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Assessing Medical Systems for the CA Prison Health Care Receivership
Maintaining a Qualified Provider Workforce: Recruitment

Final Report
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I. ABOUT THIS PROJECT AND REPORT

Project Overview

In December 2017, the California Prison Health Care Receivership Corporation (CPR) engaged Dr. Brie Williams and her Criminal Justice & Health Program at UCSF to conduct an independent assessment of specified California Correctional Health Care Services (CCHCS) medical systems with the goals of:

- assessing whether those CCHCS systems conform to community standard policy and practice in federal and/or California state (“community”) integrated health care systems, and
- developing recommendations to optimize CCHCS systems in view of those findings.

The current project calls for an assessment of four systems:

- (1) CCHCS Mortality Review Policy and Practice
- (2) CCHCS Systems for Maintaining a Qualified Workforce (including peer review systems)
- (3) CCHCS Patient Safety Program
- (4) The Medical Inspection Program of the Office of the Inspector General (OIG)

Our approach will be to establish community standards for each project based on reviews of multiple community integrated health care systems and to issue evidence-based policy and practice recommendations consistent with CCHCS’s specific needs and constraints. Our overarching goal is to aid CCHCS’s ongoing advancement towards what we have termed a “healthy health care system,” which we define as one that is self-examining, responsive to evolving community standards, and rooted in a systems-driven culture of patient safety, quality improvement, and ongoing learning. This definition is derived from the Institute of Medicine’s seminal report on health care quality, *Crossing the Quality Chasm*,¹ which defines *quality* as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” and identifies six components of quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

This report describes the first part of our analysis of item #2 above, CCHCS Systems for Maintaining a Qualified Workforce. Due to the number of processes involved in maintaining a qualified workforce (outlined below), our analysis of this item will be split into multiple reports. The current report assesses CCHCS processes for primary care provider (PCP) recruitment and sets forth recommendations to optimize recruitment processes. These recommendations are based on the following activities:

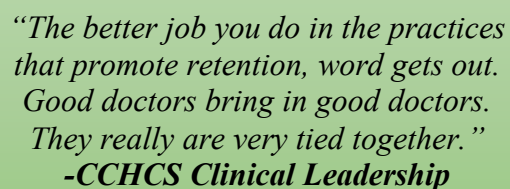
¹ Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A new health care system for the 21st century.* Washington DC: National Academies Press; 2001. Available: <https://www.ncbi.nlm.nih.gov/pubmed/25057539>

- Review of the relevant literature on primary care provider recruitment in community healthcare systems;
- Analysis of primary care provider recruitment (and related processes) at community integrated health care systems including Kaiser of Northern California, the Indian Health Service, and the Veterans Health Administration (VA), and at the nation’s leading private physician recruiting firm, Merritt Hawkins;
- Key informant interviews with recruitment staff and review of recruitment-related literature and materials from the above organizations;
- Review of relevant CCHCS policies, procedures, and definitions;
- Numerous key informant interviews with CCHCS recruitment staff, clinical leadership, and primary care providers;
- Feedback to our presentation of preliminary findings and recommendations to Judge Tigar and the Federal Receiver, Mr. Clark Kelso (November 2018).

Analysis of other aspects of maintaining a qualified provider workforce, including assessment of provider retention and professional practice evaluation processes, is currently underway and will be completed during spring, summer, and fall 2019.

Maintaining a Qualified Workforce: Defining the Scope of this Assessment

Our mandate is to review processes involved in maintaining a qualified health care provider workforce at CCHCS. Maintaining such a workforce requires a health system’s attention to every step of employment, from hiring through separation, and requires a health system to develop a comprehensive vision for the composition of its workforce. Employment processes are complex and interrelated such that changes in one area have the potential to impact the workforce more broadly. For example, sub-optimal retention strategies lead to a larger volume of vacancies, putting pressure on recruitment efforts that can in turn adversely affect the retention of remaining staff as long-standing vacancies increase workloads and dampen staff morale. Thus, reliably maintaining ~375 qualified primary care providers requires effective policies and processes across the continuum of employment.



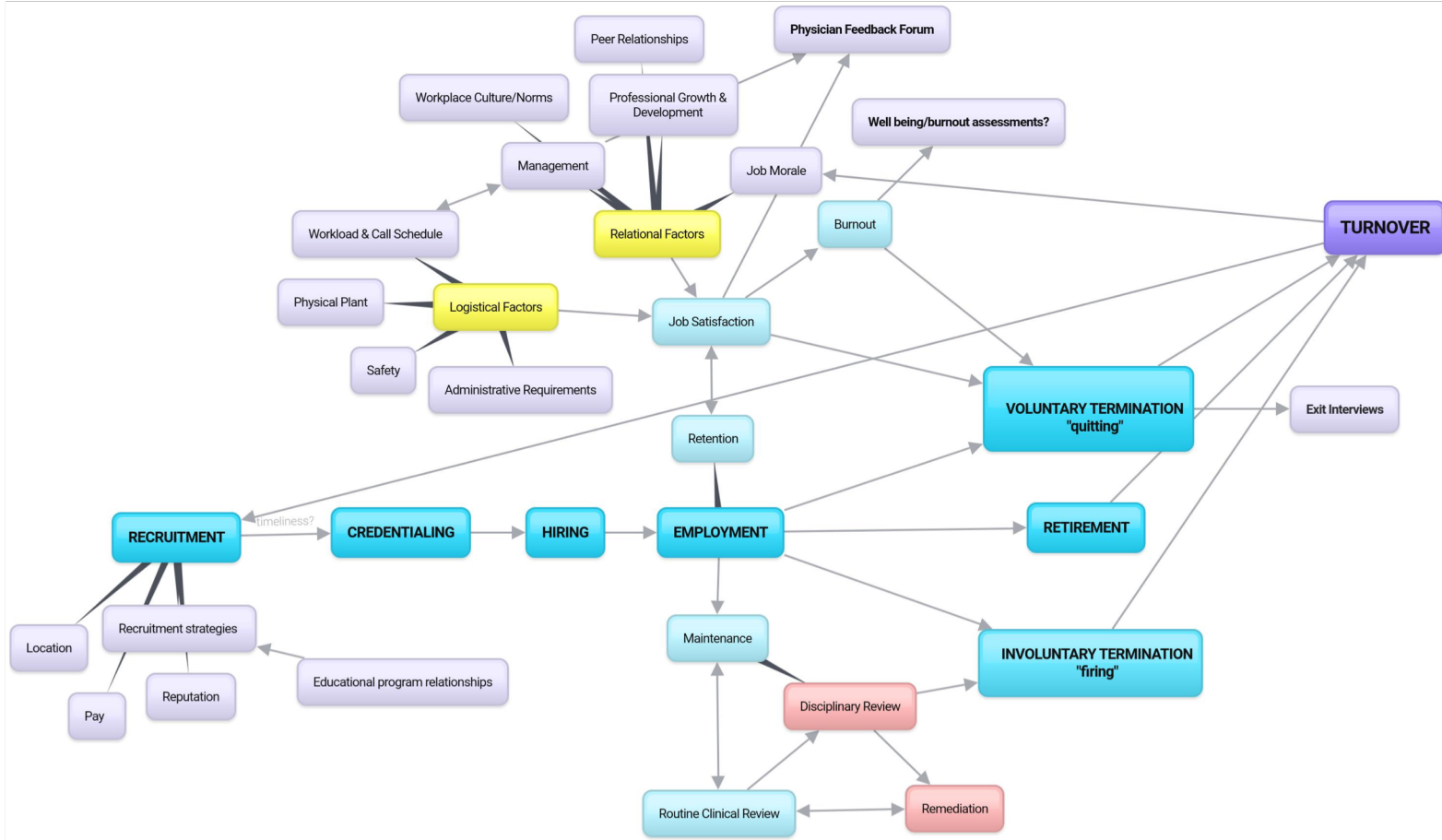
“The better job you do in the practices that promote retention, word gets out. Good doctors bring in good doctors. They really are very tied together.”
-CCHCS Clinical Leadership

We conceptualize “employment processes” (*Figure 1*) as processes that:

- lead to a primary care provider beginning to work for CCHCS;
- occur during a primary care provider’s period of employment; or
- lead up to or directly follow separation, including retirement, voluntary separation (“quitting”), and involuntary separation (“firing”)

This report focuses on the first of these: the processes that lead to a primary care provider beginning to work for the CCHCS. These processes of finding and hiring qualified

Figure 1: Significant complexity underlies employment processes



candidates, or “recruitment,” constitute an employee’s earliest interactions with CCHCS and comprise multiple components,² including:

- Preparing a job description
- Defining the profile of a quality candidate
- Drawing in candidates through multiple channels (website, print advertisements, online advertisements, etc.)
- Managing the application process including initiating the credentialing process
- Interviewing candidates
- Making selection decisions
- Preparing and presenting employment offers and incentive offers

This report synthesizes findings from the activities described in the section above and highlights areas in which CCHCS recruitment practices can improve their competitiveness with comparable community-based integrated health systems.

This report also comments on CCHCS’ opportunity to develop a unified vision for workforce composition. (By workforce composition, we refer to the provider mix – physician vs. advance practice provider and on-site vs. telemedicine provider – at any given institution and systemwide.) Although we set out to review recruitment, our conversations with CCHCS health care providers, leadership, and recruitment staff revealed a lack of a cohesive vision for current and future workforce composition. While actual recommendations regarding workforce composition and a review of community workforce composition practices are far outside the scope of this report, we outline the workforce composition-related questions and concerns that arose during our recruitment-related interviews.

² Deitelzweig SB, Mathews R, Nelson J. Best Practices in Physician Recruitment and Retention. In: McKean SC, Ross JJ, Dressler DD, Scheurer DB. eds. *Principles and Practice of Hospital Medicine, 2e* New York, NY: McGraw-Hill; <http://accessmedicine.mhmedical.com/content.aspx?bookid=1872§ionid=136859159>

II. BACKGROUND

The CCHCS Primary Care Provider Workforce

This report focuses on the group of health care providers under the “Primary Care Provider” (PCP) designation within CCHCS. This includes the following *non-mental* health clinicians:

- Physicians, including allopathic physicians (Medical Doctors, or MDs) and osteopathic physicians (Doctors of Osteopathy, or DOs); and
- Advance practice providers (APPs), including Nurse Practitioners (NPs) and Physician Assistants (PAs).

These providers, referred to as “PCPs” throughout the remainder of this report, have training in family medicine, internal medicine, and emergency medicine, and provide primary care, urgent care, acute hospital care, and emergency care to incarcerated patients throughout the CDCR.³

As of February 2019, CCHCS employed 372 PCPs.⁴ Based on discussions with CCHCS’s recruitment division, CCHCS targets recruitment of approximately 30 PCPs per year to maintain staffing levels, an estimate that is consistent with employee departures in 2016 and 2017.

Typically, such departures are a mix of voluntary resignations and retirements, though occasional involuntary terminations (fires) also occur, as in any system. A detailed breakdown of the current PCP workforce, including vacancies, is discussed later in this report.

PCP Shortages in California and Nationwide

Recruitment of PCPs to CCHCS must be considered within the broader context of a national PCP shortage. According to the Association of American Medical Colleges, the current nationwide primary care *physician* shortage totals 13,800 physicians.⁵ Over the coming decades, this national shortage is anticipated to remain stable or to increase up to 49,300 physicians. This wide range is due to uncertainty in multiple areas of the U.S. health care system, including an uncertain national health insurance coverage landscape, changing retirement and work-hour trends by current physicians, changes in the number of physicians choosing to pursue careers in primary care, and the fluctuating availability of primary care residency training programs. Regardless of the scale of the challenge, the current nationwide primary care physician shortage is expected to persist for the foreseeable future.

In California, the supply of primary care physicians is projected to decrease by anywhere from 8% to 25% over the next 10 years as more primary care physicians are retiring than are completing primary care residency training.⁶ Increasing numbers of nurse practitioners and physician assistants (“advance practice providers” or “APPs”) are expected to help alleviate this shortage. According to research by the UCSF Healthforce Center, by 2030 APPs will comprise nearly 50% of California’s primary care provider workforce, accounting for as many as 50,000

³ CCHCS employs a small number (less than 20 in total) of providers to help with primary specialty care, including HIV care and hepatitis C care. The majority of those providers are recruited from CCHCS PCP positions. These providers are a unique component of the workforce and are not specifically addressed in this report.

⁴ CCHCS Primary Care Provider Vacancy/Coverage Report. 2/4/2019. Provided by Yulanda Mynhier.

⁵ https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ec129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf

⁶ https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%20%20-%20Final_081517.pdf

providers.⁷ Despite this growth, the Healthforce Center report continues to predict an overall PCP shortage in the state, one that disproportionately burdens regions of the state where prisons are more commonly located, including the Central Valley and Southern Border regions.

PCP Shortages Disproportionately Affect Rural Areas of the U.S.

Rural regions across the U.S. face particular challenges in recruiting and retaining physicians. Consideration of these challenges are relevant to CCHCS, which must care for incarcerated patients in prisons located in some of California’s least densely populated counties. Nationwide, the primary care *physician* to patient ratio in rural areas is 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.⁸ This is particularly concerning given that rural Americans tend to be older, poorer, and in worse health.⁹

The Indian Health Service and Veterans Health Administration (VA) both employ large numbers of health care providers in rural areas and can serve as case studies of the difficulties faced by health systems tasked with a large burden of rural health care provision. In 2017, the Indian Health Service, which employs 730 physicians and 130 PAs,¹⁰ faced a vacancy rate of 25% across all health care provider positions. In Montana, Wyoming, Minnesota, Wisconsin, and Michigan, *physician* vacancy rates at Indian Health Service facilities averaged more than 45%.¹¹

The VA employs about 25,000 physicians across the U.S. and staffing shortages are detailed in an annual report issued by the U.S. Department of Health and Human Services Office of the Inspector.¹² “Physician” has been highlighted as the *number one* occupational series with the largest staffing shortages every year since 2014 (when the ranking began). The second largest staffing shortage is for nurses.

In the state of California, the Inland Empire and San Joaquin Valley regions have half as many total physicians per 100,000 residents as the Greater Bay Area (*Figure 2*).¹³ CCHCS faces a unique challenge in that many prisons are located in the state’s most sparsely populated areas. For example, the California Correctional Training Center is located in Lassen County, which has only 7.1 residents per square mile, compared to San Quentin State Prison, which is located in a county with 3,575 residents per square mile.¹⁴

In the context of a PCP shortage both nationwide and in California, alongside its disproportionate presence in rural areas, CCHCS will require reliable and sustainable strategies for recruiting a mix of qualified physicians and APPs into its many institutions.

⁷ https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/UCSF%20PCP%20Workforce%20Study_Rpt%202%20-%20Final_081517.pdf

⁸ <https://www.ruralhealthweb.org/about-nrha/about-rural-health-care>

⁹ <https://www.aafp.org/news/practice-professional-issues/20190212ruraldisparities.html>

¹⁰ <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>

¹¹ <https://www.gao.gov/assets/700/693940.pdf> See map page 12

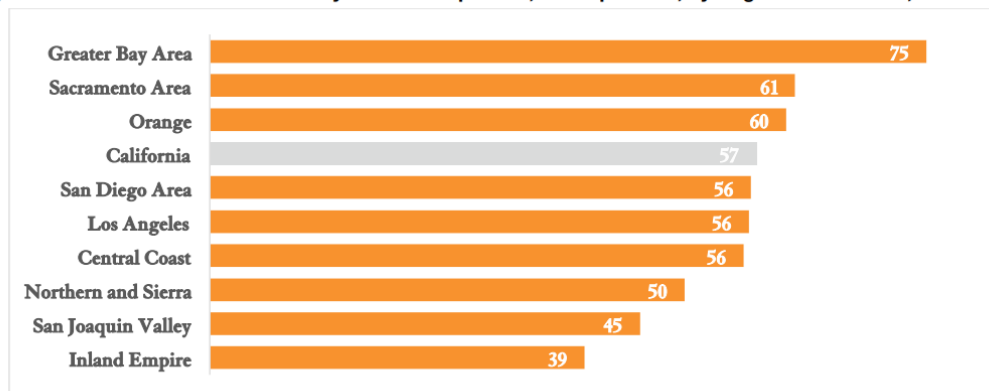
¹² <https://www.va.gov/oig/pubs/VAOIG-17-00936-385.pdf>

¹³ https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report_CA-Primary-Care-Workforce.pdf

¹⁴ <http://www.usa.com/rank/california-state--population-density--county-rank.htm>

Figure 2: Active Primary Care Physicians per 100,000 Population in California, 2015

Figure 2.3. Active Patient Care Primary Care MDs* per 100,000 Population, by Region of California, 2015



Sources: Medical Board of California, Core License File, May 2015; private tabulation. U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015.

*Includes Family Physicians, General Internists, General Pediatricians, General Practitioners, Geriatricians, and Obstetrician/Gynecologists

Note: Includes active MDs, excludes residents and fellows as well as MDs who do not provide at least 20 hours of patient care per week.

Graph source: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Research-Report_CA-Primary-Care-Workforce.pdf

Current State of CCHCS Primary Care Provider Workforce

Key informants from both inside and outside CCHCS agreed that the quality of the system's health care providers has increased substantially in the last decade, beginning in 2005 when primary care physicians had to be boarded in a medical specialty (e.g., family medicine or internal medicine) in order to begin practicing in CCHCS. However, multiple clinical leaders at CCHCS stated that on-site PCP vacancies are a vexing problem both for clinical leadership as well as clinicians themselves – particularly at the hardest to staff facilities.

Before discussing specific recruitment challenges and opportunities, describing current dynamics in PCP workforce composition at CCHCS – including recent changes in workforce composition – provide important context. By workforce composition, we refer to the provider mix (physician vs. advance practice provider and on-site vs. telemedicine provider) as well as how that mix is reflected in vacancies at institutions and systemwide.

As of February 2019, CCHCS allocated 372.1 PCP positions to care for the ~121,000 persons incarcerated at 35

“Part of the establishment of the receivership was tied to our inability to recruit qualified physicians. Early on we brought in contracted physicians paying a significant compensation rate. Then came the requirement to be board certified in a primary care specialty. As we have increased compensation rates and systems that support good patient care we have been able to move a lot of contracted staff into civil service positions.”

-CCHCS Leadership

correctional facilities.¹⁵ In addition, the system also employs PCPs and a small number of health care specialists (e.g., hepatitis C and HIV specialists) at three telemedicine centers, located in Elk Grove, Rancho Cucamonga, and Diamond Bar. The distinguishing features of the three major categories of clinicians employed by CCHCS are broken down in Table 1.

Table 1: CCHCS Workforce Breakdown

<p style="text-align: center;">On-site MD/DO/APP 342.5 FTE (92% of PCPs)</p> <ul style="list-style-type: none"> • Hired directly by CCHCS (“civil service” providers) • Work on-site in a CCHCS correctional facility • 243.6 full-time equivalent (FTE) physicians (MDs/DOs) • 64.9 FTE advance practice providers (NPs/PAs) • 34 FTE positions vacant (February 2019), representing 9% of all on-site PCP positions
<p style="text-align: center;">Telemedicine MD/DOs and 2 telemedicine APPs 27.6 FTE (8% of PCPs)</p> <ul style="list-style-type: none"> • Most are hired by CCHCS and “float” between facilities; others are hired directly by a facility and/or are empaneled¹⁶ at that facility • Patient visits conducted primarily via telemedicine with in-person clinic visits in the correctional facility every ~3 months • Comprise the fastest growing group of the PCP workforce • Nearly all telemedicine positions are filled (minimal vacancy rate)
<p style="text-align: center;">Registry physicians 26 FTE</p> <ul style="list-style-type: none"> • Hired by a private agency; not direct CCHCS employees • May work at one facility for up to several years or may frequently travel between facilities • Declining in number with telemedicine’s growth • In 2018 the number of registry providers decreased from 54 to 26, or ~1 registry PCP for every 12 on-site PCPs employees

What has happened at the facility level over the last year?

The total number of on-site civil service PCPs remained relatively stable between April 2018 and January 2019, rising from 301.3 to 308.5 (an increase of 2.3%) over that time. However, the number of telemedicine PCPs increased from 21.1 to 29.6 (an increase of 29%). These hiring trends reflect a decrease in on-site PCP *allotments* and a corresponding increase in telemedicine positions. In April 2018, correctional facilities were allotted a total of 366.7 potential on-site

¹⁵ CCHCS Primary Care Provider Vacancy/Coverage Report. 2/4/2019. Provided by Yulanda Mynhier.

¹⁶ Empanelment refers to a provider with a stable, assigned population of patients for whose primary care they are responsible. It is the basis for population health management and a cornerstone of continuity of care. Most integrated health systems, including the Indian Health Service, Kaiser, and the VA, all empanel their primary care providers.

PCP positions, 24 of which were ultimately reallocated to telemedicine, resulting in a total of 342.5 available on-site positions.

Three facilities with the lowest percentage of PCP positions filled by on-site providers as of February 2019 are rurally located and reflect the emergent use of telemedicine providers to meet patient care needs (*Table 2*).

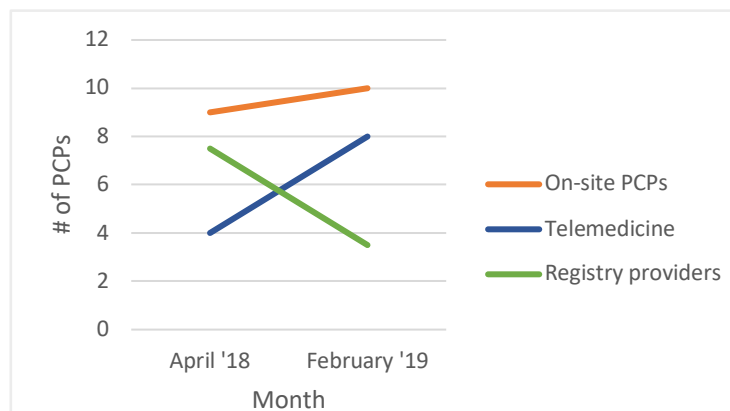
Table 2: Increase in Telemedicine PCPs is Decreasing Vacancy Rates at 3 Rural CCHCS Facilities

	CCC Susanville** ¹⁷		CTF Soledad ¹⁸		PBSP ¹⁹	
	April '18	Feb '19	April '18	Feb '19	April '18	Feb '19
Number of patients (approximate)	4,500		5,300		2,700	
Allotted PCP positions	6	6.5	11	12	5	5.5
On-site PCPs	2 (APPs)	2 (APPs)	5 (4 physicians, 1 APP)	5 (all physicians)	2 (1 physician, 1 APP)	3 (1 physician, 2 APPs)
Telemedicine PCPs	1	3	1	3	2	2
Registry providers	1	1	4.5	1.5	2	1
% Civil Service PCPs on-site	33%	31%	45%	42%	40%	55%
Vacancy rate*	50%	23%	45%	33%	20%	10%

*Vacancy rate excludes registry providers as these providers are not employed by CCHCS and generally considered positions that need to be filled by permanent civil service hires

**The chief physician at this facility also provides management and patient care via telemedicine; he is the only clinical leader in the CCHCS system who manages primarily via telemedicine

Figure 3: Number of on-site CCHCS PCPs remains stable as number of telemedicine providers increases at CCC, CTF, and PBSP



¹⁷ California Correctional Center, Susanville, CA

¹⁸ Correctional Training Facility, Soledad, CA

¹⁹ Pelican Bay State Prison, Crescent City, CA

These data highlight that while overall vacancy rates have gone down at all three institutions, the number of on-site PCPs has remained nearly stable, with a net gain of only one on-site PCP in these three institutions over nearly a year. Trends at these institutions reflect movement across the CCHCS system towards primary care via telemedicine to resolve longstanding PCP vacancies (*Figure 3*).

What is the view of clinicians and leaders about recruitment?

We discussed the evolving workforce composition towards an increasing reliance on telemedicine amidst longstanding PCP vacancies with CCHCS clinicians and leaders. Our interviews and data analysis highlight four important themes:

- 1) Clinicians and institutional leaders report that on-site recruitment is slow and is insufficiently prioritized within CCHCS
- 2) Vacancies, turnover, and recruitment challenges are creating workload and morale problems for current clinicians
- 3) Telemedicine positions can be easily filled with new PCPs
- 4) Telemedicine expansion may have the unintended consequence of negatively impacting on-site recruitment and worsening on-site PCP morale

Theme 1. On-site recruitment takes too long and is not getting enough attention

Nearly every clinical leader we spoke with, as well as many PCPs themselves, raised concerns about the time required to fill open on-site PCP positions. Clinical leadership and PCPs described open positions that went unfilled for months or even years, negatively impacting patient care and workplace morale. This concern was raised by clinical leaders in metropolitan as well as rural areas. Data described above showing that the net increase in on-site PCPs in the last year has been relatively low corroborates these concerns.

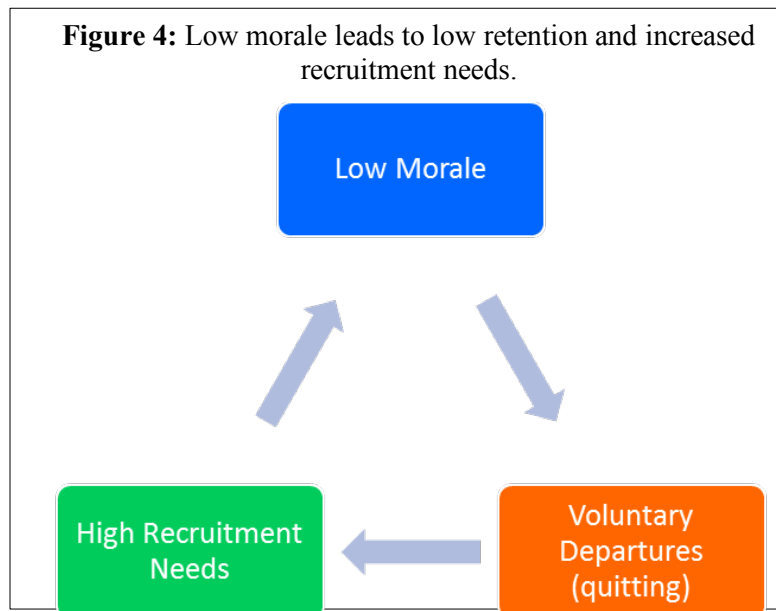
Concerns about the efficacy of recruitment for on-site positions, as well as potential solutions, are detailed at length in the following sections of this report.

“We are all hurting because we don’t have enough PCPs.”
-CCHCS CME

“A lot of people have left over the years due to low morale. And that makes morale even worse, and now I am almost thinking about leaving.”
-CCHCS PCP

Theme 2. Vacancies, turnover, and difficulties in recruitment are creating workload and morale problems

Difficulties in recruitment have wide-ranging consequences for clinicians and patient care. Numerous clinicians and CMEs described a cycle in which turnover creates greater recruitment needs than can be readily addressed, in turn leading to low morale and further difficulty in retention (*Figure 4*). For example, one facility saw the loss of three out of nine physicians in 2018, creating a significant recruitment burden. In such cases, the departures themselves often trigger morale problems because clinical leaders lack confidence that open on-site positions will be filled in a timely fashion.



Although we are not aware of specific CCHCS data describing the impact of CCHCS PCP vacancy rates on health care quality, numerous clinicians and clinical leaders reported that they found it difficult to provide quality team-based care given the number of PCP vacancies. One CME described unrealistic workloads among his current PCPs. Another pointed out that even though PCP vacancies are technically filled by temporary providers, the widespread perception among PCPs is that these providers are not providing the same level of care as stable, empaneled PCPs regularly employed by the institution. To its great credit, CCHCS has dramatically reduced its reliance on registry providers in the last year. However, this has not assuaged clinicians' concerns about the adverse impact that on-site vacancies and turnover are having on employee morale and, potentially, quality of care.

"We really need someone to take over his [CCHCS provider who left] inbox. We need someone to really take responsibility while they are here, which registry [non-civil service] physicians typically do not do. Registry doctors do not tend to act as much as part of a team."

-CCHCS PCP

A subsequent report will focus on factors affecting retention of current PCPs.

Theme 3. Filling telemedicine PCP positions is relatively easy

Concerns that were expressed to us about the difficulty with hiring into on-site positions contrast starkly with descriptions of the ease of hiring into telemedicine positions. Unlike on-site recruitment, informants describe a potential oversupply of PCP candidates for telemedicine positions. This is thought to be due to the metropolitan locations of telemedicine hub facilities as well as decreased time spent working physically inside a correctional environment. Furthermore, the salary and benefits for telemedicine and on-site providers are the same, removing those factors as incentives to working on-site.

“[With respect to developing a large telemedicine program] Most of what we have done we have done out of desperation and necessity, but it has ended up being a model that works better.”

-CCHCS Quality Leadership

Stakeholder interviews confirmed that reallocation of PCP positions from on-site to telemedicine were made in many cases due to the relative ease and success in recruiting telemedicine PCPs compared to on-site providers. However, some suggested that these re-allocations reflected a desire to quickly fill PCP positions at the expense of a thorough consideration of the ideal composition of the PCP workforce in each facility and investment in the recruitment strategies necessary to attract such a workforce.

Theme 4. Telemedicine expansion may have the unintended consequence of negatively impacting on-site recruitment and worsening on-site PCP morale

Reactions to the shift towards telemedicine among those interviewed in the course of these analyses were mixed. Some reported that even high-quality primary care via telemedicine was not adequately compensating for the limited number of on-site primary care providers. Others described initial skepticism of new PCP allotments for telemedicine that has given way recently to a belief that telemedicine is a satisfactory way to provide primary care.

“There has to be a balance. You can’t have 100% telemedicine providers. There is always going to be some advantage to having an on-site provider.”

-CCHCS Chief Physician

Some on-site clinical leaders with whom we spoke expressed concern that the telemedicine expansion is adversely affecting recruitment into on-site positions, creating new longstanding vacancies, and worsening provider morale among those who work on-site in the prisons. It was reported to us that when a position is allotted to telemedicine, control of that employee is often taken away from the institution and given to the telemedicine division, which has its own administrative and clinical leadership, decreasing the sense of agency of on-site providers and leadership. Overall, we heard both clinicians and clinical leadership caution against over-expansion of the telemedicine workforce.

“You need the boots on the ground. The ideal is more boots on the ground and less telemedicine, but if the quality is not there, I would rather have strong telemedicine and not have providers there with the negativity of the prison.”

-CCHCS Telemedicine Leadership

While a full assessment of the scope and quality of the CCHCS telemedicine program – and the apparent shift in workforce composition in favor of increasing primary care via telemedicine – is outside the scope of this report, further examination of this issue may be warranted. If the telemedicine program is perceived as undermining local clinical leadership and/or adversely affects staff engagement or morale, there could be unintended consequences for the recruitment and/or retention of on-site PCP staff and, in turn, patient care. While some use of telemedicine to fill longstanding primary care gaps is most likely appropriate and effective, misapplication of the telemedicine resource in some contexts may risk a downward spiral in on-site PCP retention and recruitment resulting in over-reliance on telemedicine beyond what is effective.

Workforce Composition: From Reactive to Proactive

The recruitment and interrelated workforce composition issues presented above highlight questions regarding what is the *optimal* workforce composition for CCHCS and what recruitment resources and strategies are needed to achieve that composition. Many on-site clinical leaders we spoke with perceive the apparent transition towards greater use of telemedicine PCPs as premature in light of their impression that efforts to recruit on-site clinicians have been insufficient and/or poorly targeted. Most clinicians and clinical leaders we spoke with also felt that the telemedicine expansion was undertaken without a clearly communicated vision for the future workforce – and provision of primary care – as a whole. Overall, those we interviewed expressed concern that CCHCS’s recent approach to workforce development, while yielding an important decrease in vacancies and the use of registry providers, has been reactive to problems with recruitment rather than a proactive effort to better support the existing workforce to improve care. To address these concerns, CCHCS might consider some key questions (*see table below*) and develop strategies to communicate its vision and rationale for CCHCS PCP workforce composition.

Key Workforce Compositions Questions Facing CCHCS

- What proportion of CCHCS PCPs should be telemedicine vs. on-site providers?
- What proportion of CCHCS PCPs should be advance practice providers vs. physicians?
- What is the environment of care at a facility where half (or fewer) of the providers work on-site, as compared to a facility where most providers are on-site?
- What, if any, is an appropriate salary difference for in-person and telemedicine providers?
- How should the ratio of advance practice providers to physicians at a particular facility be determined (for example, given variability in patient complexity across facilities)? Who should have input into this decision?
- What steps should be taken if a particular facility continuously struggles to recruit sufficient in-person PCPs?
- What are acceptable models of clinical leadership at difficult-to-staff facilities?
- If staffing/workforce composition should remain dynamic given inevitable challenges staffing PCPs, particularly in rural facilities, what processes should be in place to make changes to the staffing plan and whose input is needed in order to mitigate any potential adverse consequences?

If CCHCS chooses to further develop the vision and rationale for its ideal PCP workforce, we would further suggest that it evaluate three central potential paths forward:

- Focus recruitment efforts on expansion of the on-site APP workforce, including ensuring that an appropriate on-site APP to physician balance exists at each institution and incorporating recruitment strategies discussed in the remainder of this report;
- Focus recruitment efforts on expansion of the on-site physician workforce, including investing in recruitment strategies discussed in the remainder of this report; or
- Continue expanding telemedicine with a focus on determining (a) how having a large proportion of telemedicine providers affects the culture in each institution, and (b) an acceptable telemedicine to on-site provider ratio at each institution.

We also recommend developing such a vision with input from a broad range of CCHCS stakeholders, including regional medical directors and other leadership throughout CCHCS as well as current providers.

Recommendations: CCHCS Workforce Composition
⇒ Develop a clear vision for workforce composition in order to effectively target recruitment efforts
⇒ Consider involving key leadership and stakeholders in this process, including addressing the key questions regarding workforce composition provided here
⇒ Implement a communications effort to anticipate and address concerns within the current workforce regarding the workforce composition and primary care vision ultimately endorsed by leadership

III. Analysis and Recommendations: Optimizing PCP Recruitment at CCHCS

What follows is our analysis of CCHCS’ current recruitment activities and opportunities, and our recommendations for optimizing PCP recruitment at CCHCS. To establish the relevant “community standard” for recruitment, we benchmark CCHCS practices against recruitment strategies used by competing community employers and the nation’s leading physician recruitment agency.

1. Recruitment Pipeline

A pipeline of PCP applicants is developed using four primary tools: (1a) an organization’s website, (1b) targeted online and print advertising, (1c) in-person outreach at professional conferences, and (1d) educational training programs. In this section we will discuss the results of our review of these aspects of CCHCS’s current recruitment practices.

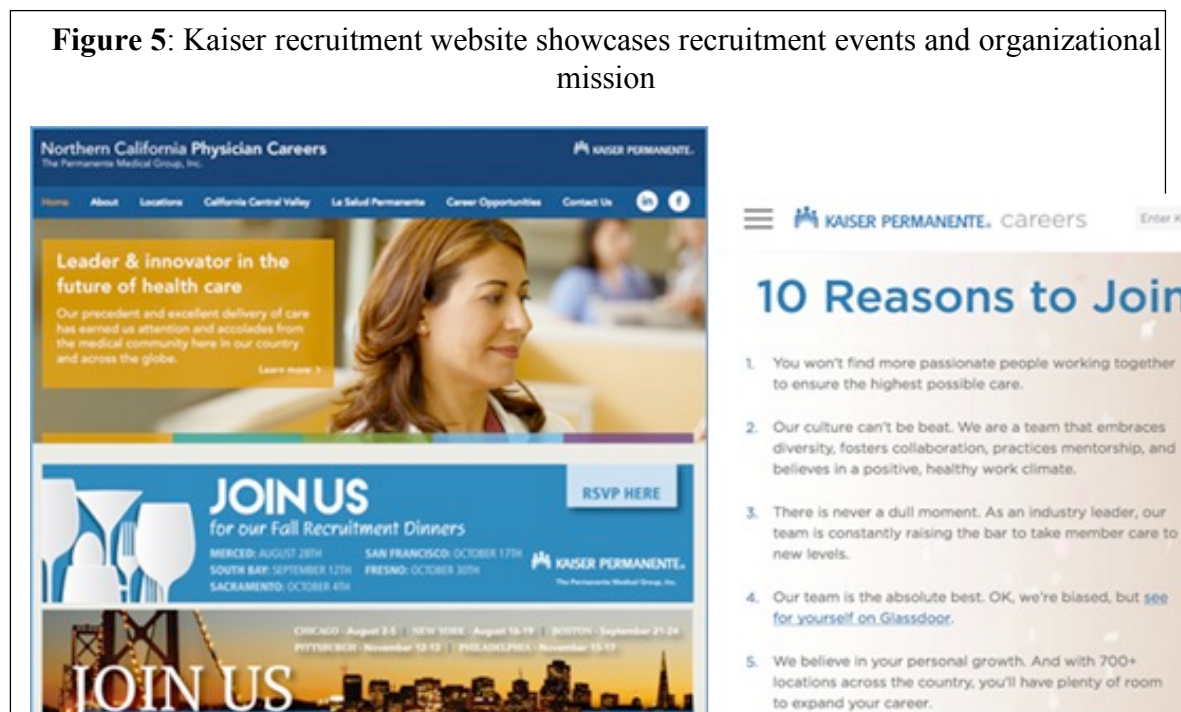
1a. CCHCS Website: Opportunities for growth and development

A recruitment website is often the first content seen by potential job applicants. Two competitors to CCHCS that excel in this area are Kaiser Northern California and the independent physician recruiter service Merritt Hawkins. Both organizations’ websites achieve the two core functions

of a recruitment website: to draw in visitors by stimulating interest – either through mission-driven messaging or particularly attractive job characteristics – and advancing the prospective employee towards contact with a recruiter.

The Kaiser Northern California Physician Recruitment Website (<https://physiciancareers-ncal.kaiserpermanente.org/> Figure 5, left panel) is visually appealing and highlights:

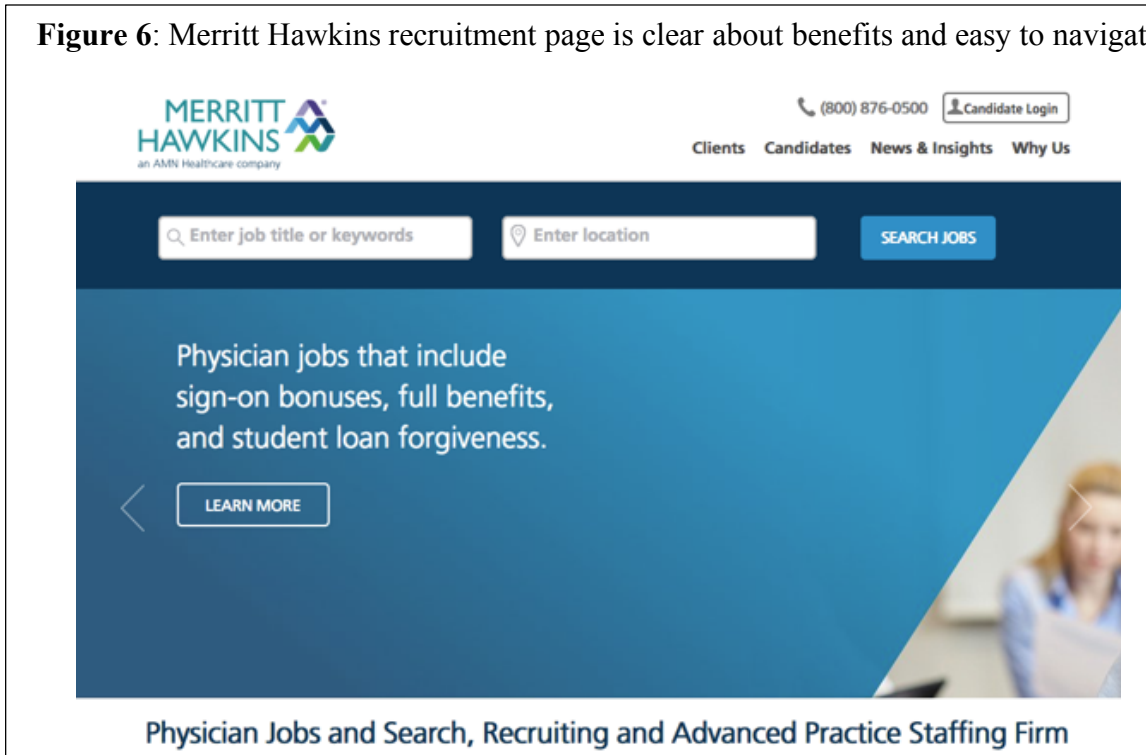
- 1) upcoming recruitment dinners across the region
- 2) presence at upcoming regional conferences
- 3) clear mission-driven recruitment messaging focused on being a “leader & innovator in the future of health care”



A second recruitment website maintained by the Kaiser Organization (<https://www.kaiserpermanentejobs.org/reasons-to-join>) focuses on recruitment of all health care personnel, not just physicians (Figure 5, right panel). This website exclusively highlights mission-driven reasons to work for Kaiser.

The website for Merritt Hawkins, the largest private physician recruiter in the U.S., uses a more sparse, direct approach, but demonstrates similar qualities (Figure 6).

Figure 6: Merritt Hawkins recruitment page is clear about benefits and easy to navigate

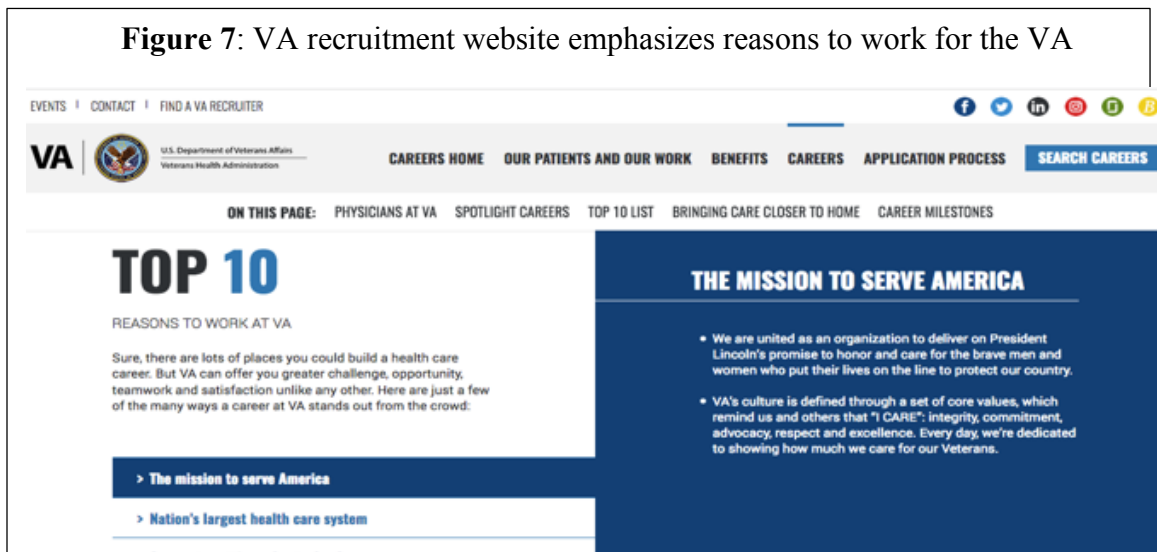


Of note are:

- 1) a simple, compelling message to immediately generate interest by highlighting the most attractive job features (e.g., sign-on bonuses, loan forgiveness)
- 2) easy to use search fields by job type and region
- 3) 800 number is listed and prominent to encourage direct contact with recruitment staff

The VA’s recruitment website also highlights key reasons to work for the VA, including its culture and core values (*Figure 7*).

Figure 7: VA recruitment website emphasizes reasons to work for the VA



Our review, as well as multiple interviews, raised concerns about the appearance, content, and functionality of the CCHCS recruitment website (<https://cchcs.ca.gov/careers/physician-careers/> Figure 8). These concerns apply to both the prior version of the website and the redesign, which was rolled out in the early months of 2019.



Compared with community websites, the CCHCS website:

- Integrates physician and APP jobs in with other positions such as cooks, pharmacy technicians, office administrators, and dental hygienists, rather than devoting a particular website only to physician and APP recruitment. In a very competitive recruitment market, this adds more complexity to searching for health care jobs and can have the unintended consequence of suggesting to potential applicants that special attention is not being paid to health care provider recruitment.
- Does not have any readily identifiable recruiter contact information on the primary landing pages (although it does on position-level pages), again making it more difficult for potential recruits to connect with a recruiter.
- Does not advertise excellent salary and benefits on the first landing page, despite these being very attractive aspects of CCHCS PCP positions.
- Does not reflect many of the core motivations of current health care providers in its mission-driven messaging. For example, the interviewees we spoke with stated that their reasons for working at CCHCS included dedication to social justice and a commitment to working with underserved patients.

In addition to conducting an analysis of CCHCS' and its competitors' websites, we also sought chief physicians' and current PCPs' opinions about the CCHCS jobs website. These key stakeholders expressed several additional concerns, including that current job listings were not accurate and that the website's current user interface lacked functionality and ease of use.

"When I have looked on the web site the job postings are not commensurate with the actual jobs that are available."
-CCHCS Clinical Leadership

Recommendations: CCHCS PCP Jobs Website
<ul style="list-style-type: none">⇒ Prioritize hardest to fill positions using a dedicated page exclusively for physician and APP recruitment⇒ Boldly highlight competitive salary and comprehensive CCHCS benefits package for PCPs on the earliest landing pages of the website⇒ Draw attention to recruiter contact information on each recruitment page (e.g., recruiter email and phone number)⇒ Ensure ease of use (should be functionally user-friendly); consider asking recent recruits about their perception of website's usability and making necessary adjustments⇒ Mission-driven focus should accurately reflect the motivations of current high-quality providers and be featured more prominently (<i>see longer discussion of this below</i>)

1b. Advertisements: An important focus on mission is lacking

Advertisements are a standard recruitment strategy typically designed to generate interest in a target demographic (e.g., mission-driven early-career physicians) and drive traffic to a website or recruitment center. As shown in the websites above, mission-driven messaging is standard among CCHCS competitors such as the VA and Kaiser Northern California. Figures 10 - 12 (*see next page*) show further examples of mission-driven web-based advertising from the VA and IHS. These advertisements make emotional appeals to potential future employees by highlighting the meaningfulness inherent in working with veterans or Native American communities, making them feel that their career ambitions can be met in a like-minded, supportive clinical environment.

Figure 10. Mission-driven web-based advertising from the VA



Figure 11. Mission-driven web-based advertising from the VA



Figure 12. Mission-driven web-based advertising from the IHS

Medicine

Indian health physicians focus on primary and family care within the communities we serve. There is ample opportunity – and pressing need – for physicians practicing a wide range of specializations. For a list of specialties, visit the [IHS Physicians Careers](#) website.

Nursing

Indian health nurses practice as generalists on a medical/surgical or outpatient/ambulatory unit, as well as pursue opportunities in a wide range of specialty areas. For a list of nursing specialties, visit the [IHS Nursing Careers](#) website.

Optometry

Indian health optometrists are actively involved in direct patient interaction and outreach, incorporating facility-wide activities such as quality assurance, infection control, safety and adhering to all HIPAA rules as part of their practice. Visit the [IHS Optometrist Careers](#) website for more information.

“It’s our job to keep people well and the medical care we provide is outstanding. I make home visits to people who are newly born, people who are dying and everyone in between. I have gotten to know the community and to earn their trust. I’m so proud of what I do.”

– IHS Nurse
IHS Loan Repayment Recipient

In the current competitive job landscape, CCHCS must highlight the deeply-held convictions about their work that motivate current high-quality PCPs. Our interviews with CCHCS providers revealed them to be a superbly mission-driven group. During our interviews, PCPs’ motivations for working with incarcerated patients included:

- dedication to social justice;
- commitment to working with underserved populations;
- passion for clinical complexity common among incarcerated patients; and
- strong desire to work in a single-payer system.

“In a room full of CMEs, overall we are committed to social justice. I think we also like single-payer, the complexity of care, proximity to specialists. Those are things I think of when I speak to potential recruits.”
–CCHCS CME

CCHCS runs a range of advertisements in print and digital media highlighting reasons a PCP might choose to work for the organization. While some adequately reflect CCHCS’s advantage as a single-payer system, other advertisements miss important opportunities to communicate the motivations identified in our interviews with current dedicated CCHCS PCPs (for examples, see *Figure 13* and *Figure 14*).

In addition to failing to reflect the mission-driven motives of current CCHCS employees, these ads also do not effectively distinguish CCHCS from other potential employers. Every health system in California is currently looking for providers passionate about primary care (*Figure 14*),

Figure 13: CCHCS advertising in *New England Journal of Medicine* does not reflect current PCPs’ motivations for working with CCHCS



New England Journal of Medicine (NEJM)

Figure 14: CCHCS recruitment ad in *ACP Internist Magazine*

What Kind of Doctor Works in Corrections?

The Kind With a Passion for Primary Care.

As an IM/FP physician, you know basic primary care is important - and anything but basic. Nowhere is this truer than at California Correctional Health Care Services (CCHCS). Here, our primary care physicians assess, diagnose, and treat a wide range of chronic and acute conditions.

Whatever your professional interest, CCHCS can help you continue to hone your skills in public health, disease management and education, addiction medicine, and so much more. All without the burdens of battling insurance companies or unrealistic RVUs.

Physicians

\$276,684 - \$290,520	(Time-Limited Board Certified)
\$262,824 - \$275,976	(Lifetime Board Certified)

Plus, with great State of California benefits, including a 40-hour workweek and CME stipend with paid time off to attend, you'll finally find a positive work-life balance.

- Doctors at select locations receive additional 15% pay
- Robust 401(k) and 457 retirement plans - tax defer up to \$48,000 per year
- Secure State of California pension that vests in five years

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Contact Donny Richardson, (916) 691-3155 or CentralizedHiringUnit@cdcr.ca.gov
Visit us online at www.cchcs.ca.gov

f in EOE

ACP Internist - 10/18

and providers who would cite a passion for primary care as the chief factor in their employment decisions are unlikely to be drawn to practice in the unique CCHCS setting.

In interviews with CCHCS recruitment personnel, we found that many failed to identify social justice as a primary motivator among health care providers who might choose to practice in the CCHCS. Recruiters' lack of insight into current employees' motivations suggests an important opportunity for CCHCS to engage their recruiters with successful, dedicated PCP employees to better understand their motivations for pursuing and continuing their careers in CCHCS. Furthermore, basing recruitment messaging on current staff values and culture has important positive downstream implications for PCP retention.

As described earlier in this report, recruitment for PCPs in California and across the U.S. is highly competitive and is unlikely to become less competitive in the years to come. CCHCS' competitors are already using mission-driven messaging across their advertising platforms. By failing to highlight the heartfelt motivations of current PCPs, and effectively distinguish the benefits of working in the unique correctional environment, CCHCS is missing a critical opportunity in its recruitment efforts.

"I'm really passionate about correctional medicine. My philosophy is that I believe in working with the most marginalized and underserved patients. And I'm very passionate about giving care concordant with a patient's gender and sexual identity."
-CCHCS APP

"The LinkedIn ads make me think they didn't ask the frontline docs what they think the main selling points of our jobs are."
-CCHCS CME

Recommendations: CCHCS PCP Recruitment Materials

- ⇒ Consider developing a PCP recruitment advisory group comprising current high-quality PCPs from around the system to provide input into recruitment strategies and content
- ⇒ Review advertisements with current high-quality PCPs to ensure advertisements are highlighting the motivations specifically identified by current PCPs
- ⇒ Identify core motivations of a range of current high-performing PCPs (via surveys, focus groups, interviews, etc.) and incorporate those findings broadly into recruitment efforts, including advertising
- ⇒ Highlight the opportunity to have a career dedicated to the pursuit of social justice in CCHCS advertising materials
- ⇒ Reference unique clinical complexity of the CCHCS patient population in advertising
- ⇒ Continue to highlight the relative ease of working in a single-payer system ("Medicine like medicine is meant to be") and the opportunity to work with underserved patients

1c: Conferences: A gateway to a career in correctional medicine with CCHCS

Many major health systems send recruitment representatives annually to relevant physician and APP conferences (such as the American Academy of Family Practitioners Conference). Presence

at these conferences serves to increase awareness of the employer, initiate contact with potential employees, and potentially to actively recruit job candidates.

CCHCS typically sends representatives (usually a CME and a recruiter) to about 10 conferences per year, including the major annual conferences for family physicians, internal medicine physicians, and osteopathic physicians. For comparison, IHS representatives attended 5 physician or APP-focused conferences in 2017,²⁰ and Kaiser Northern California sends representatives to more than 30 physician-focused conferences per year, although Kaiser is recruiting a vastly higher number of physicians encompassing the full range of physician specialties.²¹

An in-depth review of CCHCS's participation in these conferences is beyond the scope of this report. However, CCHCS appears to be putting appropriate resources towards this important recruiting tool. Concerns described above about messaging among recruiters suggest that CCHCS may benefit from an assessment of their communications and overall strategy at these conferences. CCHCS may also wish to consider direct outreach to medical residencies with a focus on providing care to underserved populations using a social justice framework (e.g., the family medicine residency at the University of California, Irvine). Additionally, CCHCS's continued presence at these conferences may be of particular import given that some involved in recruitment for CCHCS told us that many PCPs have simply never considered working in correctional health care.

Recommendations: CCHCS Conference Outreach

- ⇒ Actively recruit among current CCHCS PCPs to find those who are particularly passionate about representing CCHCS at conferences
- ⇒ Consider sending those CCHCS PCPs (rather than just CMEs) to represent CCHCS at annual conferences
- ⇒ Consider evaluation of which conferences tend to consistently yield a higher volume of recruitment contacts and stop attending those conferences which are low yield
- ⇒ Consider direct outreach to select university-affiliated residencies

1d. Teaching/Training Relationships: A promising component of the CCHCS PCP pipeline

Training relationships are a key component in building a workforce pipeline. Kaiser, the VA, and the Indian Health Service all have extensive health care trainee programs, including:

- Medical school rotations
- Residencies (post-medical school training for MDs/DOs as well as NPs) and residency elective rotations
- Fellowships (post-residency training for MDs/DOs)

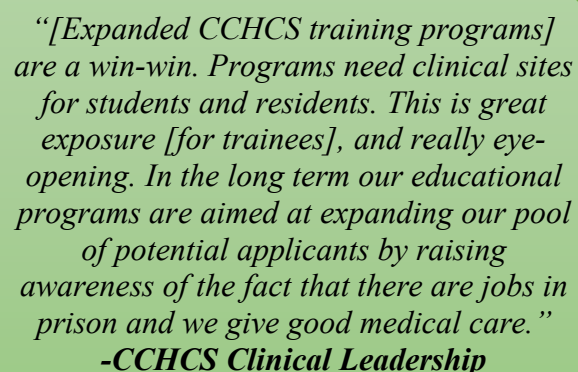
²⁰ <https://www.ihs.gov/retention/upcoming-events/>

²¹ <https://physiciancareers-nca.kaiserpermanente.org/events/>

In a published interview from 2007, Kaiser reported that 30% of former residents made a career working for Kaiser after graduation, and 15% of current Kaiser staff physicians had received at least some part of their training in a Kaiser-sponsored residency.²² This article also describes how health professions training programs have another important purpose besides developing the workforce pipeline: “the opportunity to teach is a great source of professional satisfaction.” The contribution of teaching to workplace morale and employee retention will be described in a subsequent report but this effect in itself is likely beneficial for recruitment as candidates are drawn to high morale workplaces.²³ Furthermore, many of CCHCS’ job competitors offer teaching opportunities as an attractive element of their positions.

In recent years, CCHCS has put new resources into developing training opportunities for medical students and residents. This includes the addition of a full-time staff physician in central office who coordinates educational programs across the state. In the 2017 - 2018 academic year, CCHCS hosted approximately 105 trainees (including medical students, nurse practitioner students, and medical residents) across 15 CCHCS correctional facilities. CCHCS is also in the early stages of developing a nurse practitioner residency program that aims to train up to 16 NP trainees per year across various facilities.

An NP residency training program could serve as an important pipeline for recruiting advance practice providers into the CCHCS workforce. In general, NP residencies hire from one third to half of their graduates into internal positions.²⁴ Given that there is an insufficient number of residency training programs for new NPs in general, CCHCS is well-positioned to create a new and fruitful recruitment pipeline through this program and should consider assessing the program for expansion within its first few years and/or structuring the program to optimize for recruitment. For example, one large NP residency in Connecticut has a one-year post residency employment commitment to ensure that new NP graduates join their work force for at least one year.²⁵



“[Expanded CCHCS training programs] are a win-win. Programs need clinical sites for students and residents. This is great exposure [for trainees], and really eye-opening. In the long term our educational programs are aimed at expanding our pool of potential applicants by raising awareness of the fact that there are jobs in prison and we give good medical care.”
-CCHCS Clinical Leadership

Career pipelines for health professions trainees are long; a medical student who rotates through CCHCS for training might not be seeking a job for another five years or more. The seeds of the current CCHCS training programs have just been planted and will require another three to five

²² Rasgon S. The importance of graduate medical education for Permanente physicians, Kaiser Permanente, and American medicine. *Perm J.* 2007;11(4):79-87.

²³ Savageau JA, Cragin L, Ferguson WJ, Sefton L, Pernice J. Recruitment and Retention of Community Health Center Primary Care Physicians post MA Health Care Reform: 2008 vs. 2013 Physician Surveys. *J Health Care Poor Underserved.* 2016;27(3):1011-32. doi: 10.1353/hpu.2016.0106. PubMed PMID: 27524748.

²⁴ Norwick, R.-M. (2016). "Family Nurse Practitioner Residency for Recruiting and Retention." *The Journal for Nurse Practitioners* 12(5): e231-e233.

²⁵ Personal communication, Kerry Bamrick, Community Health Center Postgraduate Residency Training Programs Director, email 2/20/2019.

years to bear fruit. We strongly support CCHCS continuing to invest in this area, including ongoing evaluation of the costs and benefits to current PCPs who participate in working with trainees.

Finally, educational programs in CCHCS will need to be designed within the context of CCHCS' larger vision for its future PCP workforce. For example, particular rotations could be developed to expose trainees to rural locations or telemedicine practice sites, depending on the ultimate vision for primary care workforce expansion.

Recommendations: CCHCS Health Professions Training Programs

- ⇒ Continue supporting expansion of CCHCS health professions training programs
- ⇒ Consider requiring a 1-year paid employment commitment following completion of the CCHCS NP residency
- ⇒ Design and implement educational training programs to be in strategic alignment with CCHCS' broader workforce composition goals

2. Hiring Process

Once initial contact with a potential PCP candidate has been made via an advertisement, website, conference, or training program, the next step is for a recruiter to begin a conversation with a candidate to exchange information and determine if there is a good mutual fit. These conversations include discussions about base salary and special hiring incentives (e.g., loan repayment and hiring bonuses). During our conversations with current CCHCS staff, three areas of concern regarding the current hiring process arose. These areas include factors related to (2a) contact with recruiters, (2b) pay for advance practice providers, and (2c) PCP incentives.

2a. CCHCS Recruiter Performance: PCP candidates need special attention from recruiters

Our review of community physician recruitment practices, including interviews with community-based physician recruiters, confirm what a VA physician recruitment specialist told us: "Physician recruitment is special."

Unlike recruitment in some other fields, physicians are accustomed to a "white glove" recruitment experience. This recruitment style is characterized as:

"An experienced recruiter will already know that if a physician emails, that email should be responded to within a matter of hours."

-VA Recruiter

- Extremely personal, including lengthy conversations with each PCP candidate to determine their professional *and* personal interests as well as their family needs
- Rapid, with follow-up occurring within hours to days after they express interest

- Very high touch, with frequent (e.g., at least weekly) follow-up

Within CCHCS, the bulk of PCP recruitment is done by a small handful of recruiters based in Elk Grove. This group of recruiters manages recruitment for different types of health care professionals, including mental health care providers (e.g., psychiatrists and psychologists), dentists, advance practice providers, and physicians. This is in contrast to the private sector, where a professional recruiter often recruits only one type of provider (e.g., physician) or in some cases only one type of physician. For example, at Kaiser Northern California different recruiters split responsibility for different types of physicians. One recruiter is responsible for recruiting family doctors, and a separate recruiter is responsible for surgical subspecialists (such as urologists or neurosurgeons).²⁶ This specialization allows recruiters to develop knowledge of the likely interests, concerns, and needs of a sub-set of highly in-demand providers and build a professional network relevant to that same sub-set.

“With a [new PCP] coming in I cannot just rely on headquarters to do their business. I am personally calling [the new PCP] up and sending them ideas about places to rent out....if I want someone to relocate they need to feel wanted. I can’t expect someone in Elk Grove to take care of someone relocating.”

-CCHCS Clinical Leadership

“I have sent monthly emails to the recruiters and I am still trying to get an initial interview for a candidate”

-CCHCS CME

In addition to how recruiters are assigned, follow-up times were another concern that surfaced in our facility-level interviews. Multiple informants described significant recruiter delays in response to emails from prospective employees, or long wait-times for follow-up after initial emails had been sent or after applications had been submitted. People we spoke with in the recruitment office state they are familiar with these concerns from the frontlines but that they have not been substantiated. (Relevant data, to our knowledge, is not kept and a detailed review of recruiter practice in real time is outside this project’s scope.)

While staffing of the CCHCS recruitment group has increased in recent years, and it is currently expanding from three to four recruiters, the team still faces a quantity of recruitment described as “daunting” by one current recruitment employee. Recruiters themselves and facility and regional leadership felt they are insufficiently staffed to compete with the private sector.

“Our in-house team is very capable of bringing physicians to a metropolitan area. We are not large to enough to give physician recruitment for rural positions the attention it deserves.”

-CCHCS Recruitment Staff

The VA has faced similar issues with recruiter performance. As at CCHCS, most physician recruitment in the VA has historically been done by human resources personnel rather than career physician recruiters. To address this discrepancy – and out of concern for persistently high physician vacancy rates – since 2011, the VA has run a novel program called the National Recruitment Program. Through this program, each VA region has a professional recruiter hired

²⁶ <https://physiciancareers-ncal.kaiserpermanente.org/career-opportunities/>

specifically to assist with filling the most intractably vacant positions. This program included 19 physician recruiters as of May 2017; these specialists represent the VA at medical conferences, develop marketing materials, and directly help hire physician candidates into VA positions.²⁷

The VA’s professional recruiters are certified by the Association of Staff Physician Recruiters (ASPR), a common industry training program for physician recruiters. Currently no CCHCS recruiters are certified through this organization, reportedly due to monetary and time constraints.

In 2018, CCHCS tried to hire an external private physician recruitment agency employing a strategy similar to that of the VA. Despite issuing four different requests for proposals, stakeholders report difficulty in hiring a firm due to technical barriers with the state contract payment process.²⁸

In sum, our interviews revealed opportunities for improvement in both the quantity and performance of CCHCS recruitment staff. Recruiters and facility-level leadership agreed that central CCHCS recruiters do not have sufficient time to devote to recruiting for the hardest to fill positions, many of which are located in the most rural areas of California. Currently, time-to-hire and other recruitment metrics are in the process of being added to the CCHCS public dashboard. This further information will help delineate where, during the hiring process, slow-downs are occurring and, more importantly, may help recruiter management to meaningfully assess current recruitment strategies and performance.

“Regional execs have personally driven families around to show them what life would be like, but that is not something that we as recruitment HQ can get involved with due to our own time limitations.”

-CCHCS Recruitment Staff

“Physician recruiting is a high touch field. I would gladly say yes to hiring more recruiters at HQ.”

-CCHCS Recruitment Staff

²⁷ <https://www.gao.gov/assets/700/692661.pdf> and personal communication with VA Recruitment consultant David Aragon, 10/31/18.

²⁸ Reportedly the state financial structure is such that they cannot pay retainer fees, however, most top firms (like Merritt Hawkins) will require a retainer fee before they are able to begin recruitment work for the client.

Recommendations: CCHCS Recruitment Staff

- ⇒ Consider evaluation, certification, and additional training of recruiters
- ⇒ Consider some specialization among recruiters (though this may require a larger recruitment staff)
- ⇒ Hiring of additional recruiters or a private recruitment agency focused on the hardest to fill positions would be in line with community organizations and may be a promising strategy; this would likely require special financing given initial efforts at this contracting process have been unsuccessful
- ⇒ Facility-level leadership have low confidence in recruitment staff; this should be addressed to improve morale and to eliminate downstream consequences that may arise when facility providers feel compelled to dedicate more time than they have available to recruitment

2b. Advance Practice Provider Pay

In the competitive primary care landscape, salary is a critical factor in most candidates' employment decisions. While pay for CCHCS physicians is generally commensurate, if not better, than pay in the community, pay for some advance practice providers lags behind pay in some California communities where CCHCS institutions are located. (Our interviews did not reveal any major concerns regarding physician base salaries.) NP and PA pay will be addressed separately below, as PAs are generally paid less than NPs both in California and nationally.

Advance Practice Provider Pay: Focus on NPs

Trends in NP pay vary across California, likely linked to a variable cost of living and localized recruitment and retention challenges (Figure 15²⁹). The relatively narrow CCHCS range suggests that NPs in some areas of the state, particularly near large population centers, may be drawn away from CCHCS in favor of higher pay (particularly experienced NPs who may be at or approaching the CCHCS pay ceiling available in localities ranging from San Francisco and Los Angeles to Redding and Reedley).

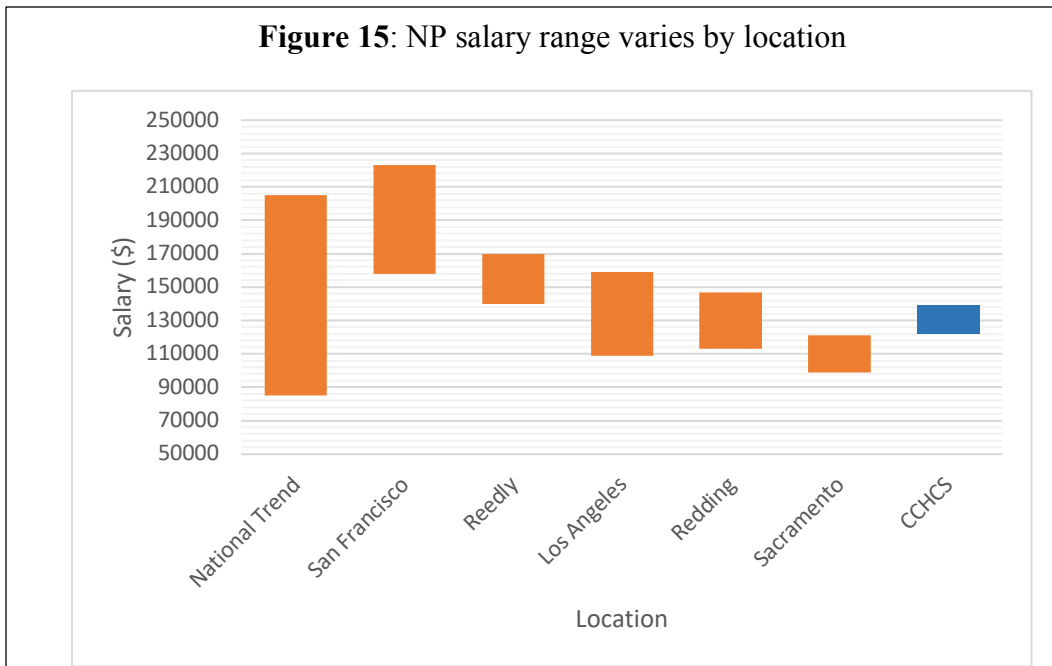
"I don't work for the CCHCS full time because I would have to take a 20% pay cut. We had a huge campaign a few years ago to correct the NP/PA pay scale and in the end we were told 'if you don't like the pay, go work somewhere else.' So I work two days a week in the community."

–CCHCS APP

²⁹ National trend data from Merritt Hawkins:

https://www.merritthawkins.com/uploadedFiles/Merritt_Hawkins_2018_incentive_review.pdf

Location data derived from a number of direct job postings (sources available upon request).



Advance practice providers and clinical leadership within the CCHCS are aware of pay discrepancies likely affecting the APP workforce in a number of facilities, both in hiring and retaining qualified providers. These perspectives were born out in our interviews with providers.

Multiple informants raised an additional concern surrounding NP pay: that nursing supervisors (who by definition have less medical training than NPs) can, and often do, reach higher pay levels than NPs. This internal pay imbalance appears to adversely affect not just hiring and retention but workforce morale among APPs.

Advance Practice Provider Pay: Focus on PAs

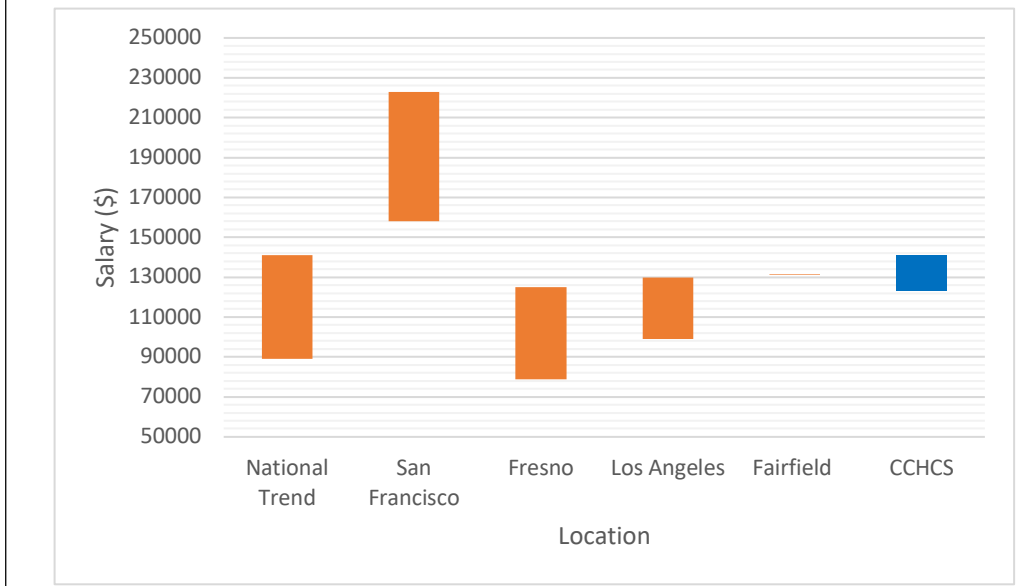
Pay for CCHCS PAs similarly lags behind pay in the community, however, the discrepancy is less pronounced as PA pay tends to be lower nationwide (Figure 16³⁰).

“Nursing (RN) supervisors make more than NPs, and NPs are extremely bitter about that. They feel like a tool used wherever the system sees fit to use them.”
-CCHCS CME

“Many of our NCPRs (nursing supervisors) are actually NPs but they don’t want to practice as NPs because they get more compensation than being regular RNs. It just doesn’t make sense.”
-CCHCS Clinical Leadership

³⁰ National trend data from Merritt Hawkins:
https://www.merritthawkins.com/uploadedFiles/Merritt_Hawkins_2018_incentive_review.pdf
 Location data derived from a number of direct job postings (sources available upon request).

Figure 16: PA salary range varies by location but is generally lower than NP pay



In our conversations with statewide clinical leadership, they noted that it was a priority to increase APP compensation but that this is a complex matter as all salaries must be approved by the California Department of Human Resources (CalHR).

“We are not competitive with APP pay in our region and it is really a terrible thing.”
-Regional Director

As highlighted previously, the future composition of the CCHCS workforce has yet to be determined. However, presuming that California’s statewide primary care workforce changes as anticipated, advance practice providers are projected to become a larger proportion of the primary care workforce overall. As such, less competitive pay may hinder CCHCS’s capacity to keep pace with community systems competing to recruit and maintain a qualified primary care workforce with a growing focus on APPs. Further, interviewees describe some apparent salary imbalances that they believe adversely affect CCHCS’ ability to retain its NP workforce, which in turn places pressure on PCP recruitment.

“We have been struggling to get APP compensation increased.”
-CCHCS Clinical Leadership

Recommendations: Advance Practice Provider Pay

- ⇒ Increase nurse practitioner pay so that it is at least commensurate with community pay in the relevant localities or regions
- ⇒ Consider increasing physician assistant salary in some localities or regions where PA recruitment is a CCHCS goal and PA pay is not competitive with other area opportunities
- ⇒ Review internal pay scales, including ensuring that advance practice provider pay is appropriate relative to RN supervisor positions

2c. CCHCS Recruitment Incentives: Not competitive with incentives offered by other health systems

In today’s highly competitive primary care landscape, in addition to a “white glove” recruitment experience, successful health systems offer competitive recruitment incentives to attract and retain qualified applicants. A review of several sample incentives offered by various health systems are provided in the chart below (*Table 3*).

Table 3: Recruitment Incentives of various health systems

Institution	Incentive Type	Description
CCHCS	Pay incentive	<ul style="list-style-type: none"> ▪ 15% higher pay for PCPs at 13 facilities
CCHCS	Relocation incentive	<ul style="list-style-type: none"> ▪ \$10,000 reimbursement for moving expenses
Kaiser Permanent	Hiring bonus	<ul style="list-style-type: none"> ▪ \$250,000 hiring bonus ▪ Employees must stay 7 years or have to pay back the bonus on a pro-rated basis³¹
VA	Rural sign-on bonus	<ul style="list-style-type: none"> ▪ Dollar amount depends on the specific region ▪ Disburses only after an employee has stayed 2-3 years
VA	Rural sign-on incentive	<ul style="list-style-type: none"> ▪ Contracted to relocate to a metropolitan area after 2 years of employment (*pending metropolitan position availability)
VA	Loan repayment	<ul style="list-style-type: none"> ▪ \$24,000 per year for up to \$120,000 over 5 years for difficult to recruit and retain patient care positions³²

³¹ Personal communication, Kaiser Northern California Employee, September 18, 2018.

³² https://www.vacareers.va.gov/Content/Documents/Print/EDRP_VA_Careers_Page.pdf

Indian Health Service	Loan repayment	<ul style="list-style-type: none"> ▪ ~\$40,000 for two years of service³³ ▪ Eligible to extend contract annually until qualified student debt is paid
Indian Health Service	Loan repayment	<ul style="list-style-type: none"> ▪ Supplemental loan repayment program allows facilities to take unused salary from vacant positions and offer it as loan repayment³⁴

Currently CCHCS offers no loan repayment options and no hiring bonuses. While it does offer 15% higher pay for PCPs at certain facilities, this location-based pay incentive is often viewed as inequitable and even counterproductive by current clinicians we spoke with as many view the determination criteria as arbitrary and some providers felt that it incentivizes internal transfers. Given that criticism of the 15% pay incentive was widespread, the incentive should be eliminated or qualification criteria should be more clearly explained to current employees and/or better aligned with goals clearly communicated in CCHCS’s broader vision for workforce composition.

“We need a retention bonus for people here 2 years, 4 years, 6 years. This is important because if you stay longer there is no increase in pay because your salary doesn’t go up like it does at Kaiser, although there are other benefits like the pension.”
-CCHCS Regional Leadership

Many providers at health care systems like CCHCS—which provide primary care in rural areas to underserved populations—qualify for student loan repayment through the National Health Service Corps, a federal loan repayment program. These awards range from \$30,000 to \$50,000 for a two-year service commitment.³⁵ Particular clinics and hospitals are awarded scores (called “Health Professional Shortage Area” scores³⁶) which determine loan repayment eligibility and quantity; facilities with higher scores receive higher levels of loan repayment. According to discussions with numerous CCHCS clinicians and leaders, due to technical aspects of the way the score is awarded no CCHCS PCP positions are currently eligible for National Health Service Corps loan forgiveness.

“If I had it my way I would pay the on-site physicians more than the telemedicine physicians.”
-Telemedicine Clinical Leadership

³³ <https://www.ihs.gov/loanrepayment/>
³⁴ https://www.ihs.gov/retention/documents/IHS_Recruitment_Toolkit.pdf
³⁵ <https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.html>
³⁶ <https://data.hrsa.gov/tools/shortage-area/hpsa-find>

Finally, while some CCHCS sites do offer flexible work hours (e.g., working four ten-hour days instead of five eight-hour days), this is not universally available at all institutions. Decisions regarding work hour flexibility are usually made at an institutional level by the CME and CEO. This was viewed as a significant incentive by most of the clinicians with whom we spoke and is recognized in the community as a further potential recruitment perk as many clinicians value the option to work fewer but longer shifts.³⁷

“Residents and students finishing training now want loan repayment. It is very arbitrary which facilities get National Health Service Corps designation. The prison could actually do loan forgiveness directly and that would be very helpful for a recent grad and might help us bring in more of those types of candidates.”
-CCHCS Regional Leadership

As with other aspects of recruitment, hiring incentives should ultimately correspond to a broader workforce composition vision and plan. For example, salary for telemedicine and on-site PCPs is currently identical, which was viewed as inequitable by some in leadership and/or as disincentivizing recruitment into on-site positions. If CCHCS wants to make a big push to recruit on-site providers, they should consider a base pay differential or bonus structure to specifically recruit for on-site positions. Such bonus structures can be leveraged to reward both initial hiring as well as retention.

Recommendations: CCHCS Recruitment Incentives

- ⇒ Implement CCHCS-specific financial incentives, such as hiring bonuses, retention bonuses, and loan repayment options
- ⇒ Investigate rural hiring bonuses or specific pay differential focused on long-vacant positions
- ⇒ Consider creating a base pay structure with different salaries for on-site and telemedicine providers
- ⇒ Consider phased elimination of or re-structuring the 15% pay incentive as presently it does not appear to be meeting its presumed objectives
- ⇒ Match recruitment (and retention) incentives to broader workforce composition goals and priorities

³⁷ <https://sullivancotter.com/attracting-and-retaining-physicians-through-benefits/>

IV. Summary

Over the past decade CCHCS has seen tremendous improvements in the quality of its primary care provider workforce. While the future primary care landscape is challenging due to a decreasing number of primary care physicians despite growing national need for such professionals, CCHCS is a highly desirable employer from the point of view of physicians and APPs committed to social justice, interested in working with underserved populations, and with a passion for clinically complex patient populations. Providers interested in working in a single payer system may also see CCHCS as distinctly attractive.

We believe the recommendations in this report will make CCHCS more competitive with comparable community integrated health care systems and will subsequently help it to attract the type of qualified and committed PCPs that will form the backbone of its workforce for years to come. Clarifying a workforce composition vision may help CCHCS determine which recruitment recommendations should be prioritized. For example, expansion of the APP workforce would likely be helped by focusing on NP pay parity and relevant CCHCS training programs. Recruitment of physicians to work on-site in correctional facilities might be best aided by further investment in advertising and recruitment outreach to conferences and social justice-oriented residency programs in California as well as changes in hiring incentives, such as implementation of hiring bonuses and/or student loan repayment options.

Regardless of what strategies are used to improve CCHCS PCP recruitment efforts, more communication with current providers and clinical leaders around the future of workforce composition and development will be an important piece of maintaining workforce morale and avoiding undue pressure on recruitment efforts associated with low retention. Relatedly, we found that current providers and clinical leaders were remarkably insightful – and consistent – in their reflections on CCHCS’ recruitment challenges and their proposals for solutions and/or areas of improvement. CCHCS leadership might consider routinely soliciting perspectives and ideas from the current workforce as they go forward, for example via surveys, focus groups, or “state of the workforce” town hall events.

As we have outlined, recruitment is comprised of a diverse range of processes, personnel, and advertising materials. Recruitment is just the first step of what will hopefully be a lengthy period of employment. Our next report on maintaining a qualified workforce will focus on professional practice evaluation of new and current PCPs.

V. Acknowledgements

We wish to acknowledge the numerous CCHCS employees who participated in the meetings, interviews, and email correspondence which were invaluable to advancing our understanding of CCHCS recruitment processes. We are particularly grateful for the candor and expertise of many CCHCS and community participants whose ideas around recruitment were essential to informing the recommendations in this report. We also wish to thank our research assistant Sanchala Sehgal, who contributed to the background research and figures contained in this document.

Appendix. Recommendations Summary

Maintaining a Qualified Provider Workforce: Recruitment
Recommendations: CCHCS Workforce Composition
<ul style="list-style-type: none">⇒ Develop a clear vision for workforce composition in order to effectively target recruitment efforts⇒ Consider involving key leadership and stakeholders in this process, including addressing the key questions regarding workforce composition provided here⇒ Implement a communications effort to anticipate and address concerns within the current workforce regarding the workforce composition and primary care vision ultimately endorsed by leadership
Recommendations: CCHCS PCP Jobs Website
<ul style="list-style-type: none">⇒ Prioritize hardest to fill positions using a dedicated page exclusively for physician and APP recruitment⇒ Boldly highlight competitive salary and comprehensive CCHCS benefits package for PCPs on the earliest landing pages of the website⇒ Draw attention to recruiter contact information on each recruitment page (e.g., recruiter email and phone number)⇒ Ensure ease of use (should be functionally user-friendly); consider asking recent recruits about their perception of website’s usability and making necessary adjustments
Recommendations: CCHCS PCP Recruitment Materials
<ul style="list-style-type: none">⇒ Consider developing a PCP recruitment advisory group comprising current high-quality PCPs from around the system to provide input into recruitment strategies and content⇒ Review advertisements with current high-quality PCPs to ensure advertisements are highlighting the motivations specifically identified by current PCPs⇒ Identify core motivations of a range of current high-performing PCPs (via surveys, focus groups, interviews, etc.) and incorporate those findings broadly into recruitment efforts, including advertising⇒ Highlight the opportunity to have a career dedicated to the pursuit of social justice in CCHCS advertising materials⇒ Reference unique clinical complexity of the CCHCS patient population in advertising⇒ Continue to highlight the relative ease of working in a single-payer system (“Medicine like medicine is meant to be”) and the opportunity to work with underserved patients
Recommendations: CCHCS Conference Outreach
<ul style="list-style-type: none">⇒ Actively recruit among current CCHCS PCPs to find those who are particularly passionate about representing CCHCS at conferences

- ⇒ Consider sending those CCHCS PCPs (rather than just CMEs) to represent CCHCS at annual conferences
- ⇒ Consider evaluation of which conferences tend to consistently yield a higher volume of recruitment contacts and stop attending those conferences which are low yield
- ⇒ Consider direct outreach to select university-affiliated residencies

Recommendations: CCHCS Health Professions Training Programs

- ⇒ Continue supporting expansion of CCHCS health professions training programs
- ⇒ Consider requiring a 1-year paid employment commitment following completion of the CCHCS NP residency
- ⇒ Design and implement educational training programs to be in strategic alignment with CCHCS' broader workforce composition goals

Recommendations: CCHCS Recruitment Staff

- ⇒ Consider evaluation, certification, and additional training of recruiters
- ⇒ Consider some specialization among recruiters (though this may require a larger recruitment staff)
- ⇒ Hiring of additional recruiters or a private recruitment agency focused on the hardest to fill positions would be in line with community organizations and may be a promising strategy; this would likely require special financing given initial efforts at this contracting process have been unsuccessful
- ⇒ Facility-level leadership have low confidence in recruitment staff; this should be addressed to improve morale and to eliminate downstream consequences that may arise when facility providers feel compelled to dedicate more time than they have available to recruitment

Recommendations: Advance Practice Provider Pay

- ⇒ Increase nurse practitioner pay so that it is at least commensurate with community pay in the relevant localities or regions
- ⇒ Consider increasing physician assistant salary in some localities or regions where PA recruitment is a CCHCS goal and PA pay is not competitive with other area opportunities
- ⇒ Review internal pay scales, including ensuring that advance practice provider pay is appropriate relative to RN supervisor positions

Recommendations: Recruitment Incentives

- ⇒ Implement CCHCS-specific financial incentives, such as hiring bonuses, retention bonuses, and loan repayment options
- ⇒ Investigate rural hiring bonuses or specific pay differential focused on long-vacant positions
- ⇒ Consider creating a base pay structure with different salaries for on-site and telemedicine providers

- ⇒ Consider phased elimination of or re-structuring the 15% pay incentive as presently it is does not appear to be meeting its presumed objectives
- ⇒ Match recruitment (and retention) incentives to broader workforce composition goals and priorities