

Clinical Provider Recruitment and Retention Plan Proposal

**Community Health Center
Medical Professional Continuous Quality Improvement Team
Recruitment and Retention Plan Proposal**

Introduction

has suffered excessive turn over of providers and other staff since its inception. A high provider turn over only negatively impacts the care delivered to our patients as well as the continuity of other initiatives and undertakings within the organization.

FQHC's and Rural Health Centers face significant competitive disadvantages when it comes to recruiting and retaining competent professionals. Historically, these centers have relied on recruitment incentives such as loan repayment, visa sponsorship, high need service bonuses and national health service contracts. *Unfortunately, the duration of those recruitment incentives is limited and they are not very effective retention tools.* The incentives are usually funded by external sources or rely on factors beyond the control of the health centers such as immigration quotas; consequently they are not always dependable or available. Once those incentives end, to retain professionals the organizations can not favorably compete with opportunities in the private sector or in metropolitan areas.

Furthermore, providers who work for FQHC's and Rural Health Centers face numerous challenges in delivering care to their patients and lack many of the tools and resources to face those challenges. *This leads in many cases to provider burn out and low levels of satisfaction with their employment.* Recruitment and retention incentives can be used to offset some of the competitive disadvantages of practicing in an FQHC or Rural Health Center such as remote location, professional isolation, few cultural and recreational opportunities, lack of adequate resources to practice state of the art medicine and poor school systems in the community. When choosing a practice, providers also look at other intangible factors such as workplace atmosphere, staff morale, practice's reputation and recognition, academic affiliations and practice leadership.

FQHC's and Rural Health Centers have to be aware that there are R. & R. tools used in the private sector that can not be replicated in their setting such as partnership, ownership and profit sharing. Consequently these centers have to become creative and offer other incentives that are competitive.

A sound R. & R. plan must be created in the context of a healthy business plan to ensure proper revenue and resources. High provider turnover brings increased recruitment costs. To have access to a pool of qualified candidates, health centers have to pay high recruitment fees or rely on State run recruitment agencies. There are many untapped technological resources such as the world wide web which can be used to increase the center's exposure to prospective providers.

Proposals:

- 1) Make Community Health Center a recognized leader in primary care in our communities and a desirable workplace at all levels.
- 2) Provide competent and efficient ancillary staff and support.
- 3) Provide academic appointments (i.e. clinical instructors or preceptors) for providers who so desire, by pursuing affiliations with academic institutions.
- 4) Continue and expand cooperation with the State Office of Rural Health, Research and Demonstrations to assure that vacancies are filled promptly and by the best available candidates at a minimum cost.
- 5) Develop our own brochure directed to provider recruitment and marketing of services. The internet is a tool increasingly used for job seeking by health care providers. Consider developing Community Health Center's own web-site and have it listed in the right search engines. This web-site should also serve for general patient access.
- 6) Compensation competitive with the private sector. Ideally it should match or exceed the compensation levels in our geographic area.

Compensation should take into account :

- a- Experience and special qualifications (OB).
- b- Seniority.
- c- Quality of care based on such data as health maintenance parameters.
- d- Group leadership and management of the center.
- e- Patient satisfaction based on surveys.
- f- Panel size or capitated lives: should correlate with total number of patients managed as opposed to office visit productivity.
- g- Resource utilization.
- h- Administrative duties.

An effective compensation formula or model should have the following qualities:

- a- It should be fair economically- not necessarily producing equal shares, but fair.
- b- It should be comprehensible, especially to the providers being compensated.
- c- It should not be difficult for management to monitor and administer, and it should be flexible enough to allow possible future modification.
- d- It should be consistent with the philosophy and mission statement of the center.
- e- It should stimulate providers to be effective with definable financial rewards for behavior and activity the center needs and wishes to encourage.

- f- A compensation model should not encourage intra-group competition and should promote team environment within the center.
 - g- It should be flexible in the weight it assigns to non-salary pay determinants, so the formula can be modified as needed to reflect changes in income streams, different values assigned to an activity, increasing sophistication of accounting methods, etc.
- 7) Competitive retirement plan with matching employer contributions.
 - 8) Productivity incentives and/or bonuses quarterly to effectively stimulate growth and change.
 - 9) Better health insurance plan with expanded coverage and lower co-payments.
 - 10) Progressive increase in vacation time according to seniority.
 - 11) Increased CME time and allowances.
 - 12) Sign in bonuses and paid moving expenses.

RECOMMENDED SALARY RANGES

PHYSICIANS

Family Practitioner without OB

- | | |
|--|------------------------|
| 1) New graduates (*): | \$104,500 - \$109,250 |
| 2) With one year of post-residency experience: | \$120,000 - \$125,000. |
| 3) With two years of post-residency experience: | \$ 130,000 - \$135,000 |
| 4) With three years of post-residency experience: | \$ 140,000 - \$145,000 |
| 5) More than 3 years of post-residency experience: | \$ 150,000 - \$165,000 |

Internist

- | | |
|--|-----------------------|
| 1) New graduates (*): | \$104,500 - \$109,250 |
| 2) With one year of post-residency experience: | \$120,000 - \$125,000 |
| 3) With two years of post-residency experience: | \$130,000 - \$135,000 |
| 4) With three years of post-residency experience: | \$140,000 - \$145,000 |
| 5) More than 3 years of post-residency experience: | \$150,000 - \$165,000 |

(*) Board Certification should be obtained prior or within one year of employment.

PHYSICIAN ASSISTANTS

- | | |
|--|-------------------|
| 1) New Graduates: | \$58,000-\$62,000 |
| 2) One to three years of post-graduate experience: | \$65,000-\$69,000 |
| 3) Four years of postgraduate experience: | \$70,000-\$75,000 |

NURSE PRACTITIONERS

1) New Graduates:	\$58,000-\$62,000
2) One to three years of post-graduate experience:	\$65,000-\$69,000
3) Four years of postgraduate experience:	\$70,000-\$75,000

INCENTIVES

PRODUCTIVITY

Physicians

- Providers who meet their productivity expectations (patient encounters) should be compensated with an annual bonus equivalent to 60 times the Medicaid reimbursement rate per encounter at the time the bonus is due. This bonus should be paid quarterly.
- Providers who exceed their productivity expectations should receive an additional bonus. This additional bonus should be a percent of the base bonus, equal to the percent of excess patients seen in relation to the expected productivity. A correction factor should be used for times when physicians are away on vacation, CME or sick leave.
- Providers whose average charges per encounter exceed the average for the practice because of their good coding practices, special procedures they perform or complexity of their patient population should receive additional compensation.
- Providers with more than three years of seniority who continue to accept at least four new patients per week should receive additional compensation. This additional compensation can be a percentage of their annual bonus.
- Physicians who do not meet their productivity expectations should not be penalized unless it becomes a consistent pattern and remedial measures fail.
- Providers involved in administrative duties over and beyond the rest of the providers such a Medical Director, Ryan White Director, Health Check Coordinator and Caminos; whose administrative time is increased in detriment to their clinical time, should not be penalized for productivity shortcomings as long as those are due to their additional duties.

Nurse Practitioners and Physician Assistants:

- For those who meet their productivity expectations an annual bonus equivalent to 40 times the Medicaid reimbursement rate per encounter at the time the bonus is due. The bonus should be paid quarterly using the same formula described above.

- Providers who exceed their productivity expectations should receive an additional bonus. This additional bonus should be a percent of the base bonus, equal to the percent of excess patients seen in relation to the expected productivity. A correction factor should be used for times when physicians are away on vacation, CME or sick leave. The formula used should be as described above.

OTHER INCENTIVES

Hospital admissions and procedures:

- Providers who admit and care for their patients in the hospital or perform procedures in the hospital, should receive a bonus equivalent to 50 % of their gross hospital charges up to \$ 5000/year.

Outreach (Nursing Homes, Retirement Homes, School based clinics):

- Providers who participate in outreach programs should receive incentives taking into account the type of program, workload and time allocated. This should be decided on a case by case basis. The outreach encounters will be computed in the productivity assessment.

Medical Director and Program Director (Ryan White):

- This activity should be compensated. Amount of compensation can be discussed on a case by case basis.
- For providers involved in those roles, a correction factor should be used when establishing productivity expectations.

VACATION

One to three years of employment: 15 working days.
Fourth year of employment : 18 working days.
Fifth year of employment and over: 20 working days.

CME TIME

One to three years of employment: 5 days.
Fourth year of employment and over: 8 days.

Allowance should be increased accordingly.

For providers involved in especial programs such as Ryan White, Migrant Health , Health Check or Caminos additional program specific CME time should be allocated.

RETIREMENT PLAN and 403 B

- Increase cap for employer contribution to \$5000/ year.
- Establish employer matching contributions to employee's 403 plan.