Retaining Healthcare Workers in Rural and Indigenous Communities

What do we need to do to keep people in the system?

Jentoft - Chinle - many staff are guests - iissues of bunching shifts vs timekeeping requires creativity in scheduling - moving administrative tasks such as responsibility for ems projects, scheduling, etc, in order to comply w IHS requirement

* Sending people to acupuncture training
  + If a program goes beyond cost and time, a CAM can be a helpful mechanism to get acquisitions to approve

Ringelberg - total 2080 hour requirement lends itself to asking people for other admin time that can be flexed - NE-2080 allows providers to just work 2080 hours over any time. Monitored quarterly. Wellness officer job opportunity is noted - systems-wide changes in wellness programs as administrative, meaningful job changes rather than pizza parties and yoga

Hired staff psychologist for the exclusive availability of staff members, after covid surge for improvement in mental well-being.

* Acknowledging and recognizing overall burnout rate, supporting PT shifts.
* Tackling job frustrations to allow docs to operate at the top of the license, deal with frustrations of the job
  + Transfer team: AZ has transfer team for small hospitals.

Paul Charlton

* Ask Paul about any 2080 program
* To implement a program at one IHS site, it helps to demonstrate to admin that another IHS site has implemented the program.
  + Less effective if 638 has done it. Workaround can be 638 -> single IHS pilot site -> dissemination

San Carlos -

            5K tuition for docs for upskilling, up to 1 month off for personal improvement

* There is still a desire to progress and be creative and dynamic in our work lives while at IHS - rather than academic center - need active solutions, need examples of people who have done fellowship but stayed employed (eg sabbatical or held position)

Jackie: fellowship in hospice/palliative care soon after hire at GIMC. requested part-time permanent (per diem fed equivalent) with fellowship, kept credentials and card, returned for occasional shifts, then returned 0.75FTE

·       Downside - year behind in stepup,

Topher -NE-2080-minus-X. Allows any number of hours. Consumes large proportion of FTE from an administrative budget standpoint, does not contribute to benefit accrual

Sheryl - some cases where BH is 638ed rather than integrated may restrict certain benefits, and slow recruiting into BH

Paul - Demand for internal locums force. There are 22 EDs run by IHS, up to now all separate islands. Current director making a push for One IHS, going into practice with one EMR that will be fully interconnected. Expectation that there will be standardized clinical pathways for best practices. IHS beginning to operate as a unit. Time to think about internal workforce flexibility, internal locums. Consider academic partnerships as an involved partner here.

VA leverage - can be adopted by IHS, eg telehealth projects.

Joint academic appointments. - CCC coordinating network - open EM advisory board to be built so that institutional knowledge is independent of any one person. Opportunity to discuss with IHS headquarters, bring them along to implement large-scale national programs. Good people are leading this project and

Asha Atwell - until 2026, addiction medicine through practice pathway available to take the boards for addiction medicine to be double boarded.

            Kristen Burkholder - U AZ has an online fac dev fellowship.

Topher: Emphasis on the slated/accountable time of people who are you as a CD are accountable for.

Jaime Eliades - DC meeting 2022, academic partnerships office, GME office has vocal support from Christiansen. Possibility of making a larger, centralized body to replace series of bilateral partnerships.