statistics show that consumers visit their primary medical care provider an average of 2.8 times per year and their dental provider an average of 2.4 times per year. This may be more depending on the population being served. By multiplying the average by the total population, you can estimate all primary care encounters/patient visits per year or *demand.*

As noted above, this straight line calculation ignores the variability of demand that can occur from service area to service area depending on patient demographics. In areas with higher morbidity and age, consumption patterns will be higher. Some statistics show that Medicaid patients see providers an average of 3.5 times per year and we know that seniors (Medicare beneficiaries) will consume significantly more care than adolescents. For increased accuracy, you may want to assess the number of encounters per age group, morbidity, type of service, and/or insurance status.

Another alternative is to work with your state's Medicaid office and its Medicaid Management Information System (MMIS) to generate encounter rates per acuity score for Medicaid patients and seek out the acuity scores of your existing patient population as broken down by age categories. Applying these metrics to the rest of the population in the service area for each age bracket may give a better sense of true demand for services as informed by age, associated morbidity and other factors.

The easiest method for determining the primary care provider need is to take the primary care provider need/demand and divide it by the number of FTE primary care providers serving that population.

A **Demand Needs Assessment** is another method for determining provider need. This method consists of: defining your service area, calculating the provider supply, calculating demand, and measuring supply versus demand.

Note: The Needs Assessment tool from the 330 grant guidance is a good, standardized resource.

b. Define the type of provider(s) needed

Provider qualifications:

- What primary care specialty are you seeking?
- What type of provider are you seeking: MD, DO, DDS, DMD, mid-level, etc?
- If mid-level, are you seeking a nurse practitioner, physician assistant, or dental hygienist?
- Board certification or board eligible required?
- Do you want an experienced provider or new graduate?
- Will you consider a foreign medical graduate (J-1 VISA)?
- What educational requirements and/or certifications are required?
- Are staff privileges at a local hospital required?
- Does the provider need to speak a specific language?
- Is prior urban or rural clinical experience required?
- Are there any limitations in scope of practice for nurse practitioners, physician assistants, dental hygienists, or behavioral health providers because of state or payer restrictions?
- Are there any licensing requirements/limitations for the provider?
- What level of supervision by a physician, dentist, psychologist/psychiatrist will be required for mid-level providers?

Note: Some of the above may vary by state.

Responsibilities of the provider:

- Scope of services expected to be provided and when and where the services will be provided
- Expected in-clinic hours seeing patients and the average number of patients expected to be seen per four or eight hour clinical session
- On-call expectations (frequency, average number of patients, etc.)
- Hospital/after-hours call requirements (which may include community call)
- Administrative responsibilities (both in the health center and at the hospital, if appropriate), i.e., quality assurance, peer review activities, provider meetings, and community involvement

Once you have determined the number and type/specialty of providers needed, you are ready to take the critical recruitment steps that follow.

STEP 2: Identify and address potential barriers to successful recruitment and retention

The following list can assist you in identifying weaknesses or barriers to recruiting and retaining providers in your community. For each weakness or barrier identified, try to develop a strategy for removing or minimizing it.

- Non-competitive compensation package, including salary and benefits
- Required OB coverage and/or in-patient coverage
- Excessive on-call/after-hours coverage
- No other local providers to share on-call and after-hours coverage

- Few professional opportunities for a spouse/significant other
- Inadequate health center facility (lack of equipment, exam rooms, supplies)
- Operating inefficiencies of the facility, clinical operations, administrative approach
- Lack of sufficient staff and/or lack of adequately trained staff
- Lack of practice management experience in the health center
- Poor billing/coding practices or lack of training for providers on proper billing practices
- Limited technology/lack of an electronic health record
- Issues with the private practice providers or lack of support by private providers
- Interpersonal conflicts within the provider community and/or health center
- Turmoil in leadership, staff turnover and/or lack of organizational stability
- Lack of basic consumer services/amenities within the community
- Lack of adequate housing
- Poor public school system/poor academic performance within the schools
- Isolation and/or lack of "intellectual stimulation" for providers

STEP 3: Consider outside resources that can enhance recruitment

a. Utilize Health Professional Shortage Area (HPSA) information

The Shortage Designation Branch in the Health Resources and Services Administration (HRSA), Bureau of Health Professions National Center for Health Workforce Analysis develops shortage designation criteria and uses these data to decide whether or not a geographic area or population group qualifies to be designated as a HPSA or a Medically Underserved Area (MUA) or population (MUP).

To inquire about the HPSA score for your community or health center, visit the Web site address http://bhpr.hrsa.gov/shortage and search by state, county, and discipline.

In 2003, Reauthorization of the Consolidated Health Center Program instituted automatic HPSAs for every federally qualified health center (FQHC) in the county. As a result, all FQHCs benefit from a HPSA designation and all are eligible to participate in several programs, including:

National Health Service Corps (NHSC): The NHSC recruits primary care medical, dental, and behavioral health professionals who are dedicated to providing care to the nation's underserved communities. There are two principle means recruiting these health professionals through the NHSC, namely the NHSC Scholarship Program and the NHSC Loan Repayment Program.

NHSC Scholarship Program: This program provides scholarships for training of health professionals, including primary care providers, who agree to serve in HPSA/MUA/MUP areas. As a rule, there is one year of obligated service for every year of training support. The NHSC pays tuition, required fees, and some other educational costs, tax free, for as long as four years and requires a minimum two year commitment. Educational costs may include books, clinical supplies, laboratory expenses, instruments, two sets of uniforms and travel for one clinical rotation. Recipients also receive a monthly living stipend ($1,326 in 2010 – 2011) which is taxable. Upon completion of their educational training and completion of a residency training (family practice, general pediatrics, general internal medicine, obstetrics/gynecology, or psychiatry, or general or pediatric dental) they are expected to begin work at an approved practice site in a high-need HPSA. For more information, go to: http://nhsc.hrsa.gov/scholarship/.

NHSC Loan Repayment Program: This program provides loan repayment opportunities for licensed primary care providers who have signed an employment contract with a NHSC-approved site to reduce or eliminate their health professions student debt. The full-time program starts with an initial award of $50,000 for two years of service; the new half-time pilot program starts with an initial award of $50,000 for four years of services. Participants may apply to extend their service until their debt is fully paid.

State Loan Repayment Programs (SLRP): In addition to the NHSC's SLRP, the Health Resources and Services Administration SLRP provides matching funds to more than 30 states to operate their own SLRP for primary care providers working in HPSAs. Eligibility requirements and benefits vary by state. Contact your State Office of Rural Health or State Primary Care Association for more information.

J-1 Visa Waiver Program (for International Medical Graduates/IMG)**:** The J-1 Visa Program allows foreign medical school graduates to pursue post-graduate training in the United States. When training is complete, the graduates must return to their country of origin for a period of at least two years. A 1994 amendment to the Immigration and Nationality Act, however, created the J-1 Visa Waiver. With an approved J-1 Visa, IMGs may forego the mandatory return to his or her home country and remain in the United States to practice medicine in a HPSA or MUA. An IMG must serve in such an area for at least three years. At the end of the commitment, foreign-born physicians may apply for permanent residency status. For more information, contact your PCA/PCO.

State Conrad 30 Programs: The State Conrad 30 Visa Waiver Program gives states the option of supporting waivers for physicians willing to practice in underserved areas. Under this program, participating states can apply to the State Health Department to grant a waiver for IMGs. Participating states can support a maximum of up to 30 waivers a year. All state waiver requests must then be submitted to the United States Immigration Authority for review before final approval is issued by the Commissioner of the Immigration and Naturalization Service.

Ready Responders: Ready Responders are officers in the Commissioned Corps of the United States Public Health Services (PHS) who provide clinical care in NHSC-approved sites and also assist the placement site to develop, implement, or maintain programs such as:

- Emergency preparedness and response
- Patient education
- Staff development

- Development of realistic recruitment and retention protocols
- Infrastructure development

Ready Responders include: primary care physicians, general and pediatric dentists, nurses (BSN or MSN), nurse practitioners, physician assistants, clinical psychologists and social workers.

About 50 Ready Responders are currently assigned to community health centers. They are intended to provide short-term assistance but may be assigned for up to three years. The advantage of assignment of Ready Responders is that CHCs are not required to pay for their salary or benefits; however, the disadvantage is that they can be called upon at any time to respond to an emergency or another need as determined by the U.S. Public Health Service.

STEP 4: Gain support from your clinical and business communities

After determining that recruitment of an additional provider(s) is needed, you need to gain support for your recruitment efforts. First, it is essential that a CHC's clinical staff fully support the decision. The clinical team must understand how and why the decision was made to hire an additional provider. The clinical leadership and CEO should present this as a collective decision to the clinical staff.

> **Note:** Clinical Leadership (Medical Director, Dental Director, Director of Behavioral Health Services) need to be involved from the outset of the process.

Once you gain support from the clinical staff, it is most effective if at least one clinical staff member can be an active member of your recruitment team. This is usually the Clinical Director but it may be beneficial to include other providers in this process.

In some situations (for example, a small, rural community), involvement of the larger community may be needed. If this is the case, the external clinical (medical, dental, behavioral health) community and the business community need to be approached. Involvement of the private practice community has two advantages. First, concerns can be addressed. They must be assured that the proposed provider(s) will address the unmet demand and not take away from their practices. Secondly, by taking this first step, you are more likely to be able to demonstrate to the prospective provider they are needed and wanted.

Involvement of the business community may include: bankers, educators, realtors, leaders of civic/service organizations, retail trade, Chamber of Commerce members, to name a few. By gaining community support, you:

- Demonstrate the community's sincere interest in a new provider
- Begin building a patient base for the new provider before he or she begins
- Make the new provider and his or her family feel more welcome in the community

If you do not formally involve the larger community, you may want to introduce the new provider by placing an ad in the local newspaper with his/her picture and short bio and/or hold an open house once the provider arrives on site.

Note: The issue of “fit” for the provider and his or her family is a critical one. As noted in the July 14, 2010, *Healthcare Finance News’* article, New Factors Affect Physician Recruitment, Retention, “making sure the new [provider] assimilates well in the community is vitally important.”

STEP 5: Form the recruitment team

The recruitment team approach is one of the best ways to involve the community and cut down on the amount of work for any one person. This team is not the same as the interview committee but rather the group that works to bring candidates to the interview committee. The following persons are examples of individuals to be considered for the core of your recruitment team:

- CHC Executive Director/CEO
- CHC Board representative
- Clinical leadership of the CHC: Chief Operating Officer, Medical Director, Dental Director, Director of Nursing, Director of Behavioral Health, Human Resource (HR) Director

You may also want to draw on the following, depending on the interests of the candidate:

- Hospital representative
- Clinical staff representative from the specialty being recruited, e.g., dental, OB, etc.
- Employers who recruit or are currently recruiting for positions for which the spouse may be qualified (if spouse or significant other is seeking employment)
- School District representative
- Community leaders from potential community where provider may live
- Civic/social/faith-based organization representative

To apply the team concept effectively to recruitment, each member must be assigned a specific job. A member of the team or their approved delegate should cover the following functions:

Recruitment Coordinator: Makes assignments and ensures completion. This individual should also send opportunity packets to interested candidates, send candidate information to the screening team and clinical staff, and tracks the status of each candidate. This individual would preferably come from the Human Resource Department. This position requires a person who possesses good organization and leadership skills. To be effective, this position may require twenty hours/week dedicated to the tasks.

Contact Person/Initial Interviewer: This is the first personal contact the candidate will have with your community and is responsible for conducting initial telephone interviews with all eligible candidates. The interviewer’s role is critical to the success of the recruitment and retention effort. The CHC must gather as much information about the candidate as needed by the recruitment team to decide how closely the candidate matches the community and the needs of the practice opportunity. If multiple interviewers are used, they should follow the same interview questionnaire, opportunity information and instructions for conducting an interview to ensure consistency from candidate to candidate. Ideally, at least two people should participate in the telephone interviews: you may want to include the CEO/ED, Clinical Director, and the Director of Operations. The contact person should have strong interpersonal skills and possess knowledge about the community and practice.

Spouse/Significant Other Recruiter: The decision of the candidate to accept the position or not is often heavily influenced by their spouse/significant other ("partner"). If that individual does not feel like the community is a fit or they are unsure of employment opportunities, this needs to be addressed early in the recruitment process. The responsibilities under this function include:

- Coordinating all activities related to recruiting the partner
- Determining the partner's interest in the community versus the candidate's
- Identifying special "needs" and "wants" of the family
- Determining how well the partner fits in the community
- Providing the specific information the partner needs about the community
- Attempting to satisfy the partner's professional or career needs
- Providing the coordinator and recruitment team an accurate assessment of how sincerely interested the partner is in moving to the community.

Reference and Credential Reviewers: Reviewers should be from the CHC and credentialing and HR departments. One of the reviewers must have access to and know how to use the National Practitioner Data Bank and must have a thorough understanding of professional education and background checks, certification and licensing processes, and hospital privileging process. Reviewers must verify the potential provider's qualifications and certifications, including license, Drug Enforcement Administration (DEA) registration Medicaid/Medicare number, etc.

Promotion Developer: Creates marketing materials about the community and practice opportunity and determines the best places for marketing the opportunity. Some examples of promotional materials include brochures, CD/DVDs, video and audio tapes. New media and online sources must be considered to attract new providers, including Facebook, Twitter, Health-e Careers, and association websites (both state and national). The successful CHC will cast a wide net of types of materials and places for distribution.

Note: There should be no more than two points of contact with the candidate – the Clinical Leader and either the CEO or Human Resources Department representative.

STEP 6: Define the practice opportunity

The recruitment process includes the candidate selling him/her and the organization selling itself as a great place to work with a desirable community in which to live and raise a family with career opportunities for the provider and partner. **Practice setting, community, and compensation are the three components that compose a practice opportunity.** Defining your opportunity will: help you understand the strengths and weaknesses of your offer versus the competition; assist you with identifying candidates who are right for your opportunity; and help candidates better understand whether your opportunity and community is right for them.

Practice setting: Describe the following:

- The size of the facility
- The layout, age and condition of the facility

Note: If you have a new facility or a very attractive facility or one is planned for, include a picture or architect's drawing of the center in the packet sent to the candidate.

- The technology available: electronic health records, tele-medicine, orientation and training available related to the use of technology, etc.
- The administrative and clinical support staff, including types (e.g., RN, LPN, MA, DA) and clinical staffing ratio (e.g., two assistants per dental provider)
- Other human and technological resources at the center
- The location of the practice site (primary site or secondary, if appropriate) in relation to the hospital, nursing home, etc.
- Availability of Federal Tort Claim Act (FTCA) malpractice coverage.

Other health care resources: List or describe other health care facilities available in the community, providers and services that will assist the provider in their care of patients. Include:

- Availability of specialty care
- Rural health or free clinics
- Relationship with the Public Health Department
- Mental health or substance abuse counseling
- Physical therapy and rehabilitation services
- Dental services
- Emergency medical system, including level of care, types of transport and distance in miles and minutes to advanced care facilities.

Describe the community*:* This is part of your "selling" process and requires as much attention as the description of the practice. Include information regarding the following, including web-based links to more information:

- Location and accessibility to desired services (universities, shopping malls, restaurants, etc.)
- Activities/sports offered in the area: skiing, fishing, camping, hiking, theatres, etc.
- Description of the school system – public and private
- Faith-based organizations
- Housing available, with links to respected realtors

- Anything else that will promote your community!

Describe the compensation package*:* Establishing a fair and competitive compensation arrangement for providers is essential to the continued growth and success of any community health center. Increasing local competition by organized medical groups, such as large group practices, and proprietary hospital corporations, will put pressure on CHCs to offer both financial and professional incentives that will entice providers to practice in community health center environments.

Be aware of state, local and national competition for primary care providers. A CHC must be prepared to emphasize what the organization uniquely offers, including the opportunity to work in a mission-driven organization, have flexible hours, and be a significant part of the community.

Compensation can vary, based on: specialty, training, years of work experience, additional skills, provision of OB or in-patient care, language skills, and willingness to take on other responsibilities, such as clinical quality improvement activities or other administrative responsibilities.

A health center should consider the following before entering into negotiations with a prospective provider. Flexibility is key to offering a compensation plan that not only is competitive in the local market but is also tailored to meet the provider's compensation expectations and provide an incentive for productivity and delivery of quality care. Compensation packages can be as simple as a guaranteed yearly salary or as complex as a base salary, benefits, incentives and bonuses. Compensation arrangements are never permanent and should be periodically modified to protect the interest of all parties. Grants or contracts may affect the use of these funds for certain compensation plans. Examples of compensation approaches are noted below.

Straight salary: A fixed amount of money paid to the provider on a weekly, biweekly or monthly basis. It is simple to administer and may be used in combination with other plans. Although this method of compensation controls operating costs, it alone provides no incentive for productivity. The salary should be adjusted regularly to reflect economic conditions, the costs of providing services, and local competition.

Incentive-based salary: A compensation plan should ideally induce a provider to be a productive and contributing member of the health center. Some CHCs offer financial incentives as part of their overall compensation packages. With incentives, the more a provider accomplishes or produces, the more pay or other benefits he or she receives. Incentives can be based on a variety of factors, including one or more of the following:

- Total revenue generated by the provider
- Patient face-to-face visits
- Total hours worked in direct patient care
- Net revenue of the CHC
- Hospital revenue generated by the CHC for in-patient admissions by the provider

- After-hours patient consultations
- Patient satisfaction survey results
- Clinical quality measures/indicators

Fringe benefits: Fringe benefits are often a significant portion of a compensation plan. Some CHCs offer a flexible or “cafeteria-style” benefits plan, which allows the individual employee to select certain benefits instead of additional cash income. This system allows the organization to control costs while providing employees with the flexibility of choosing benefits that meet their particular needs. The following list contains examples of benefits other than salary that may be offered:

- Health insurance
- Dental insurance
- Life insurance
- Disability insurance
- Vision coverage
- Retirement or pension plan
- Tax-deferred annuity
- Vacation
- Holidays
- Sick leave
- Leave without pay
- Military leave
- Bereavement leave
- Maternity/paternity/adoption leave
- Educational leave (CME or CE)
- Sabbatical leave
- Compensatory time off
- Payment for jury duty
- Professional licensing fees
- Membership dues to professional societies
- Reimbursement for professional textbooks, manuals and journals
- Conference registration, travel and per diem for professional meetings
- Allowance for tuition, travel and per diem related to CME/CE
- Automobile expenses
- Cellular phone/”smart” phone

Note: Incentive models and flexible benefits need to be applicable to all providers of that category.

STEP 7: Define your candidate

Once you have defined who you are, what you have to offer, and the basic requirements needed in a candidate, you must define to whom you want to offer the position. This goes beyond the qualities identified under the Need section and focuses on who is the <u>ideal</u> person for your practice opportunity and for your community. What professional and personal traits should he or she possess?

Bring the entire recruitment team together for a brainstorming session.

Define the position being recruited and define the characteristics of an ideal candidate. The personal and professional background should be highly compatible with the needs of the health care system and the characteristics/personality of the community. A suggested approach is as follows:

- Have each member develop professional and personal traits that they believe the candidate should have to meet the practice and community needs.
- Share items from each member’s list to promote building upon each other’s ideas.
- Record all comments.
- Go over the list to clarify, discuss, change, and gain consensus on characteristics contained in each list.
- Prioritize characteristics by voting on the list.

This process not only helps solidify what you are looking for, it prepares the CHC for other phases of the recruitment process: searching for candidates and screening candidates.

STEP 8: Create a recruitment budget

Provider recruitment is costly, both in dollars and time. A budget will give you an idea of all the different types of costs involved in the recruitment process over and above the compensation package. Some items to consider in developing a recruitment budget include:

Promotion/Publicity
- Advertising (journals or other media, such as the Internet)
- Recruitment firms
- Person-to-person recruitment, such as resident programs, job fairs
- Direct marketing (mailing lists, postage)
- Printing (display ads, brochures, flyers)
- Materials (stationary, envelopes)
- Photography, artwork, videos, etc.

Candidate Screening
- Phone interviews
- Credentials checks (National Practitioner Data Bank, credential verification, other)
- Reference checks (phone, e-mail)

Site Visit and Personal Interviews
- Airfare
- Ground transportation
- Lodging
- Meals
- Mileage reimbursement
- Social visit/social gathering costs (catering, sponsored meal)

Personnel
- Current personnel (time away from primary duties, bonus pay for extra duties)

- Temporary personnel (hired local recruitment coordinator, locum tenens coverage until new provider is recruited)

STEP 9: Search for and generate a pool of candidates

Numerous sources are available to recruit providers and are listed below. Each should be carefully considered for application in your community and to be sure that the particular recruitment effort is affordable and practical.

Residency Programs/Clinical Schools: Clinical and residency programs that focus on primary care such as family practice, obstetrics and gynecology, pediatrics, internal medicine, nurse practitioner, dentistry and psychiatry are one excellent source of potential candidates. A one-page announcement about your practice opportunity, which is suitable for posting on a bulletin board, can be sent to the directors of the various residency programs.

Note: Even more effective is to have a graduate of the program who is familiar with and supportive of your organization make the contact.

Other Organizations: Sources for primary care providers include: primary care associations, primary care offices, state office of rural health, public health departments, Area Health Education Centers (AHEC), national medical, dental and behavioral health associations, and preceptor programs.

State Medical/Dental Associations and Local/County Medical/Dental Societies: These associations are excellent sources for provider recruitment. They can publish vacancies and provide lists of available providers by specialty. In addition, they sponsor activities to increase their membership by recruiting recent graduates in the specialty areas in which you may be recruiting.

Advertising: Advertising can be effective recruitment strategy, although expensive. There are several publications and media venues to consider including:

- Professional Journals (Journal of the American Medical Association, Journal of the American Dental Association, New England Journal of Medicine, etc.)
- Websites and other publications
- Newspaper ads and job opportunity listing links
- Direct mail/e-mail

Note: Younger providers are much more likely to seek out web-based and social-networking mediums.

Recruitment Firms: A number of private recruitment and placement firms specialize in recruiting clinical professionals. If you decide to use a private recruitment firm, shop around and read contracts closely as they tend to be costly. There are usually two types of contract agreements: contingency – the CHC does not pay unless a candidate is hired; and, retained – the CHC pays a set fee, at least a percentage of which must be paid up-front, to have the firm work on behalf of the organization. Following are some options to consider.

- Recruitment functions of your local State or Regional Primary Care Association.
- Retired military primary care providers. The **Uniformed Services Health Professional Placement (USHPP)** is the only contingency placement firm that works exclusively with military health care professionals seeking employment in their transition from the military into civilian practice. USHPP also presents military clinicians who are not retiring, but who have completed their military commitments. For more information, link to http://www.valueinstaffing.org/.
- Discounted recruitment services for community health centers. For more information, link to http://www.valueinstaffing.org/.

STEP 10: Screen candidates

Screening candidates includes preliminary interviews, having discussions with the spouse/significant other, if appropriate, checking references and credentials, and conducting the on-site visit.

The initial step is usually done by telephone. During that conversation:

- Provide an overview of the community, organization, and position.
- Determine the candidate's real interest, qualifications, and suitability for position, including whether salary and benefit expectations are within the range of the CHC.

Before inviting the candidate to an on-site interview, check references. When checking references, it is important to:

- Ask for written and verbal references from those individuals listed by candidate.
- Check references other than those provided by the candidate.
- If a relatively new provider, contact the director of the residency/clinical program Ask the program director for the names of at least one faculty person and one attending clinician as a reference.
- Contact the medical director or administrator of the candidate's previous place of employment.
- Contact the Chief of Staff or Administrator of the hospital where the candidate has had staff privileges, if appropriate.
- Have a member of the clinical staff make telephone calls to other providers for reference checks, if possible. In addition, inquires into the candidate's professional and personal background should be conducted. Assessment of personal background will include checking credit history, driving and criminal records. A credit check can reveal a great deal about the suitability of the provider candidate. Credit records may reveal financial problems, including foreclosures and bankruptcy.
- In reviewing the application for employment and credentialing verification, significant gaps in the history of the provider's education or experience should be noted. If possible, any areas of concern should be discussed with the candidate and the responses verified with a third party.

- The National Practitioner Data Bank should be queried (see the NACHC Issue Brief: *Updates to the National Practitioner Data Bank*, June 2010).
- Keep in mind that a candidate may wish to relocate because he or she has some problems in the current community or place of employment, such as an inability to get along with patients and colleagues, substance abuse, or criminal behavior. Any applicant who appears anxious to join a practice without any investigation of the practice should be viewed with suspicion.

STEP 11: Interview the candidate(s)

Once the recruitment committee or administrator has identified a potential candidate that has met the criteria for further consideration and the references and credentials have been checked, the next step is inviting the candidate for an on-site visit and formal interview. Many healthcare facilities invite the spouse and family or significant other. Each facility must decide whether or not it will reimburse candidates for all or only part of the travel expenses.

Interviews and site visits are primarily focused on recruiting qualified candidates by emphasizing the positive aspects of your practice. However, this time must also be utilized to see if the candidate is compatible with your organization's mission, organizational culture, practice style, philosophy, personality and objectives. A good fit or match helps to insure a long-term relationship with the provider, your organization, and most importantly, for continuity of patient care. Remember that not every provider will fit into your organization's culture and mission. The goal is to find the right match.

Interview Questions for the Candidate

Interview questions assist in determining both whether a candidate meets the required qualifications and is a good "fit" for the position and the organization. Questions should be based on the job description, the qualities of the ideal candidate as developed by the Recruitment Committee, and required vs. preferred qualifications.

Note: Questions regarding the following may not be asked during the formal interview or informal, social settings: age, race, color, religion, national origin, physical disability, marital status, sexual orientation, military service, or parenthood/childcare arrangements.

The initial on-site interview is also an ideal time to determine the provider's salary and benefit expectations before negotiation. Often, negotiations determine course of the future relationship between the CHC and the potential candidate. Therefore, it is important that the CHC conduct a pre-negotiation assessment of the expectations of the candidate while also focusing on the health center's ability to accommodate those needs. Factors that should be considered by the CHC during the recruitment process are:

- *Dollars:* What are the provider's financial needs? This can include outstanding student loans or the need for a down payment on a house. While it would be inappropriate to ask these questions directly, the answers are often revealed during the interview process.

- *Vacation/time-off:* Most providers today are motivated by quality-of-life issues. More time off is often an incentive, even if it means less pay.
- *After-hours/on-call responsibilities:* This is foremost in the mind of most providers: how much call? When is it? With who is it shared?

Note: To address this issue, you may want to have a discussion with your hospital regarding the use of hospitalists, if not currently a part of the system, or, develop an incentive program for after-hours and/or hospital coverage.

- *Fringe benefits:* Some organizations provide different benefits for different employees. You may want to consider this approach if you are having difficulty recruiting a particular type of provider, however it is not recommended because of the potential negative affect it might have on current providers/staff.
- *Administrative responsibilities:* Some providers are content with only a clinical role; others will want to play a part in the administration and management of the health center. By being flexible, a CHC can cater to both approaches.
- *Opportunity to participate in decision-making:* Although many providers may not want administrative responsibilities, they may want to have some sense of ownership for the clinical program. Consider the opportunities for developing leadership roles on specific projects or chair of staff committees that work on clinical issues (e.g., Pharmacy Therapeutics Committee, quality improvement activities).

Commonly Asked Questions by Candidates and Spouses or Significant Others

(*Sources: National Health Service Corps, Rural Recruitment and Retention Network, and Idaho Rural Health Education Center*)

Interviewers should be prepared to respond to the following questions:

Clinical Questions

1. Why is a new provider needed?
2. Does the professional community support the recruitment of another provider?
3. How many providers are currently in the health center?
4. Why did the last provider leave?
5. How do the providers work with each other in the CHC? In the medical/dental community?
6. What is the licensing process in the state?
7. How are other providers of my specialty accepted at the hospital and in the community?

Practice Questions

1. Where is the practice located?
2. How many patients are there in the community?

3. What is the payer mix of the patients (Medicaid, Medicare, private insurance, uninsured)?
4. What is the call schedule?
5. Is hospital admitting privileges required?
6. What locations are available for office space?
7. How many exam rooms will I be provided to see patients?
8. How many patients am I expected to see each day or session?
9. What types of technology and equipment are available at the office?
10. What types of support staff are at the facility?
11. Is there licensed nursing support staff at the facility?
12. What is the ratio of providers to assistants?
13. Which services will be provided at the facility and which will be provided by other sources?
14. How far is the nearest hospital?
15. Where are the consulting physicians/dentists/behavioral health specialists? Referrals? Is it difficult to arrange referrals?
16. What type of emergency transportation is available?
17. CME/CE allowance (reimbursement and time off)?
18. What type of support will you provide me in developing my practice?
19. What will be expected of me and how will I be evaluated?
20. Who will be my direct supervisor and what is their leadership style?
21. Tell me about your Quality Improvement Program?
22. Will I be involved in Peer Review?
23. By what means will I have to communicate with the administration, staff at the facility and other clinicians?

Community Questions

1. What types of employment opportunities are available for my spouse/significant other?
2. What types of educational opportunities are available?
3. What types of housing are available in the area?
4. What does the local school situation look like?
5. What types of faith-based organizations are in the area?
6. What are the social, recreational, entertainment and cultural activities available?
7. What kind of environment does the community offer?
8. What types of shopping and other consumer services are available locally?

STEP 12: Meet with the spouse (or significant other) and children

Most recruiters agree that in order to recruit a provider, the spouse or significant other and family also must be recruited. The spouse or significant other play critical roles in the provider’s decision to work live and remain in a community. Even if the provider finds the practice suitable, he or she is unlikely to accept the position if the community cannot meet the needs of the family. Keep in mind, you are not only recruiting the provider, you are recruiting the family.

Contact must be established with the spouse or significant other during the initial telephone contacts before the visit, if possible, to learn more about the needs and expectations of the partner. The professional and personal needs of the spouse can then be better addressed during the visit. Information on nearby colleges and universities, employment opportunities, housing and recreational and community activities can be forwarded to the spouse/significant other. A good way to introduce the providers' family to the community is by sending copies of the local newspaper to them. You should also include a map or information from the Chamber of Commerce, community development authority or your state's visitor center.

If there are existing relationships with family or friends in the vicinity, emphasize the support system that exists. Arrange a time where the spouse, family or significant other can spend time with friends or family. Existing relationships may be one of the primary reasons a candidate, spouse or family choose to practice in your locality.

STEP 13: Conduct a creative site visit

In addition to allowing for the formal interview process to occur, the on-site visit can help sell the opportunity to the provider and his or her family. Ideally, a site visit should be between two to four days and allow the provider and family ample time to meet key members of the clinical and local community, as well as time to explore the community on their own.

Following are some suggestions that can assist a CHC to plan for a successful site visit.

Who should the candidate meet with?

1. One-to-one meetings with other clinical staff provide an opportunity for honest discussion regarding the strengths and challenges of the practice. Inform your providers ahead of time to be balanced in their discussions. Hopefully, they are pleased with their practice. If not, you may need to do some work on retaining your present clinical staff.
2. Tour the hospital and meet key hospital staff members, especially the Administrator, Chief of Staff, and the Director of Nursing.
3. The candidate may want to meet with community leaders and clinical staff away from the community health center.
4. Host a lunch/dinner between the potential candidate and the clinical leader and selected clinical staff.

What should the candidate and her/his family (as appropriate) see?

1. Tour and experience the community – first with an escort and then alone –allowing the candidate and spouse/significant other to see the pros and cons of your community. This might include a tour of homes for sale with a local realtor.
2. Visit the facility where the candidate would practice.

3. Tour other relevant health care facilities.
4. If there are school-age children, meet the school principal(s) and tour the school(s).
5. Visit places of particular interest to each candidate and spouse – ask them before the site visit.

Being creative in site visits demonstrates to the prospective provider you listened to what they value in their professional and personal lives. Even if you decide to stick to a conventional site visit, you could create a virtual site visit showing the provider the fun and relaxing things available in your community.
In planning a site visit, be flexible. Apply the information that you learned about the provider and his or her family to develop the itinerary for the site visit. For example, if the provider has mentioned that he or she has a special interest or a family member has a special interest or need, such as sailing or shopping, be sure to include some information about those special interests. Too often, communities use the same general itinerary for every candidate, which ignores the fact that each candidate has uniquely different interests in your opportunity and community. The most effective site visits are those that tailor the itinerary to the candidate and spouse's interests and preferences. Of course, this can only be achieved when you know enough about the candidate and spouse to decide what would interest them about your opportunity and community.

What should you plan to do with the provider and his/her family?

1. Ideally, plan a social gathering where candidates can meet other staff, board members, private providers, and community members.
2. If there is a spouse or significant other, you may want to arrange a dinner or outing with the clinical lead and his/her spouse or significant other. Allow the spouses to have open discussion regarding the realities of the practice (daily schedule, time arriving at home, call, etc).
3. Have the candidate and his/her family experience a popular activity in your area that might be of interest – horseback riding, white water rafting, hunting, skiing, live theatre, etc.

Note: If you have the resources available, have a gift basket highlighting products or fruits from your area and a welcome card waiting for them upon arrival at their hotel. You might want to include a disposable camera so they can capture special moments on film. If they have children, small, age-appropriate gifts are always appreciated.

A well organized site visit provides the opportunity to assess some of the more subjective aspects of the candidate and to better judge the candidate's compatibility with members of the practice and the match between the candidate, his or her family and the community. Candidates may sometimes evaluate the quality of the job offer in terms of how successful the site visit goes. Site visits consists of three stages: planning the visit, conducting the visit and follow-up afterward.

There are several ways to conduct a site visit, but there is no one "sure-fire" way. In other words, what works for one provider may not work for the next provider. Avoid conducting a site visit with a candidate and spouse who also are planning to visit other opportunities in your state or in neighboring states on the same trip. While such multiple-site visits may save each organization on the tour some money, you risk paying for candidates who simply use the multiple-community site visit as an expense-paid tour of your state. The sincerely interested candidate will find time to make the trip just to your community, especially if the CHC is paying the expenses. The site visit is too important to risk sharing the candidate and spouse's attention with the competition. National Health Service Corps Scholars may have an allowance to pay for their travel to and from potential assignment sites. Inquire with the candidate to determine if they have a travel allowance should they be an NHSC Scholar award recipient.

Follow-up after the visit

If you want to hire a provider, an offer can be made before he or she leaves the community. Many who are experienced and successful at recruiting have already discussed salary amounts and negotiating points such as sign-on bonuses and moving expenses with the CEO or CFO prior to the candidate's visit. You may consider having a contract ready to present to the candidate at the end of the visit if you feel it is a good match.

There should be little delay before contacting the provider following the on-site interview, no later than one week after their visit. A letter can be sent to the provider following the site visit documenting what was discussed (see attached Letter of Intent or Job Offer). The Clinical Director, CEO, or Director of Human Resources should telephone to confirm the health center's interest in hiring the provider and to get a commitment from the individual. Once the provider makes a commitment, a signed agreement should be obtained.

There may be some negotiation that occurs prior to agreeing upon a final contract. The negotiator or whomever is responsible for contracting in your organization can handle this. An attempt should be made to be as specific and complete as possible without extensive wording. The final employment agreement might include, but is not limited to, details related to a starting date, amount allowed for moving/relocation costs, sign-on bonuses, productivity incentives, time allowances for academic appointments or clinical teaching, or administrative duties. Productivity and quality expectations should be included as well.

If you decide that your organization will not offer the individual the position, then a polite letter should follow to inform them of the decision.

If the provider will be relocating, someone should be responsible for assisting the provider and his or her family in the relocation process. Living accommodations, spouse's and children's interests, school registration, religious and social affiliations and/or banking concerns may all need attention.

Retention

If you recruited a provider using the recruiting for retention approach, paying particular attention to matching the candidates' characteristics (ideal candidate) with the needs of your community and organization (practice opportunity), you will already have done a considerable amount of retention building. In fact, by ensuring a good match between the provider and the organization and community, you have built a solid foundation for retention. The closer the provider and family's interests match that of the organization and the community, the more likely the provider and community will be satisfied with one another over the long run.

However, this is just the beginning of an effective retention program. Once the new primary care provider arrives on site, you must implement strategies that accomplish the following:

- Welcome and orient the new provider and spouse/significant other to the professional clinical community and to the broader community.
- Anticipate and address concerns or issues that may be contributing to discontent by the newly recruited provider or those of the family, to avoid the potential for the provider or family member to want to leave the community or the health center.
- Allow ample time for the provider to enjoy life beyond the practice.
- Provide a thorough orientation to the organization, clinical practice and the specific position.

Note: This orientation should be well planned in advance with key staff members prepared to meet with the new provider. There should be ample time for learning, reflection and practicing before the provider is introduced fulltime into his/her position. Consider a mentor who will serve as both a guide and sounding-post during this time.

Once in their position, the following need to be part of a successful retention plan for <u>all</u> providers:

1. Health center systems and policies should support clinicians with the tools and systems essential to providing a work environment that promotes and sustains quality of care, including high patient satisfaction. This includes human resources (well trained and adequate numbers of staff), facility and infrastructure, organizational culture, and technology, including electronic medical records.
2. Management based collaboration, work structured to be meaningful and challenging, as well as a commitment to share information and ensure participation in decision- making are key strategies for a stable and productive staff committed to the mission and future of the health center (Policy Information Notice 98-23, Health Center Program Expectations).
3. A competitive compensation and benefit package that is kept current with the market and also supports long-term retention, and enhances productivity and quality. Appropriate incentive plans and deferred compensation plans which are compatible with fiscal resources, the health center mission and management philosophy, and are in accord with state and federal laws, should be explored as methods to maximize the retention of productive, quality and committed health professionals (PIN 98-23).
4. Regularly scheduled staff meetings that promote open communication, feedback, and problem-solving.

5. Keep the after-hours and weekend on-call schedule reasonable – for example, one out of every three - four working days, one out of every three - four weekends, or one out of every three weeks is considered reasonable.
6. Provide adequate time and funding for CME/CE.
7. Provide for peer interaction outside the community through attendance at state and national CHC organizations.
8. Develop telecommunication links to practitioners in other communities and to medical education and support resources if those are not readily available in the area.
9. Sponsor periodic social gatherings.
10. Find a niche for providers to improve retention. It helps to survey providers during the contracting process in order to identify areas of special interest, for example: performing procedures; focusing on a special area of practice, such as pediatrics; academics/teaching; or, medical informatics. If at all possible, offer opportunities to fulfill these special areas of interest or skill sets.

Retention-building activities such as these should be ongoing. When a provider leaves your CHC, you should learn something from his/her departure. Some of the questions to consider are:

- What have been contributing factors to turnover among providers?
- What do providers perceive as the most important supports necessary to "succeed" in a clinical position within your organization?
- To what extent are those supports and other targeted support services such as mentoring, financial support and professional development made available?
- How can we improve our organization in order to retain providers?
- If you could change anything about the organization, what would that be?

Summary

Recruitment is an ongoing task that evolves over time. CHCs must work to constantly improve results. Turnover is not always a bad thing. Very few providers remain in one community or practice location for their entire career. Like American society in general, primary care providers are becoming more transient. Since they are in such high demand today, primary care providers are especially apt to be lured away from CHCs with promises of less work and more pay. Too many CHCs are surprised by the loss and are not prepared to quickly replace him or her. Delays in recruiting a new provider cause deterioration in access to care for the community and place the entire system at risk because of diminished revenues and referrals. Even when you have a full complement of providers, continue to cultivate relations with potential candidates by:

- Becoming a training site for medical and dental students, primary care residents, behavioral health specialists and midlevel provider students
- Staying in touch with these residents and students after they finish their rotation in your community and long into their careers (They may come back!)
- Encouraging clinical staff members to cultivate a rapport with potential candidates at CE events.

- Bringing in locum tenens (temporary coverage) providers who also may be looking for permanent practice opportunities

And remember, it is easier and cheaper to retain than to recruit!

ADDENDUM A
Sample Annual Recruitment Plan

Quarterly Activities

JANUARY – MARCH

1. Develop strategy and begin to implement: mailings, meetings, etc.
2. Register search with NHSC, AMA, placement services and recruiters
3. Prepare/update recruitment package: opportunity descriptions, community information, description of benefits, etc.
4. Identify recruitment conferences and exhibit possibilities
5. Schedule visits to appropriate conferences and recruitment fairs
6. Mail second letter to graduating residents
7. Hold quarterly provider recruitment committee meeting

APRIL – JUNE

1. Send third letter to graduating residents
2. Continue to implement strategy
3. Interview as appropriate
4. Hold quarterly provider recruitment committee meeting

JULY – SEPTEMBER

1. Contact providers in government service (IHS, military, etc)
2. Send fourth letter to graduating residents
3. Meet with heads of residency programs
4. Continue to implement strategy
5. Hold quarterly provider recruitment committee meeting

OCTOBER - DECEMBER

1. Determine anticipated needs for the following year:
    - ♦ Survey current clinical staff regarding their assessment of the need
    - ♦ Assess potential for loss of current providers
    - ♦ Assess need for growth in services and related growth in number/type of providers
2. Develop annual recruitment budget to be included in approved operating budget
3. Identify residency programs and contact program directors/advisors.

4. Send letter of introduction to next year's graduating residents/professionals
5. Hold quarterly provider recruitment committee meeting

ADDENDUM B

Sample Generic Health Care Provider Recruitment Plan

All community health centers should have a recruitment policy and plan.

Sample recruitment policy:

______ (Name of CHC) will develop a comprehensive recruitment plan as part of its strategic plan and will update this plan as part of its annual operational planning in order to ensure full and appropriate provider staffing.

Sample goal:

____ will recruit ___ (number) of (type of provider) during this year based on resignations, terminations, attrition or growth.

Sample strategies:

- ♦ To concentrate efforts on health care professionals who are completing training programs, government obligations or military service.
- ♦ To anticipate the competition by contacting prospects early.
- ♦ To have a continuous, year-round effort of activities.

Sample workplan: (see Sample Annual Recruitment Plan for an alternative format)

Strategy	Activities	Individual(s) Responsible	Timeframe/Deadlines
Strategy 1a: To concentrate efforts on health care professionals who are completing trainings programs	1. Contact all residency programs and inform them of the organization and professional opportunities 2. Send letter of introduction to next year's graduating residents	1. Clinical Director 2. Clinical Director	Last quarter of the year Last quarter of the year
Strategy 1b: **To concentrate efforts on health care progressions**			

who are completing government obligations			
Etc.			