HEALTH CENTER COMPREHENSIVE WORKFORCE PLAN

A Retention & Recruitment Plan Template







2022

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# INTRODUCTION

The Solutions, Training, and Assistance for Recruitment and Retention (STAR²) Center is a project of the Association of Clinicians for the Underserved (ACU). In July 2014, ACU received funding under the national cooperative agreement (NCA) program – now referred to as the National Training and Technical Assistance Partners (NTTAP) program – to develop a clinician workforce center for retention and recruitment at health centers (HCs) (e.g., community health centers (CHCs), federally qualified health centers (FQHCs), migrant health centers (MHC), health care for the homeless (HCH) health centers, public housing primary care (PHPC) health centers, teaching health centers, look-alikes, etc.). In partnership with the Federal Bureau of Primary Health Care (BPHC), ACU created the STAR² Center – pronounced Star Center – to provide free resources, training, and technical assistance to HCs facing high workforce needs. In 2016, ACU subcontracted John Snow, Inc. (JSI) to assist in research, training, and designing resources and tools to support the STAR² Center, including developing the Retention & Recruitment Plan Template and its accompanying documents originally prepared by Patricia DiPadova, MBA at JSI. In 2022, ACU updated these resources, which included changing the name of the tool from the HC Provider Retention and Recruitment Plan to the HC Comprehensive Workforce Plan (CWP), which includes an instructions guide, a template, and an action plan. The HC CWP is meant to be a working, living document that users can easily modify to stay up-to-date with the changing workforce needs of HCs and the evolving healthcare environment.

This revised version pays additional attention to and includes more in-depth detail in the area of diversity, equity, and inclusion (DEI). DEI should be embedded in every step of the retention and recruitment process. Thus, the template does not include a separate DEI section. Guidance on how to incorporate a DEI lens in all workforce efforts is provided throughout the document. The template addresses opportunities to increase diversity in recruitment by expanding outreach to professional communities led and leveraged by underrepresented healthcare professionals. It includes steps to eliminate bias in hiring by establishing and training hiring committees that represent the diversity your organization seeks across its workforce. It addresses equity by outlining the importance of conducting regular pay equity audits. Additionally, it focuses on inclusion by identifying professional development and organizational advancement opportunities, such as mentorship programs, to support staff members who might not have the same access to professional growth as those with more privileges. You can also review the STAR2 Center resource, [Building an Inclusive Organization Toolkit](https://chcworkforce.org/web_links/building-an-inclusive-organization-toolkit/), for more information on how to guide and create a HC with these principle at its core. ACU continues its commitment to DEI through its [Justice, Equity, Diversity, and Inclusion (JEDI) Initiative](https://clinicians.org/programs/justice-equity-diversity-inclusion/), which serves as a resource for individuals, organizations, and other healthcare stakeholders interested in advancing JEDI principles.

# HOW TO USE THIS RESOURCE

The purpose of the HC CWP document is to provide a structure and a process for improving retention and recruitment practices in your organization. This resource is available as a Microsoft Word document to make it easier for HCs to customize it for their own needs. The HC CWP document contains an instruction section, a template, and an action plan worksheet. The tool begins with instructions that explain each section of the template and provides examples of how to fill out the different tables available in the CWP template. Each major item in the template is then included in the action plan worksheet. If parts of the document do not apply to your organization, simply skip them. Some parts, such as the assessment and the retention sections, might be completed by administrative staff, while the human resource department and/or recruitment team might choose to complete the recruitment section using the information gleaned from the assessment and retention sections. A separate Excel document, titled [Candidate Tracking Sheet](https://chcworkforce.org/web_links/acu-health-center-provider-retention-and-recruitment-plan-template/), is available to provide a convenient system for tracking applicants throughout the recruitment process including the initial application, interview, onsite visit, and final hiring decision. The action plan worksheet is for documenting identified gaps or barriers, opportunities, and strategies for addressing unmet needs that arise as a result of completing the CWP. It also assists in quality improvement efforts for retention and recruitment.

If you have questions about this tool and would like to access our other resources and services, please contact the STAR² Center at [info@chcworkforce.org](mailto:info@chcworkforce.org); call us at 1-844-ACU-HIRE (1-844-228-4473); or visit our website at [www.chcworkforce.org](http://www.chcworkforce.org).

# COMPREHENSIVE WORKFORCE PLAN DEFINITION

****A CWP describes the process for which a HC assesses the needs of its patients and community while identifying strategies for building and sustaining its capacity to support those needs through qualified personnel that embody mission-driven, equitable, and inclusionary values. The CWP is a dynamic document that requires regular review to address the evolving needs of your HC’s workforce, patients, and community. Optimally, an annual review is recommended, but the frequency is dependent on your HC’s needs and the rapidly changing workforce and healthcare landscape. The [Definition of a CWP](https://chcworkforce.org/web_links/comprehensive-workforce-plan/) along with examples for its various components is available as a STAR2 Center resource.

# INSTRUCTIONS

The instructions section of this resource details and defines each of the components of a CWP. It also includes examples for each of the tables available in the template portion of the document. When filling out the template, refer back to this section for more guidance on how to complete your HC’s CWP. As previously mentioned, this is a dynamic document – use the portions that apply to your HC.

## VISION

The vision serves as the foundation for your HC’s CWP. The goal is to think “big” and work in tandem with HC staff and patients to identify the current and future workforce needs of your organization and the community your HC serves.

Although related, a HC’s vision is not the same as its mission. The vision looks to the future and offers inspiration. On the other hand, the mission speaks to the organization’s current objectives and answers the question, “why does your HC exist?”[[1]](#footnote-1) [[2]](#footnote-2)

The following are examples of non-profit vision statements:[[3]](#footnote-3)

*Human Rights Campaign* – Equality for everyone.

*Oxfam* – A just world without poverty.

*Smithsonian* – Shaping the future by preserving our heritage, discovering new knowledge, and sharing our resources with the world.

## ASSESSMENT

The first step in any planning process is to assess your current situation and identify opportunities, barriers, and unmet needs. There are simple tools built into this template to assist you with this; however, the STAR2 Center has developed additional [tools and resources](https://chcworkforce.org/resources/) that are ideal supplements for your HC’s planning process.

The first is the STAR2 Center [Self-Assessment Tool](https://chcworkforce.org/web_links/acu-self-assessment-tool/) and its primary purpose is to help you identify strategies that may improve your success with workforce retention and recruitment. Using your responses, the tool provides brief recommendations on topics you might want to pursue and many of these focus areas have corresponding resources on the [STAR² Center](https://chcworkforce.org/resources/) website. In addition, the tool can inform the training and technical assistance provided to your HC. The report generated from this tool can be used with your individual HC retention and recruitment profile to paint a comprehensive picture of the workforce challenges your organization faces and identify next steps to effectively address those challenges.

Another tool is the STAR2 Center’s [Financial Assessment Tool](https://chcworkforce.org/web_links/star%c2%b2-center-financial-assessment-tool/) that helps you calculate estimated costs of provider vacancies and recruitment. This tool was created in Excel and can be downloaded for your HC’s use. If you do not have all of the input data available, the tool provides national estimates to assist you. It is crucial to assess turnover because it negatively affects so many aspects of a HC’s operations including quality of care, continuity of care, pressure on remaining staff from being short-staffed, loss of patients, increased family pressure if more time is spent working or covering shifts, and changes in referral patterns.[[4]](#footnote-4)

The STAR2 Center also offers a [Strategic Planning Workbook](https://chcworkforce.org/web_links/star%c2%b2-center-strategic-workforce-planning-workbook/) that focuses on ways to move your organization toward fulfilling its mission and achieving its vision and goals given the ever-changing healthcare environment. It outlines ways to analyze data and provides a framework for thinking strategically about present and future workforce needs. 

### PRACTICE ASSESSMENT

Any planning process should be built on a firm understanding of your practice. The best way to do this is to conduct a practice assessment. Without a comprehensive assessment of operations and staff needs, it is difficult to determine your true recruitment gaps. What appears to be a need for more providers or staff may actually be less than efficient practice models, lack of support, staffing shortages, etc. An assessment may also point to areas in need of improvement that, with a quality improvement process, may result in greater staff retention. Using the findings of the assessment, your HC can make an improvement plan to fill gaps and make corrections. In addition, your HC may consider different retention and recruitment strategies depending on the findings of the assessment.

Once your HC collects its assessment findings and makes the necessary adjustments to its retention and recruitment efforts, it is important to continue to test the new and/or improved workforce strategies. Again, this means regularly assessing the efficacy of these strategies, policies, and initiatives to ascertain whether the results were favorable in improving your HC’s workforce retention and recruitment efforts or if other changes are necessary.

The following implementation questions may help guide the process of analyzing successes and identifying growth opportunities for your HC’s strategies, policies, and initiatives. Although regular review at a three-month, six-month, or year mark is recommended, the frequency should be based on your HC’s needs and resources.

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#### Provider Capacity & Demand

The amount of demand on a provider’s production metrics can result in dissatisfaction. A provider with low demand may feel disengaged or unfulfilled, while a provider experiencing too much demand may feel overworked and ultimately burnout. While patient care is moving toward other models that are not primarily based on patient visits, this transition is still underway. Patient visits remain the predominant measure of provider productivity; however, it is important to assess productivity in a holistic manner. This is especially true when identifying the ways healthcare providers from historically marginalized populations establish the patient-provider social concordance. Assessment results that indicate longer patient visits should not be viewed as an indication of poor provider productivity. In fact, longer patient visits often yield better quality of care, increased collaborative decision-making with patients, and more detailed electronic health record (EHR) notes. If the assessment remains solely tied to the number of patient visits, it runs the risk of increasing pressure on the provider to demonstrate value based on one metric and not a broader category of important factors.

As mentioned, patient visit data is one of the many metrics used to help assess provider capacity and demand. Below you will find the Provider Productivity Tables (Table 1a and Table 1b). These tables serve as a mechanism for a gross assessment of a provider’s productivity based on clinical visits. The benchmarks, comparison measures, and definitions for the information used to complete Table 1a and Table 1b are found in the [Uniformed Data System (UDS) Report](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020) and the [UDS Manual](https://bphc.hrsa.gov/data-reporting/uds-training-and-technical-assistance).

Comparing the individual productivity to UDS data offers a snapshot of how providers compare to national data for their specialty. If your HC is large enough, it is also useful to assess each specialty along with the individual provider. If you have more than one clinic, you should also analyze the individual providers by site. It is important to note that this comparison does not *explain* any variation in productivity for an individual provider, specialty, or clinical site; it merely shows that variation exists. It is a measure that should be reviewed in the context of your HC’s retention and recruitment needs.

Table 1a. Provider Productivity (Clinical Visits)

Measurement Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Name | Provider Type | Provider Specialty | FTE | Clinical Visits | Clinical Visits per 1.0 FTE | UDS Mean Clinical Visits per 1.0 FTE | Percentage Difference from Mean |
| (Last, First) | (Degree or Licensure) | (Area of Expertise) |  | Number of patients seen | (Clinical Visits ÷ FTE)  (Column 5 ÷ Column 4) | Use [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020)  (UDS Clinical Visits ÷ UDS FTE) | [ (Column 6 ÷ Column 7) - 1.0] X 100  \*Column 6: Clinical Visits per 1.0 FTE  \*Column 7: UDS Mean Clinical Visits per 1.0 FTE  \*\*A negative result indicates percent *below* the UDS mean; a positive result is percent *above* the national mean. |

Table 1b. Provider Productivity (Virtual Visits)

Measurement Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Name | Provider Type | Provider Specialty | FTE | Virtual Visits | Virtual Visits per 1.0 FTE | UDS Mean Virtual Visits per 1.0 FTE | Percentage Difference from Mean |
| (Last, First) | (Degree or Licensure) | (Area of Expertise) |  | Number of patients seen | (Virtual Visits ÷ FTE)  (Column 5 ÷ Column 4) | Use [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020)  (UDS Virtual Visits ÷ UDS FTE) | [ (Column 6 ÷ Column 7) - 1.0] X 100  \*Column 6: Virtual Visits per 1.0 FTE  \*Column 7: UDS Mean Virtual Visits per 1.0 FTE  \*\*A negative result indicates percent *below* the UDS mean; a positive result is percent *above* the national mean. |

You will need to use [Table 5: Staffing & Utilization](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020) of the UDS Report to complete Table 1a and Table 1b. Furthermore, make sure to review the available metrics on the UDS Report each year, as these are subject to change.

The following scenario provides a more in-depth example for how to complete and use the Provider Productivity Tables:

Two providers (Provider 1 and Provider 2) work at a HC, both in family medicine (FM). One works 1.0 FTE and sees 3,250 patients per year; the other works part-time, averaging 0.75 FTE, and sees 2,100 patients in a year.

To find the Visits per 1.0 FTE (clinical or virtual) for each provider, divide the number of patients seen by that provider by their FTE worked per year. For example, Provider 1 sees 3,250 patients, divided by 1.0 FTE. This one is simple because they work 1.0 FTE, so their Visits per 1.0 FTE are 3,250 – their total annual patients seen. Provider 2 works three quarters of 1.0 FTE at their HC, so we divide their annual patient visits of 2,100 by 0.75 FTEs. The Visits per 1.0 FTE of Provider 2 – how many patients they would see if they worked 1.0 FTE – is 2,100 divided by 0.75, which equals 2,800.

To compare these providers’ Visits per 1.0 FTE to the national mean, or average for their specialty, we would look at the [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2019) and find the “Family Physicians” (family medicine or FM) row. We would take the Clinic Visits number in column “b” (or the Virtual Visits in “b2” if we are looking at that comparison instead) and divide it by the national FTEs (column “a”). This gives us the UDS Mean Visits per 1.0 FTE for that specialty. In 2019, UDS Table 5 shows us the total FM national clinic visits were 18,233,695, and the FM national FTEs were 6,441.49. That means that in 2019, the UDS Mean Visits per 1.0 FTE for FM practitioners was 18,233,695 divided by 6,441.49, which equals 2,831 visits per FTE. This allows us to compare and see that Provider 1 is far above the national average, while Provider 2 is very close to it. This information is one detail in many to help understand if providers may be under- or over-worked, able to take more time talking with and counseling patients, or in need of additional support.

The Percentage Difference from the UDS Mean is found by dividing the provider’s Visits per 1.0 FTE by the UDS Mean Visits per 1.0 FTE for their specialty. The Visits per FTE for Provider 2 is 2,800. For 2019, the FM Visits per FTE average was 2,831. To find the percent difference for Provider 2 – what percent they were away from the national average – we divide 2,800 by 2,831. This gives us the decimal percentage, in this case, 0.99. We can subtract 1.0 from this number and then multiply by 100 to get it as a full percentage. A negative sign will indicate it is that percent *below* the national mean, while a positive number indicates it is that percent *above* the national mean. For Provider 2, we take 0.99, subtract 1.0, and get -0.01. We multiply that by 100 and get -1%. This means Provider 2 had just 1% *fewer* clinical visits than the national average.

Provider 1, however, saw 3,250 patients in their clinic, so the percentage difference from the national mean in 2019 is:

3,250 ÷ 2,831 = 1.15

1.15 - 1.0 = 0.15

0.15 x 100 = 15

Meaning that in 2019, Provider 1 saw 15% *more* patients in clinic than the national average. A result like this could mean Provider 1 is very efficient, but it could also mean they are overworked or not spending enough time talking with patients to make sure they have all the information and support they need. This is just one metric of many when assessing your HC’s operational, staffing, and workforce wellness needs.

Finally, a short note on virtual versus clinic visits. If you look at Table 5 on the UDS Report and compare 2019 to 2020, you will see a drastic difference in the numbers of virtual visits between those two years. When comparing your providers’ Visits per 1.0 FTE, do not forget to differentiate between virtual and in-clinic, and compare appropriately. You may want to analyze those numbers separately, based on the system you have for providing telemedicine (virtual) versus in-person (clinic) appointments.

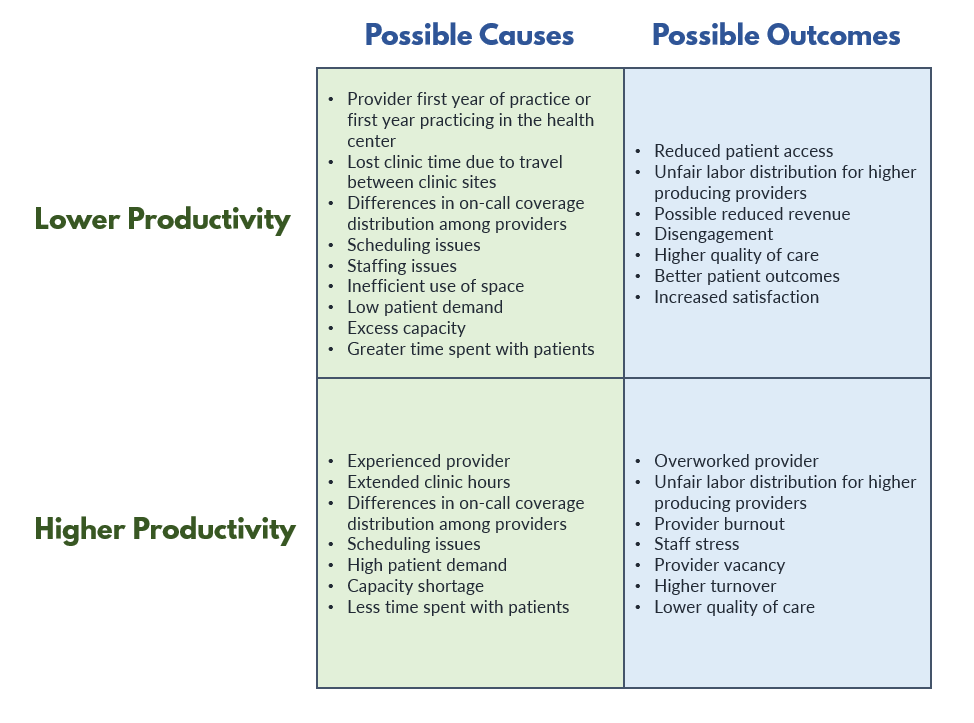
#### Productivity Analysis

Utilizing the findings from the Provider Productivity Tables (Table 1a and Table 1b), you can also conduct a productivity analysis. This analysis allows you to review any productivity that is significantly different from the UDS Mean Visits (as calculated in the Provider Productivity Tables) for each provider type and specialty. Very small FTEs (<0.10) may result in large differences due to the small number of clinic hours. You may want to focus on providers with an FTE of 0.4 or greater for meaningful differences. Note differences of more than 10 percent in either the positive or negative direction and explore reasons for those differences. Document this analysis in Table 2. Possible causes and outcomes of productivity differences are listed below in Figure A. This is not an exhaustive list and the causes and outcomes should be viewed holistically, with a DEI lens, and not as inherently negative or positive.

Table 2. Analysis of Productivity Differences

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider Name | Provider Type | Provider Specialty | Percentage of Difference from Mean | Possible Reasons for Difference |
| (Last, First) | (Degree of Licensure) | (Area of Expertise) | (Column 7 of Table 1a or Table 1b) |  |

Figure A. Productivity Differences – Possible Causes & Outcomes



#### Appointment Access

Patient demand on providers can also be measured through appointment access measures. This measure can help round out the productivity picture for providers. HCs with productive providers and long appointment wait times are at the high end of needing to recruit new providers. They are also at greater risk of losing their current providers due to overwork and increased stress. Patient appointment access should be measured using the [Third Next Available Appointment Method](http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx). A sample tool (Table 3) for collecting this data is included below. More information on the definition and collection of data using this method is available at the [Institute for Healthcare Improvement (IHI)](http://www.ihi.org/).

IHI defines the “third next available” appointment as the “average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.” IHI uses the term “third next available” appointment rather than “next available” appointment because it more accurately reflects true appointment availability.[[5]](#footnote-5)

Likewise, this method of assessing appointment access also aligns with the [National Committee for Quality Assurance (NCQA)](https://www.ncqa.org/) Patient-Centered Medical Home (PCMH) concept area, *Patient-Centered Access and Continuity*, which “guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.”[[6]](#footnote-6)

Many EHRs also have automated reports for the “third next available” appointment. If your EHR has reports that will generate this metric, validate once by calculating the data yourself and comparing it to the reports. Make sure the reports are set up with the same definition for “third next available” appointment.

In Table 3, appointment access for three main types of appointments - sick visits, routine follow up visits, and preventive visits – are measured for each provider and also separately for each provider team. The measures are compared to practice policies based on clinical norms and those set by the clinical practice. These policies set the norms for access, which may be as simple as defining the range for various appointment types (e.g., sick patients having access to clinical care the same or following day, routine follow up appointments within one week, and physicals within two to three weeks). The access measures should only include those appointments available to the person scheduling the appointment. Appointment slots requiring triage or requests to the provider should not be included as available.

Table 3. Weekly Appointment Access Report Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Third next appointment | | |  |  |
| Specialty  (medical, dental, behavioral health, vision) | Provider Name | Provider Type | Appointment Type | Date | # Days Provider | # Days Team | Meets Written Policy  (Y/N) | If No, Reason/Corrective Plan |
| Family  Medicine |  | | Sick Visit |  |  |  |  |  |
| Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 1 | MD | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 2 | DO | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 3 | PA | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Pediatrics |  | | Sick Visit |  |  |  |  |  |
| Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 4 | MD | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 5 | PA | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Psychiatry |  | | Sick Visit |  |  |  |  |  |
| Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 6 | MD | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 7 | NP | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |

\*If the “third next available” appointment is the same day, report it as “0”.

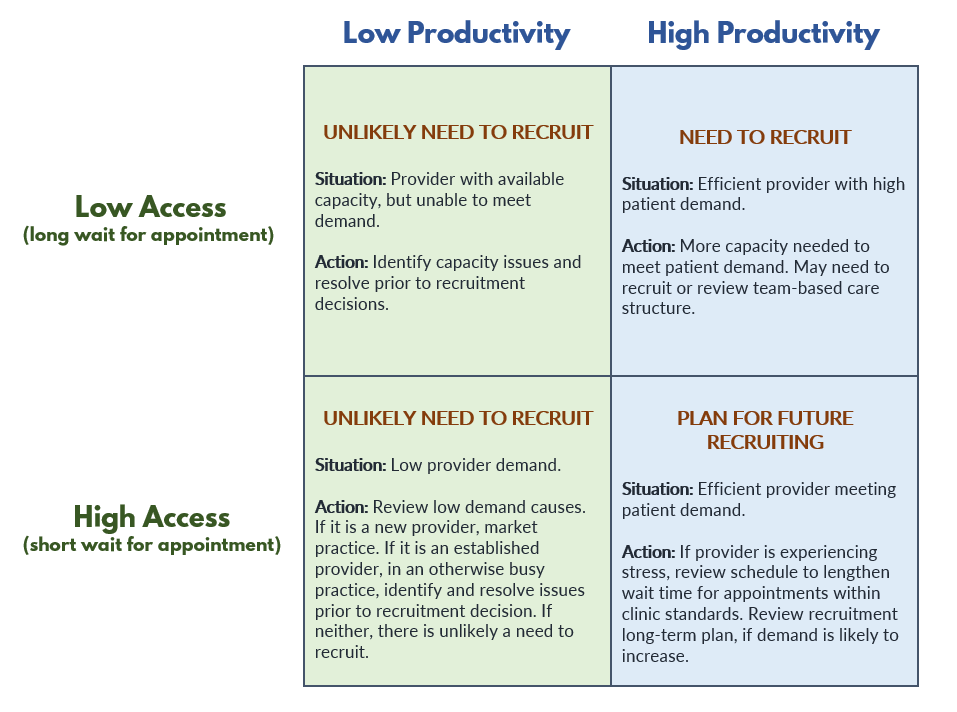
Appointment timeframes that consistently fall outside of policy guidelines need to be examined to determine potential causes. Long waits may not necessarily indicate a need to recruit, but may instead point to issues with provider schedules or appointment scheduling. Document appointment access issues and productivity by provider, team, or service in Table 4. Review whether the issues are due to capacity or other non-capacity related issues.

Table 4. Analysis of Appointment Access & Productivity

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provider Name | Team or Service | Access within Policy Limits | Productivity | Identified Capacity Gap | Other Non-Capacity Gap |
| (Last, First) |  | (Y/N) | Low (>10% Below Average), Average, High (>10% Above Average) |  |  |

Figure B shows the relationship between provider productivity and demand and suggests how you might use this information in making recruitment decisions for your HC. If a provider has high productivity and long wait times for appointments, this may indicate that there may not be enough capacity to meet patient demand. A provider with high productivity and short wait times for appointments may indicate an efficient provider who is meeting demand. If this provider communicates any stress, minor schedule changes may relieve the workload while still meeting patient demand. A provider with low productivity and long wait times for appointments may benefit from an analysis of appointment scheduling, available office hours, staff efficiency, adequate exam room space, etc. This provider has enough patients to increase productivity, but some factor or a set of factors is decreasing provider capacity. In this case, these issues should be identified and resolved prior to initiating a recruitment effort. It is possible that additional providers are not needed to expand capacity. A provider with low productivity and short wait times for appointments is likely a provider with a small patient panel or new to the field or practice. If this situation is occurring, in an otherwise busy practice, it should also be reviewed to determine the cause. If necessary, organizational and practice changes may be needed prior to initiating recruitment efforts. As stated before, keep in mind that providers do need time to provide adequate counseling and joint decision-making with their patients, and constructive provider-patient interactions should not be sacrificed for more “efficient” workflow.

Figure B. Relationship Between Provider Productivity & Patient Appointment Access



#### Care Teams & Provider Mix

Inter-professional care teams support a strong HC care model and can be a powerful tool in advancing provider retention and recruitment. This team structure plays a crucial role in the quality of care your HC provides its patients and serves as a fundamental part of the PCMH model as outlined in the various concept areas of the NCQA PCMH Recognition Program. These concept areas include the *Team-Based Care and Practice Organization*, which “helps structure a practice’s leadership, care team responsibilities and how the practice partners with patients, families and caregivers,” and the *Care Coordination and Care Transitions* that “ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.”[[7]](#footnote-7)

A review of the provider mix – the ratio of physicians to non-physician providers – can provide insight into potential problems and solutions related to retention and recruitment. Non-physician providers, such as nurse practitioners, physician assistants, and certified nurse midwives, play a critical role in meeting patient demand and providing high quality care in your HC. An adequately staffed care team, with a proper mix of physician and non-physician providers, can advance your HC’s care model and enhance retention and recruitment strategies. To assess your HC’s provider mix, document the ratio of total non-physician providers to total physicians in Table 5. For this table, do not include registered nurses or ancillary staff in the ratio. You can include a line per team, service, or site for more detailed information to better guide your recruitment strategies. Be sure to assess staffing ratios for all specialties and clinics at your HC, including behavioral health, oral health, and vision services.

Table 5. Ratio of Total Non-Physician Providers to Total Physicians

|  |  |  |
| --- | --- | --- |
| Date Assessed | HC Staffing Ratios | UDS Mean Staffing Ratios per FTEs |
|  | (Total NPs, PAs, and CNMs ÷ Total Physicians)  \*Based on your HCs staffing numbers | (Total NPs, PAs, and CNMs ÷ Total Physicians)  \*Use [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020), rows 10a and 8  (row 10a ÷ row 8) |

#### 

#### Support Staff

Maintaining a reasonable support staff to provider ratio, as well as using well-trained support staff appropriately, will aid in your HC’s retention and recruitment efforts. Without enough support staff, providers will not be as efficient, may have to take on additional work, may be dissatisfied with their positions, and may experience burnout. Overworked support staff is also unlikely to remain at the HC and similarly, experience burnout. Conversely, having too many support staff may result in inefficient use of HC resources that could serve other purposes.

Table 6 provides a way to compare the current staffing ratios for your HC’s support staff, which include nurses, other medical personnel, administrative staff, etc. Comparison should be made by provider specialty to yield the most accurate review of staffing levels. While staffing levels are unlikely to fall on the exact mean, these ratios provide some context for comparing whether your staffing is under or over other HCs and similar types of primary care practices. Adjustments in staffing ratios may increase productivity and quality of care. If these adjustments are necessary, you may want to put them in place and assess the impact prior to recruiting new providers or staff.

Table 6. Ratios of HC Support Staff to Provider Staff in Comparison to UDS Mean

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date Assessed | HC Support Staff | HC Provider Staff | Ratio of HC Support Staff to Provider Staff | UDS Support Staff FTEs  *\*will be a large number* | UDS Provider Staff FTEs  *\*will be a large number* | Ratio of UDS Support Staff to UDS Provider Staff per FTEs | Comparison of HC Ratio with UDS Ratio |
|  | Based on your HC’s staffing numbers  \*It can be individual support staff (ex: nurses); multiple support staff (nurses + laboratory personnel); or total support staff (may include administrative staff) | Based on your HC’s staffing numbers  \*It can be physician specialty, (ex: pediatricians); non-physician provider (physician assistants); total physicians or a mix of different physician specialties (family physicians + OBGYN); total non-physician providers or a mix of non-physician providers (ex: nurse practitioners + physician assistants) | Column 2 ÷ Column 3 | Use UDS Table 5  \*It can be individual support staff (ex: row 11, nurses); multiple support staff (row 11 + row 13, nurses + laboratory personnel); or total support staff (may include administrative staff) | Use UDS Table 5  It can be physician specialty, (ex: row 5, pediatricians); non-physician provider (ex: row 9b, physician assistants); total physicians or a mix of different physician specialties (ex: row 1 + row 4; family physicians + OBGYN); total non-physician providers or a mix of non-physician providers (ex: row 9a + row 9b, nurse practitioners + physician assistants) | Column 5 ÷ Column 6 | Column 4 ÷ Column 7  \*A number greater than 1 indicates you have a larger support staff to provider ratio than the national average; a number less than 1 indicates your ratio is lower than the national average. |

On a final note, these comparisons can be made for other departments, such as dentistry/oral health (the ratio of dental hygienists, dental assistants, and other dental staff to dental provider – UDS Table 5 rows 16-18), mental health (the ratio of mental health support staff to psychiatrists, clinical psychologists, and clinical social workers –UDS Table 5 lines 20a-20c), and vision services (the ratio of vision care support staff to ophthalmologists and optometrists – UDS Table 5 lines 22a-22c).

#### Scheduling

*Provider/Patient Schedules*

Provider patient schedules are comprised of several dimensions. The most basic is the overall schedule – the type and number of providers covering office hours on specific days and times. The second dimension is the time a clinical session starts and ends, including lunch breaks and administrative responsibilities. The third is the number and type of patients who are seen at any particular time during a clinical session. Likewise, provider schedules are determined by many factors – the days and times the office is open, support staff availability, exam room availability, provider specialty, patient panel demographics, and provider preference. Develop a plan for how your HC will evaluate its provider and patient scheduling to best fit its operational needs and those of providers, staff, and patients.

*Office Schedules*

The following graph (Figure C) of a HC’s office schedule shows the number of providers seeing patients by time and day of the week. In this schedule, the range of providers working on any given session varies from one provider to 18 providers. Even the peak times of each session have a variation of eight to 18 providers. This graph also shows that providers rarely work through an entire session, with peaks occurring at 9:30 AM and 1:20 PM and tapering off after those times. In this real example, support staff FTEs are relatively constant throughout the week, the number of exam rooms is constant, and patient demand is often unmet on Fridays. This type of a schedule can result in enormous stress on the practice system with support staff and room availability stretched beyond capacity during the busy sessions and provider satisfaction plummeting. In addition, productivity is reduced during peak times because patients cannot be roomed efficiently and have a longer wait for support staff attention. The sessions with lower numbers of providers can result in too few appointments to meet demand and potentially inefficient use of support staff.

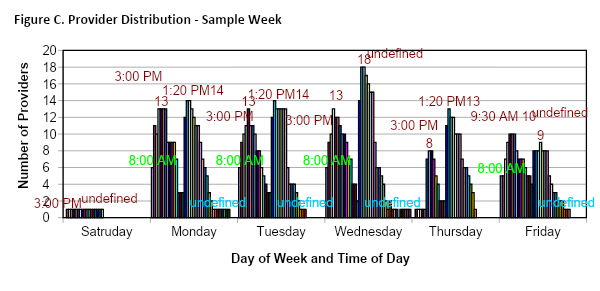


Table 7 is a tool to record and track the number of providers, support staff, and exam rooms for a one-week period. It may also be used as a tool to spot-check your HC’s schedule on a quarterly basis. Even in small HCs, there can be minor schedule changes or drift in schedule times that can disrupt patient flow and provider/staff satisfaction, and present a false picture of recruitment needs.

Table 7. Weekly Asset Matching – Providers, Support, Exam Rooms

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Team | | Monday | Tuesday | Wednesday | Thursday | Friday |
| AM | Providers |  |  |  |  |  |
| Support |  |  |  |  |  |
| Rooms |  |  |  |  |  |
| PM | Providers |  |  |  |  |  |
| Support |  |  |  |  |  |
| Rooms |  |  |  |  |  |

*On-Call Schedules*

On-call coverage, particularly for small or rural HCs, can be a major issue for both retention and recruitment. If call coverage is an issue at your HC, consider exploring the following strategies:

* Contract with a local practice to share on-call providers
* Contract with the local hospital for coverage
* Expand non-physician providers to include first tier call coverage with physician back-up
* Expand office hours during times with high call volumes, typically 7:00-9:00 PM, to alleviate stress on the covering provider

Be sure to accurately communicate your HC’s on-call coverage requirements to all providers during the recruitment process. This information is ideally included in the job announcement, but at a minimum should be addressed during the interview process.

#### Provider & Staff Satisfaction

Monitoring provider and staff satisfaction can help your HC avoid retention issues before they occur. By knowing what is working well and where improvements need to be made, your HC can respond to provider and staff concerns before they make a decision to leave. In addition, asking providers and staff about issues that are important to them shows your desire to work collaboratively and make improvements.

See below for a list of issues that may adversely affect workforce satisfaction and serve as potential barriers to retention and recruitment:

* Staffing: lack of training, lack of partnership between support staff and providers, ineffective staffing models
* Work load: often exacerbated by staffing issues, insufficient resources
* Management: need for better “facility flow” and infrastructure, lack of power to make improvements, staff feel unheard by management
* Financial considerations: salaries not competitive or equitable, lack of inclusive benefits
* Scheduling/vacation: inflexible schedules, lack of work/life balance
* Workplace culture: lack of wellness and mental health support, insufficient or no focus on DEI

While none of these issues are insurmountable, it does take strategic work to create meaningful, long-lasting change. The following are some topics to consider when addressing your HC’s workforce satisfaction. Keep in mind that this is not an exhaustive list and it is important to talk to your HC staff and ask them what they need and want.

* Invest in and focus on compensation and pay equity
* Sponsor periodic social gatherings for providers, staff, and their partners and families
* Conduct regular DEI training
* Focus on different staff wellness areas: emotional, financial, physical, and communication
* Conduct supervisor/leadership training to develop high-functioning managers.

Along with the previously mentioned topics, staff satisfaction surveys, stay interviews, and exit interviews are crucial to assessing the potential issues affecting your HC’s retention and recruitment efforts. It is important that your HC conduct staff satisfaction surveys and stay interviews on a regular basis – this can be every six-months, once a year, or another timeframe that works best. The goal is consistency and action. Staff should feel comfortable expressing their concerns in a staff satisfaction survey, given time during the workday to complete the survey, and be able to submit responses anonymously. Staff should receive the results of the survey and leadership needs to communicate action steps that address the survey results in a timely manner. Staff supervisors or the human resources department should conduct stay interviews on a regular basis – at minimum once a year. It should be clear to staff that they will face no workplace repercussions or penalties for sharing honest responses. On the other hand, exit interviews provide a chance to gain insight and feedback on issues that may not otherwise be identified, may be too sensitive for someone remaining in the practice to feel comfortable discussing, or if already identified, the information may help to prioritize issues.

The [STAR2 Center](https://chcworkforce.org/resources/) offers many resources to assist your HC in its work to improve provider and staff satisfaction. These resources include:

* [Clinician Wellbeing Resource Bundle](https://chcworkforce.org/bundle/burnout/)
* [DEI Resource Bundle](https://chcworkforce.org/bundle/cultural-competency/)
* [Compensation Resource Bundle](https://chcworkforce.org/bundle/compensation/)
* [Workforce Self-Care Resource Bundle](https://chcworkforce.org/bundle/workforce-self-care-resources/)
* [STAR2 Center Original Resources Bundle](https://chcworkforce.org/bundle/star%c2%b2-center-original-resources/)
* [STAR2 Center Talks Workforce Success Podcast](https://chcworkforce.org/web_links/star%c2%b2-center-chats-with-workforce-leaders/)
* [The Power of Stay Interviews Webinar](https://chcworkforce.org/videos/dick-finnegan-the-power-of-stay-interviews/)

### SUCCESSION PLANNING

Even at a well-staffed HC that has engaged and satisfied employees, it is essential to plan for the future to maintain a stable workforce. Keep in mind the aspirations of all staff when thinking about succession planning. It is important to discuss plans with staff on a periodic basis. Reaching the age of 65 is not necessarily indicative of retirement; many employees retire before or well after the age of 65, depending on their professional and personal needs. In fact, retirement is not the only concern. Your HC needs to also prepare for staff experiencing family changes that result in parental leave, decreases in FTE, staff returning to school, and many other circumstances. Work closely with your HC’s staff and communicate regularly when undertaking a succession planning process. Making these discussions a routine part of your workforce initiatives may help staff think about these issues and encourage more advanced planning. Having a plan in place helps to direct the conversation to the long-term plans of the HC rather than putting the onus on the individual. Use Table 8 to record your HC’s succession planning processes.

Table 8. Succession Planning (Retirement, Extended Leave, and FTE Changes)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Staff Member  Name | Department | Role in HC | Staff Member Age Range | | | Over Age 50 | | All Ages | |
| <50 | 50-65 | >65 | Discussed Retirement (Y/N) | Planned Retirement Age | Major Leave Plans | FTE Changes |
|  | \*document the department to help keep track of staffing needs, not just by position or role, but also by department |  |  |  |  | \*if there is other pertinent information from the succession planning discussion with the employee add it to this column |  | \*provide appropriate amount of detail to help with the success planning process | \*provide appropriate amount of detail to help with the success planning process |

## RETENTION

While one typically thinks of recruitment prior to retention, this resource is organized in a way that focuses on staff retention prior to undertaking staff recruitment. *The best strategy to minimize recruitment problems is to retain staff in the long-term.* Even if it is not possible to retain a current provider or staff member or if your HC is expanding and adding providers and staff, it is worthwhile to look at retention issues prior to undergoing a recruitment effort. If any challenges are identified, these may be resolved or, at the least, recognized prior to recruitment. Understanding retention issues can help your HC focus on recruiting candidates who enhance and advance your organization’s culture and environment.

### MISSION

A critical factor in advancing staff retention is maintaining an alignment between your HC’s mission statement and the beliefs and values of your HC’s staff. The mission should guide all decision-making processes at your HC, including its workforce initiatives. A mission is required for all non-profit organizations. It is crucial to revisit and revise your HC’s mission every few years to ensure that it remains true to your organizational objectives and accurately represents the values and beliefs of your HC. Work with your Board of Directors to a mission statement, and solicit feedback from all HC staff. Everyone in the HC should be involved in some part of the process including creating, reviewing, or providing feedback on the wording and meaning of HC’s mission. Your HC’s mission should be short, easy to read and understand, and accessible to all. The mission sets the tone for all of the work your HC does and it not only outlines the manner in which your HC treats its patients and community, but also how it values its workforce. Furthermore, taking a [mission-driven approach to retention and recruitment](https://chcworkforce.org/web_links/kansas-health-institute-rural-kansas-hospital-focuses-on-mission-driven-medicine-to-recruit-doctors/) can yield excellent results in finding the right candidates and retaining top talent at your HC.

The following are examples of non-profit mission statements: [[8]](#footnote-8)

*TED* – Spread ideas.

*The Humane Society* – We fight the big fights to end suffering for all animals.

*Human Rights Watch* – Defends the rights of people worldwide.

*Doctors without Borders (Médecins Sans Frontières)* – To provide lifesaving medical care to those most in need.

*American Heart Association* – To be a relentless force for a world of longer, healthier lives.

*Smithsonian* – The increase and diffusion of knowledge.

*The Alzheimer’s Association* – Leads the way to end Alzheimer’s and all other

dementia.

### COMPENSATION

It is essential for your HC to regularly review its compensation models to remain competitive and retain top talent.[[9]](#footnote-9) The overall compensation package should be competitive in your local market and equitable across race, gender, disability status, sexual orientation, and more. The STAR2 Center’s [Pay Equity Checklist](https://chcworkforce.org/web_links/pay-equity-checklist/) is a helpful tool for organizations getting started in the process.

If your HC identifies inequities or pay gaps in its compensation model, updating salary scales should be a top priority.[[10]](#footnote-10) Compensation equity serves as a crucial tool in the retention of staff, highlights your HC’s commitment to DEI, and illustrates the value and respect HC leadership has for its employees. Level-setting salaries should not be reserved for or given solely to providers or those in leadership positions; fair, equitable, and effective compensation structures should be available to every single employee at the HC, regardless of their position. As best as possible, adjust salaries to account for increases in living expenses and changing financial needs. This requires a commitment by leadership to conduct regular assessments of the HC’s compensation package.

Example:

Date: October 2021

Findings: Staff salaries reviewed by role/position and compared to U.S. Bureau of Labor Statistics (BLS), MGMA data, ACU’s Data Profile Dashboards, and local salary scales. Salaries for physicians are 20 percent below the local market, 10 percent below for non-physician providers, and 25 percent below for support and administrative staff.

Action plan: Effective January 2022, the HC will increase salaries by 15 percent per year for two consecutive years and reassess in October 2024.

#### Staff Incentives

Consider offering incentives as part of your HC’s overall compensation package to make it more appealing to current staff and potential recruits. Be sure to involve employees in the compensation planning process and to get their buy-in before adjusting your HC’s compensation model. Create compensation policies in advance of any changes, include the specific formulas and definitions your HC is using to undertake such changes, and ensure that staff understand the process. Test and assess those changes by conducting a “shadow” model in advance of the actual implementation, which means running a mock overhaul of the compensation process for a three- to six-month period to fully understand the impact of any revisions. Get feedback and adjust the model as needed prior to full implementation.

### BENEFITS

Similar to the compensation review, your HC should conduct a benefits review. Consider offering robust educational benefits to encourage retention and to promote quality improvement initiatives in your HC. Communicate on a regular basis with staff about the benefits package. Solicit input and feedback on the quality and usefulness of current benefits and assess recommendations for changes and additions. Use Table 9 to review your HC’s benefits package and document action steps for improvement. The first and second line of the table are completed as an example.

Table 9. Benefit Review

|  |  |  |  |
| --- | --- | --- | --- |
| Benefit | Details | Review Results | Action Plan |
| Vacation | 3 weeks; 4 weeks after 2 years; 5 weeks after 5 years | Competitive | None |
| Holidays | All federal holidays | No floating holidays | Add two floating holidays a year |
| Sick |  |  |  |
| Educational Leave |  |  |  |
| Educational Travel |  |  |  |
| Educational Conference |  |  |  |
| Health Insurance |  |  |  |
| Dental Insurance |  |  |  |
| Life Insurance |  |  |  |
| Disability Insurance |  |  |  |
| Vision Insurance |  |  |  |
| Loan Repayment |  |  |  |
| Retirement Plan |  |  |  |
| Parental Leave |  |  |  |
| Mental Health/Wellness Leave |  |  |  |
| Tuition Reimbursement |  |  |  |
| Other (specify) |  |  |  |

As you are assessing the benefits your organization offers, be sure to apply a DEI lens. The following are examples of ways to update benefits:

* Examine your holiday policy to ensure people with diverse cultural and religious backgrounds can celebrate their holidays through opportunities like floating holidays
* Think about bereavement leave policies and how the definition of “family” can differ across cultural identities
* Ensure your health insurance covers gender-affirming care to support transgender staff

There are countless ways to apply a DEI lens to your HC’s benefits package so that it is inclusive, welcoming, and encourages retention for all.

### 

### WORK SCHEDULES

A low- to no-cost strategy for staff retention and recruitment is work schedule innovation. Adequate clinical coverage and on-call coverage is the highest priority for HCs, but this is not always achieved with traditional full-time schedules. There are many advantages to part-time or flexible work schedules. For example, rather than hire a full-time provider, consider hiring two providers each working three days a week. This type of schedule can be attractive to parents of young children or older providers beginning to ramp down their schedules. It can also be beneficial by allowing two providers to overlap during busy times, such as Monday mornings, or stretch the clinic schedule to six days per week. This type of schedule can also provide built-in vacation coverage through job-sharing arrangements. Flexible, full-time schedules may accommodate evening call coverage and allow providers to take time off during the week. Longer days may also allow providers to have more days off during the week and at the same time extend the HC hours. Evening hours could be combined with on-call coverage to make more time available to providers. Likewise, hybrid or telework schedules are an essential retention and recruitment tool that gives other HC staff the flexibility they need, seek, and expect at their place of employment. Hybrid schedules that mix on-site and remote work can also add flexibility and support wellness. It is important to preserve patient access while also offering flexible work schedules. Be careful to assess the needs of patients, the schedule demands place upon support staff, and exam room availability before finalizing any provider schedule changes (see [Scheduling](#Scheduling)).

Indicate your HC’s schedule opportunities in Table 10. Be sure to document requests for flexible schedules that might be met as part of the larger retention and recruitment plan. The first and second lines of the table are completed as an example.

Table 10. Staff Schedule Types

|  |  |  |  |
| --- | --- | --- | --- |
| Schedule Type | Availability | Assessment | Action Plan |
| Part-time | Available | Three part-time staff | None |
| Job Sharing | Not available | No job sharing partner | Consider for next provider recruited |
| Flexible Schedules |  |  |  |
| School hours |  |  |  |
| Evenings |  |  |  |
| Weekends |  |  |  |
| Long days |  |  |  |
| Hybrid Schedules |  |  |  |
| Remote/Telework Schedules |  |  |  |

### CAREER PATHS

Employees are more likely to stay with an organization if there are opportunities for professional growth and advancement. Individuals from underrepresented or marginalized communities and groups may not have had the same opportunities as their more privileged peers. An equitable approach to career advancement is to provide professional development and advancement opportunities for employees who belong to underrepresented populations. For example, mentorship programs can be a two-way learning opportunity where underrepresented employees can learn new skills to support career advancement, while mentors gain new perspectives from the mentee. Laying out career paths and making employees aware of requirements and how to meet them to advance their careers is important for providing a transparent and accessible means of progressing in an organization.

Use Table 11 to indicate the types of professional growth and advancement opportunities currently available in your HC for providers and non-clinical or support staff. Also, document your assessment of each opportunity and the action steps your HC will take to incorporate professional growth and advancement into the practice. The first line of the table is completed as an example.

Table 11. Professional Growth and Development

|  |  |  |  |
| --- | --- | --- | --- |
| Type | Availability | Assessment | Action Plan |
| Clinical Oversight (other providers or clinical teams) | Mentorship program for new providers | Three year mentorship program with opportunities for career advancement into leadership positions | Continued assessment of its efficacy |
| Administrative Oversight (programs/services) |  |  |  |
| Teaching Opportunities |  |  |  |
| Clinical Students (i.e., medical, dental, behavioral health, vision) |  |  |  |
| Clinical Residents |  |  |  |
| Clinical Interns |  |  |  |
| Other clinical, technical, student, or volunteer |  |  |  |
| Leadership Opportunities (special projects, committees, community outreach, etc.) |  |  |  |
| Telemedicine Opportunities |  |  |  |
| Certification or Specialization Training Programs |  |  |  |
| Other (specify) |  |  |  |

### ORGANIZATIONAL CULTURE

A culture based on a strongly held and widely shared set of beliefs is the key to a successful organization. These beliefs should be supported by strategy and structure.[[11]](#footnote-11) A strong organizational culture can lead to a better understanding of employees’ roles and expected behaviors, as well as a strong sense of community, teamwork, and retention. Employers should lead their staff in creating and perpetuating a high-performing, culturally humble, and inclusive workplace. Values sit at the heart of organizational culture. Leaders can serve as the drivers and deciders of these values, which will help give direction and consistency.

#### Burnout

Burnout is often the culmination of multiple factors negatively affecting employees’ job satisfaction and resilience. Inequitable and insufficient pay, a workplace culture in opposition to or lacking DEI principles, excessive on-call time or overtime, inflexible work schedules, inadequate resources or staff, conflicts with management, and a lack of clear and accessible paths for professional growth and promotion can all cause or contribute to employee burnout and present a major challenge to retention.

While burnout can be a challenge to overcome, especially when it is widespread, there are resources available to help avoid or counteract burnout in the workforce. Examples of such resources are the [STAR2 Center Burnout Self-Assessment Tool](https://chcworkforce.org/web_links/star%c2%b2-center-burnout-assessment-tool/) and the [Mind Tools Burnout Self-Test](https://chcworkforce.org/web_links/mind-tools-burnout-self-test/) that help employees understand their likelihood of experiencing burnout while offering resources to help build resilience or recover from burnout.

#### Staff Wellness & Resilience

While often presented as an individual responsibility, it is not prudent or helpful to place the burden of resilience on the employee. Instead, your HC should build organization-wide mechanisms for staff wellness. A culture that fosters resilience is critical to creating and retaining a strong workforce and avoiding burnout. Building a culture of resilience and wellness begins with fostering an environment that actively solicits and responds to staff feedback. Leadership and management must also model practices that support resilience, such as healthy work schedules, practicing good communication, supporting employees with equitable pay, encouraging the use of paid leave time, flexible work schedules, and enacting policies centered on DEI principles. The goal should be to build a workplace culture that supports diversity and welcomes change rather than assimilation. It is imperative to understand that supporting employee mental health is paramount to building a resilient workforce capable of providing their community with the highest quality of care.

## 

## RECRUITMENT

Once your HC completes its assessment, reviews its retention efforts, and identifies the need to hire new staff, the recruitment process begins. It is a multi-step process with different components that build upon each other to ensure a smooth undertaking that results in the addition of mission-driven providers and staff who align with, enhance, and advance the HC’s mission, vision, values, and organizational operations. Below is a visual

depiction of the recruitment process and each of its components.

### COMMUNITY RECRUITMENT PLANS

Before you begin recruiting be aware of other planning initiatives in your region. Talk with or research the recruitment plans of local hospitals, other primary care providers or private practices, and reach out to your state or regional Primary Care Association (PCA). It is important to assess competition for providers and support staff and identify potential opportunities for collaboration. Make sure to conduct this assessment on a regular basis.

### RECRUITMENT TEAM

It is important to have the right people involved in the recruitment process to make sure you have the decision makers at the table to get buy-in and present your HC to a candidate in the best light. Establishing the recruitment team in advance provides structure and organization, allows staff to have input early on, and makes it easier to act quickly when a candidate expresses interest.

Your HC’s recruitment team should vary depending on the position being recruited. In addition to including staff from various disciplines and departments – medical, dental, behavioral health, vision, legal, etc. – members of the recruitment team should reflect the diversity of the community being served. Consider race, ethnicity, sexual orientation, gender identity, language, disability status, and culture. Having diverse representation and perspectives on the recruitment team can help mitigate potential bias when it arises.

To help eliminate bias in recruitment, it is important that all members of the recruitment team receive appropriate training. Trainings, such as the ones listed below, make it easier for team members to recognize bias and give or receive feedback.

Recruitment team training:

* Implicit bias/anti-discrimination training
* DEI principles and practice

#### Roles & Responsibilities

Establish clear roles and responsibilities for each member of the recruitment team, keeping in mind their stake in the recruitment process, their availability, and respective skills. For example, you may want to have a clinical support staff member be part of an interview and provide input, but this may be the limit of this person’s role. Whereas the Chief Medical Officer (CMO) or Medical Director may not wish to deal with the administrative responsibilities, but clearly needs to spend one-on-one time with final candidates and potentially be part of the screening process. A medical example of the recruitment team and responsibilities is detailed below in Table 12.

Table 12. Recruitment Team Members & Corresponding Responsibilities (Medical Example)

|  |  |
| --- | --- |
| Position | Responsibilities |
| CMO | With CEO, defines position, contributes to drafting ad; assists with screening calls; final interviews; visit dinner event |
| CEO/Administrator | With CMO, defines position; contributes to draft ad; assists with screening calls; final interviews; visit dinner event |
| Recruitment Staff *(may not have this title, but need to appoint someone in this role)* | Coordinate with recruiting firm (*if any*); draft final ad and coordinate with media and social media outlets; screening calls; coordinate all parts of visit and interviews; track candidates; develop and negotiate contracts; assist with moving arrangements and community connections (e.g., *schools, partner employment*) |
| Provider Team Members | Input defining position; contributes to drafting ad; final interviews and visit events, as necessary |
| Clinical Support Staff | Part of site tour and informal interviews during visit |
| Administrative Staff | Support recruitment staff; potentially part of site tour and informal interviews during visit |
| Community Member | Potentially part of final interviews; visit dinner event |
| Provider Team Partner | Provide assistance and support to candidate partners/families; lunch with partner |

### RECRUITMENT PRIORITIES

Define a “big picture” written set of priorities to guide your recruitment plans. Use the information gleaned from the [Practice Assessment](#PracticeAssessment) and [Succession Planning](#SuccessionPlanning) process to identify job vacancies and develop realistic timelines for completing the recruitment process. Document these findings in Table 13. Plan as far out as you have information – at least three to five years. Dates do not need to be static, so use the information you have to the best of your ability. For example, if you have a physician who has indicated they plan to retire in five years, include that information. While their retirement plans could change, including this information in your HC CWP is a reminder to ask them about their retirement goals and refine the information as the date approaches.

When setting priorities, consider the length of time it could take to fill each position and plan for adequate time to fill expected vacancies. [The Association for Advancing Physician and Provider Recruitment (AAPPR)](https://aappr.org/) defines “days to fill” as the “difference between the date a search was initiated and the date a contract was signed.” According to the *AAPPR In-House Physician Recruitment Benchmarking Report 2019 Executive Summary*, the average days to fill a primary care physician position was 149 days in 2018 and 62 days for an advanced practice position. Provider shortages and other societal factors continue to fuel large delays in filling provider vacancies. The length of time to fill vacancies in HCs, especially those in rural areas, may be significantly higher. “Days to fill” data comes from organizations with in-house staff recruiters and does not include the positions that go unfilled.[[12]](#footnote-12) [[13]](#footnote-13)

Diversity among employees and leadership should be a priority for HCs. The goal is to have a staff composition in which the demographics match that of the patient population. If your HR lacks adequate representation, consider diversifying your recruitment outreach. The STAR2 Center’s [Building an Inclusive Organization Toolkit](https://chcworkforce.org/web_links/building-an-inclusive-organization-toolkit/) provides examples and tools to help recruit diverse candidates.

Table 13. Staff Recruitment Priorities

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Position | FTE | Replacing | FTE | Is it a New Position? | Reason | | | | | Date | |
| Current Vacancy | Planned Vacancy | Retirement | Growth | Other | Anticipated Need | Begin Recruitment Process |
| NP | .75 | Jill Smith, NP | .5 | No |  |  | X |  |  | Immediate | 3/6 |
| FP | 1.0 |  |  | Yes |  |  |  | X |  | 8/17 | 4/17 |

### RECRUITMENT BUDGET

Plan for a realistic recruiting budget to ensure your HC has the resources required to mount a successful recruitment effort. Refer to [Table 14](#Table14) in the template section of this document to fill out your HC’s recruitment budget. The table includes a wide range of areas to think about when planning for a realistic and effective budget. While some of the sections may not be pertinent to your HC’s recruitment needs, it is important to break down the budget in as much detail as possible to accurately assess the real and total cost of recruitment. You can then calculate your HC’s turnover costs – using the STAR2 Center’s [Financial Assessment Tool](https://chcworkforce.org/web_links/star%c2%b2-center-financial-assessment-tool/) – to compare the often higher cost of losing an employee, especially a provider, with making a strong investment in your HC’s retention and recruitment processes.

### RECRUITMENT FIRM

While not all HCs utilize outside recruitment firms due to their costs, if you do choose to use a recruiting firm, maintain a record of the firm’s name, contact information, fees, references, etc. Keep rating information in your CWP for future reference about the quality of your HC’s experience with the recruiting firm. Also, take notes about the experience to identify areas of improvement and prepare for the next recruitment cycle. Refer to [Table 15](#Table15) in the template section of this resource to document your HC’s process and experience with using a recruitment firm. It is important to note that if you plan to use a firm, contact those who may offer discounts based on your non-profit status. Moreover, if you have a standing relationship with a firm, request a discount based on your non-profit status.

### ADVERTISING & SOCIAL MEDIA

Plan and track all advertising done directly by your HC or by a recruiter. Record any differences from your plan so that future recruitment efforts will begin with the most accurate information. Utilize sources that are familiar with HC recruiting challenges, work with mission-driven organizations, and have access to employees looking for mission-driven opportunities. Include sources that reach diverse communities such as career boards led by professional associations and educational institutions for underrepresented and systemically marginalized people. Post with state, regional, and national agencies including Primary Care Organizations (PCOs) and PCAs. Document your advertising efforts in Table 16. The first line of the table is filled out as an example.

Table 16. Media Outlet Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Media Outlets | Contact Name | Phone | Email | Timing | Frequency | Fees | Rating 1-5 |
| Online Recruitment Site (e.g., Indeed) | Idealist | N/A | Idealist.org | 5/15 to 8/15 | ongoing | $105 per job posting | 5 |
| National Journal Ads (online or print) |  |  |  |  |  |  |  |
| Journal 1 |  |  |  |  |  |  |  |
| Journal 2 |  |  |  |  |  |  |  |
| Journal 3 |  |  |  |  |  |  |  |
| PCO |  |  |  |  |  |  |  |
| PCA |  |  |  |  |  |  |  |
| Health Workforce Connector |  |  |  |  |  |  |  |
| Regional Advertising (specify) |  |  |  |  |  |  |  |
| Social Media Site (e.g., LinkedIn) |  |  |  |  |  |  |  |
| Career Boards |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

#### Advertisement Text

Keep a copy of the various job announcements your HC posts in your CWP. Prior to posting, review the advertisement to make sure it meets your HC’s needs. For providers who respond to the job announcement, ask them for their opinion about what drew them to the announcement and what other information would be helpful to include.

Draft advertisement text in advance to minimize turnaround time for posting on various media outlets. Include the advertisement text in the HC CWP to avoid having to “reinvent the wheel” each time there is an open position. In particular, there should be standard text describing the mission, region, population served, and commitment to DEI.

Your HC’s DEI commitment statement is different from your equal opportunity employer language. It lets people from diverse backgrounds know that they are welcome and encouraged to apply. It also sets the tone for the kind of workplace culture and experience they can expect as someone who identifies with a historically excluded group.

Example DEI commitment statement:

*The University of Rochester Medical Center aspires to make every person feel safe, welcome, and supported at all times; to be a place where everyone, regardless of identity or challenges they face, is lifted up to become their best and healthiest selves; to serve as a powerful force for eliminating racism, division, and exclusion in our communities and beyond.[[14]](#footnote-14)*

It is also important to include a salary range in the advertisement text.[[15]](#footnote-15) This indicates your HC’s commitment to pay equity. Too often, low wages are exploited by organizations that offer only a slightly higher pay increase than a previous employer. This marginal pay increase may allow organizations to benefit from the fact that the individual was previously underpaid. Additionally, questions to candidates about their salary expectations may not close the pay equity gap since individuals belonging to marginalized groups – especially Black, Latino/a/e/x, and Indigenous women – may not have been fairly compensated in prior positions, and may not know to negotiate the same rate as a peer from a more privileged group. Being transparent about the salary range avoids confusion and time wasted on candidates who were expecting a drastically different wage, but even more importantly, it helps promote equity and fight bias in pay.

#### Strategies for Social Media

Make optimal use of social media to get the word out about your HC and available job opportunities. Most candidates frequently use social media for information, so make sure your HC is connected to potential recruits by building an internet presence that goes beyond your website. A robust social media presence is part of your HC’s branding – it gets the message out about who you are, what you do, who you serve, and why. Social media is also a valuable tool for reaching patients; for example, posting about flu and other vaccination clinics.

Make sure to actively engage on different social media sites (e.g., Twitter, YouTube, Instagram, Facebook, TikTok, etc.) as part of your HC’s recruitment strategy. Create a profile on multiple social media platforms, post jobs and provider testimonials, highlight your HC’s workplace culture and current staff, and build a strong presence that markets your HC’s brand. Keep in mind social media platforms are constantly changing, so it is important to stay up to date with the most widely used platforms to reach the largest audience. LinkedIn is the platform best known for engaging professionals; for this reason, set up a company profile and establish broad connections, post jobs, join groups, and send messages to prospective candidates outside of their extended network. Use YouTube to introduce your organization to potential candidates and create videos highlighting your HC, staff, patients, and community. Ensure your HC’s website is easy to navigate and visually appealing. Potential candidates will browse your website to gain a greater perspective of the HC’s mission, patient population, community, services, staff, and workplace culture.

### SCREENING PROCESS

Once you begin to attract candidates, be sure to carefully track the results. It is critical to respond quickly, communicate often, and ensure a rapid turnaround of questions, interviews, and site visits. You can also use the [Candidate Tracking Sheet](https://chcworkforce.org/web_links/acu-health-center-provider-retention-and-recruitment-plan-template/), a separate component of the HC CWP, for tracking applicants through the recruitment process.

It is helpful to track where candidates see listings – specific job posting websites, social media, learning about opportunities from colleagues, or being recruited during rotations through training or graduate medical education programs at your HC. Tracking how long a position is advertised before receiving applications adds to the understanding of which outlets are most efficient and effective. Knowing which recruitment outlets are working and which ones are not can help direct your efforts and make future recruitment quicker and more successful.

#### Telephone Interview

An employee in a director or manager level position should contact the candidate within five business days of reviewing their job application for a brief telephone interview. This expresses interest and is important to make sure you do not lose a potential candidate.

Develop the content for the telephone interview in advance. Use a set of predetermined questions to guarantee you are not forgetting any essential questions and that the interview process remains fair across all candidates. The telephone interview can go beyond the key questions, but should collect basic information to help your HC determine the next steps for each candidate.

Below is a sample of the interview process:

* Describe the position
* Describe the HC, town/region, population served, and salary range (including how the final salary will be determined)
* Ask the candidate:
  + How did you hear about the position?
  + Why are you interested in this position?
  + Do you have any special clinical or professional interests?
  + Are there clinical procedures or types of patients/conditions you are not comfortable with?
  + Do you have any malpractice history?
  + Is there any reason you would not be able to get credentialed?
  + Tell me more about your training and/or specialty?
  + Is your license currently active?
* Field questions from the candidate
* Discuss the HC recruitment process and next steps
* Listen to the candidate

Next Steps:

* Record the interaction for later review by the recruitment team
* Review the candidate’s CV and make sure they are Board eligible
* Present results to the recruitment team
* If the recruitment team thinks the candidate is right for the position, arrange a follow-up phone, virtual, or onsite interview
* Keep the candidate updated on the status of the interview process
* Check references
* If the recruitment team thinks the candidate is not right for the position, contact the candidate by phone or via email to let them know – do not leave candidates without any final communication

#### Candidate Visit

If the initial interview phase is successful, the recruitment team needs to arrange a visit as soon as possible. Often there are two visits involved in a normal recruitment cycle, one with the candidate and then another for the candidate and their partner/spouse and family, especially if the candidate is relocating. Do not delay in scheduling the visit(s); lag times can lead to lost candidates due to either perceived lack of interest from the HC or very competitive environments. Use [Table 18](#Table18) in the template section of this resource to document the details and common elements of a candidate visit. To ensure a smooth visit, pick the candidate up at the airport and assign a key staff person to guide the candidate through the itinerary and another person to assist the partner/spouse and family. Keep in mind that this type of visit is often reserved for clinicians or staff at leadership levels; however, make sure to use the protocol that works best for your HC.

### CANDIDATE FOLLOW-UP

It can be easy, especially in a HC without a dedicated workforce staff, to delay in following up with candidates when juggling many different organizational priorities. For this reason, it is important to set expectations and goals for timely follow-up with candidates at each stage of the recruitment process. Table 19 is a sample of a completed follow-up plan.

Table 19. Candidate Follow-Up Plan

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Follow-Up After Each Event | Frequency | Timeline | Type of Contact | Responsible Person |
| Application Received | Minimum of up to five attempts | Within five work days | Email, telephone | Administrative Assistant |
| 1st Telephone Interview | Minimum of up to five attempts | Within five work days | Email, telephone | CMO |
| 2nd Telephone Interview (if applicable) | Minimum of up to five attempts | Within five work days | Email, telephone | Provider conducting 2nd interview |
| 1st Visit | Minimum of up to ten attempts | Within five work days | Email, telephone | CMO |
| 2nd Visit (if applicable) | Minimum of up to five attempts | Within five work days | Email, telephone | Recruiting Staff or HR |
| Offer | Minimum of up to ten attempts | Within ten work days | Email, telephone, and mail | CEO |

### CONTRACT DEVELOPMENT & NEGOTIATION

Ideally, a provider or staff contract needs to be developed prior to the first telephone interview. In addition to specifying the work expectations and compensation/benefits, the contract should include provisions for moving expenses, a sign-on bonus (if applicable), and professional development time and expenses. Not every HC uses contracts, but if yours does, make sure to attach a boilerplate version of your HC’s provider or staff contract to your CWP. Update the contract as necessary. Be prepared to discuss the general terms of the contract during the telephone interview and specific details during the candidate visit. You will find a list of topics to consider including in your [HC’s contract](#ContractTermTemplate) in the template portion of this resource.

### ONBOARDING

Recruitment does not end when an offer is extended and accepted. One of the most important parts of recruiting is onboarding. Onboarding is also key to beginning a relationship with a new provider or staff member and serves as the bridge back to retention as it is the process of integrating an employee into the practice. The process begins just before or as soon as an agreement is in place and before the new employee starts working in the practice. Onboarding is not orientation and it is not a quick process; it continues through the first six-months to a year of employment. Comprehensive onboarding improves staff retention rates through greater communication and increased employee satisfaction. Develop an onboarding plan or checklist to ensure you are maximizing the retention of new providers and staff while also increasing understanding of the practice and solidifying positive communication among all parties.[[16]](#footnote-16) [[17]](#footnote-17)

Tips for successful onboarding:

* Assign a mentor to orient the new staff members and help integrate them into the HC and community
* Assign a person and realistic timeline to each onboarding activity to ensure accountability
* Provide opportunities for the new staff member to get out in the community and meet other employees
* Conduct weekly check-in meetings with the employee as soon as they start; taper off to bi-monthly and monthly
* Provide opportunities for peer interaction
* Develop telecommunication links to other healthcare workers in the community
* Provide opportunities for accessing continuing clinical education and support resources

Common Onboarding Activities:

* Licensing
* Credentialing
* Billing setup
* Clinical staff privileges at local hospital
* Third-party insurance enrollment
* Appointment scheduling setup
* IT issues and training on computer systems
* Human resources
* Anti-racism/DEI/cultural humility training
* Training on how to obtain clinical consults, tests, and support for patient care
* Defining expectations for productivity, quality, and work effort
* Community orientation
* Training on patient population and social determinants of health (SDoH)
* Policies/procedures
* Ancillary departments
* Quality improvement/clinical review
* Orientation to the facility, office staff, EHR, etc.
* Relationship building with other HC staff

## WORKFORCE DEVELOPMENT

Workforce development is a critical aspect of retention and recruitment, encompassing efforts to build the capacity of staff already at the HC and move them into more advanced roles. Furthermore, it includes working with outside education and training institutions to provide a clinical training environment that also acts as an outreach and recruitment opportunity. Creating a learning environment within the HC often helps with staff recruitment by enticing providers who are interested in helping educate the next generation of clinical staff, and with retaining employees who feel a greater level of job satisfaction by being able to work with, help train, and mentor burgeoning providers.

Ultimately, a well-designed development strategy invests in career ladders, advancement opportunities, talent development, and succession planning to prepare and train a diverse and inclusive group of employees for an upward career trajectory that leads to the successful and equitable achievement of leadership positions.

### PATIENT-CENTERED MEDICAL HOME

Many providers and healthcare workers are attracted to organizations that have a PCMH model, which prioritizes the provider-patient relationship and encourages team-based care. If your HC is recognized as a PCMH, include this information in your HC’s job announcements, branding and marketing materials, and discuss it with candidates during the interview process.

### NATIONAL HEALTH SERVICES CORPS

[The National Health Services Corps (NHSC)](https://nhsc.hrsa.gov/) offers financial and other support to primary care providers and sites in underserved communities.

The following information is excerpted from the NHSC website:

The NHSC has programs for loan repayment and scholarships. Health centers can recruit candidates eligible for loan repayment or in the scholarship programs through the NHSC. For more information, see [www.nhsc.hrsa.gov](http://www.nhsc.hrsa.gov). Community Health Centers, Federally Qualified Health Centers, Look-Alikes, Indian Health Service Facilities, Tribally-Operated 638 Health Programs, Urban Indian Health Programs, Federal Prisons, and Immigration and Customs Enforcement (ICE) Health Service Corps sites are auto-approved and do not need to submit an application during the site application period. Contact the Bureau of Health Workforce’s (BHW) Division of Regional Operations for more information about the auto-approval process at [www.nhsc.hrsa.gov/nhsc-sites/contacts/regional-offices-state-contacts.html](http://www.nhsc.hrsa.gov/nhsc-sites/contacts/regional-offices-state-contacts.html).[[18]](#footnote-18)

HCs can use the status as an NHSC-approved site to recruit new providers and help retain current staff. Notify your current staff that they may be eligible to apply for loan repayment assistance. Priority consideration is given to eligible applicants whose NHSC-approved site has a Health Professional Shortage Area (HPSA) score of 26 to 14, in descending order. Eligible applicants may receive up to $50,000 in loan repayment for an initial service commitment until funding is exhausted. Inform primary care providers when you interview them that your site is NHSC-approved and therefore they may be eligible to apply for loan repayment, if they accept your open position. Post job openings on the NHSC Recruitment Site ([Health Workforce Connector](https://connector.hrsa.gov/connector/)) to alert prospective and current Corps members to your needs.

*Loan Repayment*

Licensed health care providers may earn up to $50,000 toward student loans in exchange for a two-year commitment at an NHSC-approved site through the NHSC Loan Repayment Program (NHSC LRP).

*Scholarship Program*

Medical students (MD or DO) may earn up to $120,000 in their final year of school through the Students to Service Loan Repayment Program (S2S LRP). Students must commit to serving either three years full-time or six years part-time at an NHSC-approved site with a HPSA score of 14 or higher.

*State Loan Program Participation*

Through the NHSC, states and territories may offer a State Loan Repayment Program (SLRP) for health professionals that provide primary care in HPSAs within their state. Not all states offer an SLRP.

#### Other State Loan Repayment Programs

Review and document any other loan repayment programs that might be available in your state. Information for these programs should be available through your state or regional PCA or health department website.

### HEALTH PROFESSIONS EDUCATION & TRAINING

#### Medical Education Connections through Residency Programs

Hosting residents through an accredited Medical, Nurse Practitioner, or Physician Assistant Residency Program can offer unique recruiting opportunities. If your HC is already connected to a residency program, maximize your probability of hiring within the residency pool.

#### Health Professions Education & Training Pathway Development

This development refers to the connection between educational programs and the workforce. HCs can benefit greatly by partnering with educational institutions to serve as a real-world learning environment for clinical and technical education students. HCs will gain the opportunity to show students the career options offered by HCs, and recruit students who are interested in serving in a HC after graduation.[[19]](#footnote-19)

### PARTNERSHIPS WITH HEALTH EDUCATION PROGRAMS

Pathway development can involve residency or other graduate medical education (GME), but HCs can form valuable partnerships with many other health education programs to advance their recruitment efforts. Students from nursing, medical assistant, dental assistant, dental hygienist, social work, psychology, and other relevant clinical or technical education programs – even Emergency Medical Technician (EMT) and Paramedic programs – often need clinical, volunteer, or field placement hours. Working with these programs and bringing these students into the HC environment can afford critical recruiting opportunities.

#### Examining Training Program Satisfaction & Recruitment Performance Rates (Internal)

When operating any type of clinical training or GME program, it is important to assess satisfaction from learners, preceptors, and other staff involved in the training program. This information can guide changes to improve the program and can be used to support the argument for the benefits of such a program (e.g., staff overall satisfaction and a feeling of purpose, training future providers, increasing awareness of the HC as a place for meaningful employment).

Another factor that is important to track is recruitment stemming from these training programs. When reviewing candidates for positions at your HC, surveying how they learned about the HC and the employment opportunity, and whether or not they received any clinical training or GME at the HC will provide useful data for understanding the efficacy of these programs for recruitment of new providers. An additional approach may be surveying learners as they complete their educational rotations, asking questions like: “Are you likely to apply for employment at this HC or other HCs?” or “Following your residency rotation, how likely are you to keep practicing at this or another HC?”

## FURTHER OPTIONS FOR EXAMINING STAFF RETENTION & RECRUITMENT

#### Provider Tenure, Turnover, and Vacancy Rates

Tracking how long staff maintains employment at your HC, especially provider tenures and turnover rates, is critical to assessing the costs your HC is facing – or the potential savings you are seeing if turnover is low and employment tenures are long. These data are readily available from basic HR processes, but may need to be compiled into a table or other means of analyzing these data. Looking at trends over longer periods is also useful for seeing changes in your workforce and being able to take proactive measures. For example, have average staff employment tenures been decreasing over the past ten years, or have you turned over more positions on average in the past two years than in the three years before that? These data are extremely useful, but need to be collected consistently – at least annually – for several years before showing workforce trends you can begin to act on.

These types of data can also be broken out into categories that reflect the diversity in your HC (e.g., race, ethnic identity, gender identity, sexual orientation, disability status, etc.). Being able to see tenure and turnover rates for employees of various identity groups may reveal retention and recruitment diversity successes, or issues with retention of a diverse workforce that need to be addressed.

All of this information can help guide your efforts to make your workforce resilient, engaged, diverse, and sustainable – but it needs to be collected and analyzed. New questions may require new data to answer, but examining these basic trends in your workforce annually can be extremely beneficial.

# CWP TEMPLATE

The HC CWP Template provides a blank version of each of the tables and tools outlined in the HC CWP Instructions. For easy access, each of the headers for the different sections of the template are hyperlinked back to their corresponding instructions, which provide examples and explanations for how to complete this portion of the document.

[CWP Review Tracker](#Definition)

**COMPREHENSIVE WORKFORCE PLAN**

**Last Date of Review**

**Anticipated Next Date of Review**

[Vision](#Vision)

The HC vision is:

The vision was last updated on

The next date of review is planned for

[Provider Capacity & Demand](#_Provider_Capacity_&) (Table 1a & Table 1b)

Table 1a. Provider Productivity (Clinical Visits)

Measurement Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Name | Provider Type | Provider Specialty | FTE | Clinical Visits | Clinical Visits per 1.0 FTE | UDS Mean Clinical Visits per 1.0 FTE | Percentage Difference from Mean |
| (Last, First) | (Degree or Licensure) | (Area of Expertise) |  | Number of patients seen | (Clinical Visits ÷ FTE)  (Column 5 ÷ Column 4) | Use [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020)  (UDS Clinical Visits ÷ UDS FTE) | [ (Column 6 ÷ Column 7) - 1.0] X 100  \*Column 6: Clinical Visits per 1.0 FTE  \*Column 7: UDS Mean Clinical Visits per 1.0 FTE  \*\*A negative result indicates percent *below* the UDS mean; a positive result is percent *above* the national mean. |

Table 1b. Provider Productivity (Virtual Visits)

Measurement Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Name | Provider Type | Provider Specialty | FTE | Virtual Visits | Virtual Visits per 1.0 FTE | UDS Mean Virtual Visits per 1.0 FTE | Percentage Difference from Mean |
| (Last, First) | (Degree or Licensure) | (Area of Expertise) |  | Number of patients seen | (Virtual Visits ÷ FTE)  (Column 5 ÷ Column 4) | Use [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020)  (UDS Virtual Visits ÷ UDS FTE) | [ (Column 6 ÷ Column 7) - 1.0] X 100  \*Column 6: Virtual Visits per 1.0 FTE  \*Column 7: UDS Mean Virtual Visits per 1.0 FTE  \*\*A negative result indicates percent *below* the UDS mean; a positive result is percent *above* the national mean. |

[Productivity Analysis](#ProductivityAnalysis) (Table 2)

Table 2. Analysis of Productivity Differences

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider Name | Provider Type | Provider Specialty | Percentage of Difference from Mean | Possible Reasons for Difference |
| (Last, First) | (Degree of Licensure) | (Area of Expertise) | (Column 7 of Table 1a or Table 1b) |  |

[Appointment Access](#_Appointment_Access) (Table 3 & Table 4)

Table 3. Weekly Appointment Access Report Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Third next appointment | | |  |  |
| Specialty  (medical, dental, behavioral health, vision) | Provider Name | Provider Type | Appointment Type | Date | # Days Provider | # Days Team | Meets Written Policy  (Y/N) | If No, Reason/Corrective Plan |
| Family  Medicine |  | | Sick Visit |  |  |  |  |  |
| Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 1 | MD | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 2 | DO | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 3 | PA | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Pediatrics |  | | Sick Visit |  |  |  |  |  |
| Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 4 | MD | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 5 | PA | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Psychiatry |  | | Sick Visit |  |  |  |  |  |
| Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 6 | MD | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |
| Provider 7 | NP | Sick Visit |  |  |  |  |  |
|  | | Follow Up |  |  |  |  |
| Preventive Visit |  |  |  |  |

\*If the “third next available” appointment is the same day, report it as “0”.

Table 4. Analysis of Appointment Access & Productivity

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provider Name | Team or Service | Access within Policy Limits | Productivity | Identified Capacity Gap | Other Non-Capacity Gap |
| (Last, First) |  | (Y/N) | Low (>10% Below Average), Average, High (>10% Above Average) |  |  |

[Care Teams & Provider Mix](#_Care_Teams_&) (Table 5)

Table 5. Ratio of Total Non-Physician Providers to Total Physicians

|  |  |  |
| --- | --- | --- |
| Date Assessed | Health Center Staffing Ratios | UDS Mean Staffing Ratios per FTEs |
|  | (Total NPs, PAs, and CNMs ÷ Total Physicians)  \*Based on your HCs staffing numbers | (Total NPs, PAs, and CNMs ÷ Total Physicians)  \*Use [UDS Table 5](https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2020), rows 10a and 8  (row 10a ÷ row 8) |

[Support Staff](#_Support_Staff) (Table 6)

Table 6. Ratios of HC Support Staff to Provider Staff in Comparison to UDS Mean

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date Assessed | HC Support Staff | HC Provider Staff | Ratio of HC Support Staff to Provider Staff | UDS Support Staff FTEs  *\*will be a large number* | UDS Provider Staff FTEs  *\*will be a large number* | Ratio of UDS Support Staff to UDS Provider Staff per FTEs | Comparison of HC Ratio with UDS Ratio |
|  | Based on your HC’s staffing numbers  \*It can be individual support staff (ex: nurses); multiple support staff (nurses + laboratory personnel); or total support staff (may include administrative staff) | Based on your HC’s staffing numbers  \*It can be physician specialty, (ex: pediatricians); non-physician provider (physician assistants); total physicians or a mix of different physician specialties (family physicians + OBGYN); total non-physician providers or a mix of non-physician providers (ex: nurse practitioners + physician assistants) | Column 2 ÷ Column 3 | Use UDS Table 5  \*It can be individual support staff (ex: row 11, nurses); multiple support staff (row 11 + row 13, nurses + laboratory personnel); or total support staff (may include administrative staff) | Use UDS Table 5  It can be physician specialty, (ex: row 5, pediatricians); non-physician provider (ex: row 9b, physician assistants); total physicians or a mix of different physician specialties (ex: row 1 + row 4; family physicians + OBGYN); total non-physician providers or a mix of non-physician providers (ex: row 9a + row 9b, nurse practitioners + physician assistants) | Column 5 ÷ Column 6 | Column 4 ÷ Column 7  \*A number greater than 1 indicates you have a larger support staff to provider ratio than the national average; a number less than 1 indicates your ratio is lower than the national average. |

[Scheduling](#_Scheduling) (Table 7)

Provider/Patient Schedules

**The HC reviews one, several, or all of the following patient/provider scheduling metrics: (Yes or No)**

* Type and number of providers covering office hours
* Clinical session start/end time
* Number and types of patients seen at any particular time during a clinical session

**The HC reviews one, several, or all of the following factors that affect provider scheduling: (Yes or No)**

* Dates and times the HC is open
* Support staff availability
* Exam room availability
* Provider specialty
* Patient demographics

Office Schedules

Table 7. Weekly Asset Matching – Providers, Support, Exam Rooms

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Team | | Monday | Tuesday | Wednesday | Thursday | Friday |
| AM | Providers |  |  |  |  |  |
| Support |  |  |  |  |  |
| Rooms |  |  |  |  |  |
| PM | Providers |  |  |  |  |  |
| Support |  |  |  |  |  |
| Rooms |  |  |  |  |  |

On-Call Schedules

**Current On-Call Ratio and Description of Call Rotation**

**Number of days on call per month:**

**Description of call rotation:**

*(e.g., one weekday per week and one weekend per month; one week 24/7 per month; non-physician clinician coverage until 10 PM each day, physician coverage 1:7 after 10 PM)*

[Provider & Staff Satisfaction](#_Provider_&_Staff)

**Staff Satisfaction Survey conducted:**

*(share results and action steps with all staff)*

YES  NO NOT IN THE PAST YEAR UNKNOWN

**Frequency**

**If available, date of last Staff Satisfaction Survey**

**Date of next planned Staff Satisfaction Survey**

**JEDI (Justice, Equity, Diversity, & Inclusion) training conducted:**

YES  NO NOT IN THE PAST YEAR UNKNOWN

**Frequency**

**Topic(s) discussed**

**If available, date of last JEDI training**

**Date of next planned JEDI training**

**Staff Wellness activities conducted:**

YES  NO NOT IN THE PAST YEAR UNKNOWN

**Frequency**

**Focus area(s)** *(i.e., emotional, physical, financial, communication)*

**If available, date of last Staff Wellness** **activity**

**Date of next planned Staff Wellness activity**

**Staff Engagement activities conducted:**

YES  NO NOT IN THE PAST YEAR UNKNOWN

**Frequency**

**Description of activity held**

**If available, date of last Staff Engagement activity**

**Date of next planned Staff Engagement activity**

**Leadership training conducted:**

YES  NO NOT IN THE PAST YEAR UNKNOWN

**Frequency**

**Topic(s) discussed**

**If available, date of last Leadership training**

**Date of next planned Leadership training**

**Stay Interview conducted:** *(with all staff)*

YES  NO NOT IN THE PAST YEAR UNKNOWN

**Frequency**

**If available, date of last Stay Interview** *(with all staff)*

**Date of next planned Stay Interview** *(with all staff)*

**Exit Interview conducted:** *(with all departing staff, regardless of reason)*

YES  NO UNKNOWN

[Succession Planning](#_SUCCESSION_PLANNING) (Table 8)

Table 8. Succession Planning (Retirement, Extended Leave, and FTE Changes)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Staff Member  Name | Department | Role in HC | Staff Member Age Range | | | Over Age 50 | | All Ages | |
| <50 | 50-65 | >65 | Discussed Retirement (Y/N) | Planned Retirement Age | Major Leave Plans | FTE Changes |
|  | \*document the department to help keep track of staffing needs, not just by position or role, but also by department |  |  |  |  | \*if there is other pertinent information from the succession planning discussion with the employee add it to this column |  | \*provide appropriate amount of detail to help with the success planning process | \*provide appropriate amount of detail to help with the success planning process |

[Mission](#_MISSION)

The HC mission is:

The mission was last updated on

The next date of review is planned for

The mission is prominently displayed on:

* Website
* Organization’s Intranet
* Waiting Room
* Break/Lunch Room
* Conference Room
* Social Media Pages
* Other:

The mission is discussed with:

* Administrative Staff
* Behavioral Health Staff
* Clinical Support Staff
* Dental Staff
* Enabling Services Staff
* Legal Services Staff
* Medical Staff
* Vision Services Staff
* Other Health Center Staff

[Compensation](#Compensation)

Salary review conducted on:

Department reviewed:

Findings:

Action Plan:

Next review scheduled for:

Staff Incentives

Select the components of the HC’s incentive-based compensation and note the percentage of the total salary compensation attributed to each component.

Complete percent of total compensation:

* Base Salary:

Incentives based on:

* Production (revenue, visits, RVU based):
* Quality:
* Patient Satisfaction:
* Significant Leadership Activities (involvement in internal or external committees, mentorship, etc.):
* End of year bonus:
* Other:

[Benefits](#_BENEFITS) (Table 9)

Table 9. Benefit Review

|  |  |  |  |
| --- | --- | --- | --- |
| Benefit | Details | Review Results | Action Plan |
| Vacation |  |  |  |
| Holidays |  |  |  |
| Sick |  |  |  |
| Educational Leave |  |  |  |
| Educational Travel |  |  |  |
| Educational Conference |  |  |  |
| Health Insurance |  |  |  |
| Dental Insurance |  |  |  |
| Life Insurance |  |  |  |
| Disability Insurance |  |  |  |
| Vision Insurance |  |  |  |
| Loan Repayment |  |  |  |
| Retirement Plan |  |  |  |
| Parental Leave |  |  |  |
| Mental Health/Wellness Leave |  |  |  |
| Tuition Reimbursement |  |  |  |
| Other (specify) |  |  |  |

[Work Schedules](#_WORK_SCHEDULES) (Table 10)

Table 10. Staff Schedule Types

|  |  |  |  |
| --- | --- | --- | --- |
| Schedule Type | Availability | Assessment | Action Plan |
| Part-time |  |  |  |
| Job Sharing |  |  |  |
| Flexible Schedules |  |  |  |
| School hours |  |  |  |
| Evenings |  |  |  |
| Weekends |  |  |  |
| Long days |  |  |  |
| Hybrid Schedules |  |  |  |
| Remote/Telework Schedules |  |  |  |

[Career Paths](#_CAREER_PATHS) (Table 11)

Table 11. Professional Growth and Development

|  |  |  |  |
| --- | --- | --- | --- |
| Type | Availability | Assessment | Action Plan |
| Clinical Oversight (other providers or clinical teams) |  |  |  |
| Administrative Oversight (programs/services) |  |  |  |
| Teaching Opportunities |  |  |  |
| Clinical Students (i.e., medical, dental, behavioral health, vision) |  |  |  |
| Clinical Residents |  |  |  |
| Clinical Interns |  |  |  |
| Other clinical, technical, student, or volunteer |  |  |  |
| Leadership Opportunities (special projects, committees, community outreach, etc.) |  |  |  |
| Telemedicine Opportunities |  |  |  |
| Certification or Specialization Training Programs |  |  |  |
| Other (specify) |  |  |  |

[Organizational Culture](#_ORGANIZATIONAL_CULTURE)

The HC’s values are:

These values align with staff values:  Yes  No  Unsure

The HC developed or plans to develop a staff wellness plan:  Yes  No  Unsure

[Community Recruitment Plans](#_COMMUNITY_RECRUITMENT_PLANS)

The HC has had conversation with or researched the recruitment efforts and opportunities of:

* Local primary care providers
* Local private practices
* Local hospitals
* State or regional PCAs

Opportunities for collaboration:

[Recruitment Team](#_RECRUITMENT_TEAM) (Table 12)

Table 12. Recruitment Team Members & Corresponding Responsibilities (Medical Example)

|  |  |
| --- | --- |
| Position | Responsibilities |
| \*add the title of the HC employee involved in the recruitment team | \*list out the employee’s responsibilities in the recruitment process; different for each person |

[Recruitment Priorities](#_RECRUITMENT_PRIORITIES) (Table 13)

Table 13. Staff Recruitment Priorities

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Position | FTE | Replacing | FTE | Is it a New Position? | Reason | | | | | Date | |
| Current Vacancy | Planned Vacancy | Retirement | Growth | Other | Anticipated Need | Begin Recruitment Process |
|  |  |  |  |  |  |  |  |  |  |  |  |

[Recruitment Budget](#_RECRUITMENT_BUDGET) (Table 14)

Table 14. Recruiting Budget Worksheet

|  |  |
| --- | --- |
| Staff Costs (Planning, Recruiting, Onboarding) | |
| Business Office (Patient Accounts/Billing) Salary and Benefits per Hour |  |
| CEO/Administrator Salary and Benefits per Hour |  |
| Clinical C-Suite Salary and Benefits per Hour |  |
| Human Resources Salary and Benefits per Hour |  |
| IT Hourly Rate Plus Benefits |  |
| Nurse/MA Hourly Rate Plus Benefits |  |
| Other Providers Average Hourly Rate Plus Benefits |  |
| Support Staff Salary and Benefits per Hour |  |
| **Total Staff Costs** |  |
| Outside Recruiting Expenses | |
| Recruiting Service |  |
| Advertising Costs – up to three national online or print services for three months including career boards  managed by and for minority professionals (e.g., National Black Nurses Association, Out Professional  Network) |  |
| **Total Outside Recruiting Expenses** |  |
| Interview Expenses | |
| Number of In-Person Interviews |  |
| Hotel Expense per Night per Interview |  |
| Travel Expense per Interview |  |
| All Staff Breakfast with Candidate per Interview |  |
| CMO Lunch with Candidate per Interview (include candidate and guest) |  |
| Number of People Included in Interview Dinner per Interview |  |
| Interview Dinner Cost Per Person per Interview (include tax and gratuity) |  |
| Cost of Other Interview Items (e.g., gift baskets, babysitting service) |  |
| *Total Cost Per Interview* |  |
| **Total Interview Expenses (Number of Interviews x Total Cost per Interview)** |  |
| Hiring Expenses | |
| Relocation Costs |  |
| Signing Bonus |  |
| Publicity Costs |  |
| Other Costs (e.g., phone, lab coat, computer) |  |
| **Total Hiring Expenses** |  |
| Total Recruitment Budget |  |

[Recruitment Firm](#_RECRUITMENT_FIRM) (Table 15)

Table 15. Recruiting Firm Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Firm Name | Contact Name | Phone | Email | Address | Fees | References | Date Last Used | Position Filled | Rating  1-5 |
|  |  |  |  |  |  |  |  |  |  |

Notes:

[Advertising & Social Media](#_ADVERTISING_&_SOCIAL) (Table 16 & Table 17)

Table 16. Media Outlet Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Media Outlets | Contact Name | Phone | Email | Timing | Frequency | Fees | Rating 1-5 |
| Online Recruitment Site (e.g., Indeed) |  |  |  |  |  |  |  |
| National Journal Ads (online or print) |  |  |  |  |  |  |  |
| Journal 1 |  |  |  |  |  |  |  |
| Journal 2 |  |  |  |  |  |  |  |
| Journal 3 |  |  |  |  |  |  |  |
| PCO |  |  |  |  |  |  |  |
| PCA |  |  |  |  |  |  |  |
| Health Workforce Connector (HRSA) |  |  |  |  |  |  |  |
| Regional Advertising (specify) |  |  |  |  |  |  |  |
| Social Media Site (e.g., LinkedIn) |  |  |  |  |  |  |  |
| Career Boards |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

Advertisement Text (Template)

|  |  |
| --- | --- |
| Job Announcement Title |  |
| **Body**   * + Type of organization   + Location (rural, urban)   + Statement of position type (FT or PT)   + Salary range   + HC mission, vision, and values   + Promote mission-driven health center environment   + Brief description of the positive aspects of the region (e.g., cultural opportunities, outdoors, nature experience, local culture, food)   + Promote any positives (e.g., flexible schedules, teaching opportunities, stipend for travel expenses)   + Include any recognition (e.g., PCMH)   + Include possible incentives (e.g., professional development benefits, bonuses, loan repayment)   + DEI commitment statement |  |
| Contact Person and Information |  |

Strategies for Social Media

Table 17. Use of Social Media

|  |  |  |  |
| --- | --- | --- | --- |
| Social Media | Use (Y/N) | Assessment | Action Plan |
| Website |  |  |  |
| Use for Job Posting |  |  |  |
| Highlights HC |  |  |  |
| Community Links |  |  |  |
| LinkedIn Company Profile |  |  |  |
| Use for Job Posting |  |  |  |
| Highlights HC |  |  |  |
| Community Links |  |  |  |
| Twitter |  |  |  |
| Use for Job Posting |  |  |  |
| Highlights HC |  |  |  |
| Community Links |  |  |  |
| Facebook |  |  |  |
| Use for Job Posting |  |  |  |
| Highlights HC |  |  |  |
| Community Links |  |  |  |
| YouTube |  |  |  |
| Highlights HC |  |  |  |
| Highlights Community |  |  |  |
| Community Links |  |  |  |
| Instagram |  |  |  |
| Highlights HC |  |  |  |
| Highlights Community |  |  |  |
| Community Links |  |  |  |
| TikTok |  |  |  |
| Highlights HC |  |  |  |
| Highlights Community |  |  |  |
| Community Links |  |  |  |
| Other (specify) |  |  |  |

[Screening Process](#_SCREENING_PROCESS) (Table 18)

Telephone Interview

The HC has an established protocol for identifying potential candidates:

Yes  No  Unsure  It is in development

The HC’s standard interview questions include:

Candidate Visit

Table 18. Visit Details Worksheet

|  |  |  |  |
| --- | --- | --- | --- |
| Item | Details | Responsible/Lead Person | Date Finalized |
| Arrange Logistics 2-3 days |  |  |  |
| Travel – flights, ground transportation |  |  |  |
| Reserve hotel |  |  |  |
| Gift baskets – if children are coming, include age-appropriate toys |  |  |  |
| If children attend, babysitting service |  |  |  |
| Create & distribute itinerary |  |  |  |
| Provide directions & maps |  |  |  |
| Visit |  |  |  |
| Pick up at airport |  |  |  |
| Provider itinerary |  |  |  |
| Breakfast with staff (support staff included) |  |  |  |
| Tour of community |  |  |  |
| Tour HC |  |  |  |
| Meet with providers and provider team |  |  |  |
| Meeting with CEO |  |  |  |
| Review of contract/benefits/etc. |  |  |  |
| Lunch/meeting with clinical c-suite |  |  |  |
| Partner Itinerary |  |  |  |
| Schools |  |  |  |
| Child care providers |  |  |  |
| Banks |  |  |  |
| Realtors |  |  |  |
| Lunch with community member(s) |  |  |  |
| Local recreational facilities & sights |  |  |  |
| Meetings with potential partner employers |  |  |  |
| Joint Itinerary |  |  |  |
| Dinner with key providers, administration, partners/spouses, family |  |  |  |
| Attend cultural events |  |  |  |

[Candidate Follow-Up](#_CANDIDATE_FOLLOW-UP) (Table 19)

Table 19. Candidate Follow-Up Plan

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Follow-Up After Each Event | Frequency | Timeline | Type of Contact | Responsible Person |
| Application Received |  |  |  |  |
| 1st Telephone Interview |  |  |  |  |
| 2nd Telephone Interview (if applicable) |  |  |  |  |
| 1st Visit |  |  |  |  |
| 2nd Visit (if applicable) |  |  |  |  |
| Offer |  |  |  |  |

[Contract Development & Negotiation](#_CONTRACT_DEVELOPMENT_&)

**The HC has the following** **contract terms in its boilerplate template:**

* Work Expectations
  + Clinical Office Hours
  + Administrative Responsibilities
  + Call Schedule
  + Office Sites
* Compensation
  + Details of Incentive Compensation (if applicable)
    - Base Salary
    - Incentives for production (revenue, visits, or RVU based) including goals
    - Incentives for quality, including metrics
    - Incentives for patient satisfaction, including goals
    - Incentives for internal administrative task completion, including expectations
    - Incentive for committee participation
    - Incentive for participation in mentorship programs
    - End of year bonus
* Benefits
  + Vacation Time
  + Holidays
  + Sick Leave
  + Mental Health/Wellness Leave
  + Health Insurance
  + Dental Insurance
  + Vision Insurance
  + Life Insurance
  + Disability Insurance
  + Retirement Plan
  + Child Care
  + Paid Parental Leave
* Professional Development
  + Educational Leave
  + Educational Travel
  + Educational Conference or Other Required Educational Expenses
  + Tuition Reimbursement
  + Membership to Professional Association
* Moving Expenses
* Signing Bonus
* Other benefits such as sabbatical leave

**Boilerplate Contract is Included as Attachment:**  Yes  No

**Last Date Contract Reviewed/Updated:**

[Onboarding](#_ONBOARDING)

The HC has an onboarding process:

Yes  No  Unsure  It is in development

The onboarding process lasts at least six-months (ideally one-year):

Yes  No  Unsure  It is in development

The onboarding process has the following activities *(see* [*Onboarding*](#Onboarding) *in the instructions section of this resource for activity ideas)*:

**The onboarding process was last assessed on:**

**Date for next assessment of the onboarding process:**

[Patient-Centered Medical Home](#_PATIENT-CENTERED_MEDICAL_HOME)

The HC’s PCMH recognition status:

* Recognized at Level \_\_\_\_ on \_\_\_\_\_\_\_\_*(date)* by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (recognition organization such as NCQA)
* Not recognized but application in process and expected on or about \_\_\_\_\_\_\_*(date)*
* Not recognized and application not in process
* Unknown

[National Health Services Corps](#_NATIONAL_HEALTH_SERVICES)

The HC is:

* An NHSC approved site
  + Current providers were notified of this status
  + Recruiting materials include information about the NHSC status
  + Job openings are posted on the NHSC recruitment site
  + In the process of becoming NHSC approved site
* Not NHSC approved site
* Unknown

The HC’s home state:

* Has a state loan repayment program; contact information is as follows:
* Does not have a state loan repayment program
* Unknown

[Health Professions Education & Training](#_HEALTH_PROFESSIONS_EDUCATION)

The HC is:

* Connected to a residency, internship, externship, or field placement program
  + The HC optimizes HP-ET recruitment through the following actions with residents, interns, externs, students, or trainees:
    - Meet with leadership and providers during their tenure to build positive relationships
    - Whenever possible, include in provider teams
    - Hold social events with current staff
    - Identify those who are motivated by the HC’s mission, community, and work well with fellow staff
    - Approach early to assess interest in working long term at the HC
    - Other (specify):
* The HC is not connected, but is in the process
* The HC is not connected

# ACTION PLAN

The Action Plan worksheet provides various tables to document the gaps/barriers, opportunities, strategies for improvement, and timeline for each component of your HC’s CWP. It also serves as a tool to help manage quality improvement efforts for your HC’s retention and recruitment processes.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Assessment](#_ASSESSMENT) | Gaps/Barriers | Opportunities | Strategies for Improvement | Timeline |
| Provider Capacity and Demand |  |  |  |  |
| Productivity Analysis |  |  |  |  |
| Appointment Access |  |  |  |  |
| Care Teams and Provider Mix |  |  |  |  |
| Support Staff |  |  |  |  |
| Scheduling |  |  |  |  |
| Provider and Staff Satisfaction |  |  |  |  |
| Succession Planning |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Retention](#_RETENTION) | Gaps/Barriers | Opportunities | Strategies for Improvement | Timeline |
| Mission |  |  |  |  |
| Compensation |  |  |  |  |
| Benefits |  |  |  |  |
| Work Schedules |  |  |  |  |
| Career Paths |  |  |  |  |
| Organizational Culture |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Recruitment](#_RECRUITMENT) | Gaps/Barriers | Opportunities | Strategies for Improvement | Timeline |
| Community Recruitment Plans |  |  |  |  |
| Recruitment Team |  |  |  |  |
| Recruitment Priorities |  |  |  |  |
| Recruitment Budget |  |  |  |  |
| Recruitment Firm |  |  |  |  |
| Advertising & Social Media |  |  |  |  |
| Screening Process |  |  |  |  |
| Candidate Follow-Up |  |  |  |  |
| Contract Development |  |  |  |  |
| Onboarding |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Workforce Development](#_WORKFORCE_DEVELOPMENT) | Gaps/Barriers | Opportunities | Strategies for Improvement | Timeline |
| PCMH |  |  |  |  |
| NHSC |  |  |  |  |
| State Loan Repayment |  |  |  |  |
| HP-ET |  |  |  |  |
| Partnerships with Health Education Programs |  |  |  |  |

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19. This work has also been referred to as “Pipeline Development” but the ACU is using “Pathway Development” intentionally to respect and honor the expressed wishes of Indigenous people. [↑](#footnote-ref-19)