# CALIFORNIA'S OPEN DOOR PROVIDERS:

## *Ten Case Studies of the Health Care Workforce*

JULY 2002

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**Acknowledgments**

This report was made possible through the support of the California HealthCare Foundation, which, in partnership with The California Endowment, funds the California Workforce Initiative.

The authors thank Nadine Burke, M.D. for research support in the project's preliminary stages. Additional support for research activities contributing to this report came from the California Association of Public Hospitals and Health Systems, the Calfornia Health Care Safety Net Institute, and the California Primary Care Association. The authors gratefully acknowledge the numerous individuals, institutions and organizations who provided information for this report.

The findings and views contained in this report do not necessarily reflect the views of the California HealthCare Foundation, The California Endowment, the University of California, the reviewers, or contributors of the project.

Design: John Malmquist Design / Berkeley, California



Suggested citation style: Dower C, McRee T, Briggance B, Vance J, O'Neil E. *California's Open Door Providers: Ten Case Studies of the Health Care Workforce.* San Francisco CA: California Workforce Initiative at the UCSF Center for the Health Professions. July 2002.

### California Workforce Initiative

The California Workforce Initiative, housed at the UCSF Center for the Health Professions and funded by the California HealthCare Foundation and The California Endowment, is designed to explore, promote and advance reform within the California health care workforce. This multi-year initiative targets supply and distribution, diversity, skill base and regulation of health workers, utilization of health care workforce and health care workers in transition.

CALIFORNIA WORKFORCE INITIATIVE

### The Center for the Health Professions

The mission of the Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities.

The Center is committed to the idea that the nation's health will be improved if the public is better informed about the work of health professionals.

THE CENTER FOR THE HEALTH PROFESSIONS
*University of California, San Francisco*

### California HealthCare Foundation

CHCF, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information, visit us online at www.chcf.org.

CALIFORNIA HEALTHCARE FOUNDATION

### The California Endowment

The California Endowment, the state's largest health foundation, was established to expand access to affordable, quality health care for underserved individuals and communities. The Endowment provides grants to organizations and institutions that directly benefit the health and well-being of the people of California.

THE CALIFORNIA ENDOWMENT

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# EXECUTIVE SUMMARY

Critical health care issues related to the available supply of professional workers have emerged across the nation as hospitals and clinics struggle to provide needed services. Despite this increased awareness, little attention has been paid to these issues as they play out in health care "safety net" or "open door provider" institutions. These institutions provide:

- The majority of care for 1 in 5 Californians
- Fully ¾ of Level I trauma centers and ½ of the burn beds in California
- Often the only access to health care for rural, low-income or uninsured Californians
- Disproportionately high percentage of care to Medi-Cal patients
- Vital training facilities for physicians and other health workers

**Open Door Provider**

— a hospital, academic medical center, community-based health center or other entity dedicated to assure the accessibility of cost-effective, high quality and culturally appropriate health care services for low-income and uninsured populations, beyond those emergency and stabilization services required by law. Open door providers also ensure the availability of critical public goods, such as trauma and burn care, essential to the health and well-being of the public-at-large (California Association of Public Hospitals and Health Systems (CAPH), 1999).

Sustaining, through recruitment and retention, the right number of quality workers at public hospitals and community clinics is necessary to ensure access to care for low-income, uninsured and vulnerable populations. As there is no system of care that backs up the safety net, without adequately staffed safety net institutions, all Californians could find their well-being in jeopardy.

To understand this issue better, the Center for the Health Professions, with help from a number of organizations and individuals, conducted an examination of workforce issues in California's safety net institutions. This report starts with descriptions of the characteristics that define and describe open door providers and provides overviews of health care workforce issues common to all delivery sites. Ten case studies of California public hospitals and community clinics are included to provide qualitative information about the workforce experiences of these open door providers. Findings and recommendations are offered as next steps to ensure the workforce needs of California's open door providers are met.

### Characteristics of open door providers

1. *Populations served* tend to be low-income, un- or under-insured for health care, and drawn largely from underserved racial or ethnic communities.
2. *Mission or mandate* is to serve anyone regardless of health insurance status or ability to pay.
3. *Services* offered by hospitals include full range of inpatient and outpatient services plus, in many cases, trauma and burn units; clinics offer full range of outpatient services.
4. *Funding sources* are limited and unstable.
5. *Physical plants and equipment* range from new and state-of-the-art to old, run-down and crowded.
6. *Bureaucracy* at hospitals run by county governments pervades all work; all open door providers work with government insurance program bureaucracy.
7. *Staffing* needs include interpreting services, discharge or referral planning in coordination with other health and social services for indigent and un- or under-insured patients, Level I trauma and burn care staff, public health nurses, community outreach workers, and volunteer clinicians.

### Health care workforce issues common to all delivery sites

#### Issues that cross professions

- *Workforce shortages*, recruitment, and retention challenges increasingly common
- *Decreasing levels of satisfaction* among workers
- Rising *staffing costs*
- *Race and ethnicity* of health care professionals does not reflect general population
- Health care workers in *rural areas* in short supply
- *Emergency departments* feel staff and usage pressures

#### Profession-specific overviews

- *Physician Workforce* - geographic maldistribution, gender and race/ethnicity imbalances, some specialty shortages
- *Nursing Workforce* - statewide and national nurse staffing shortages; gender and race/ethnicity imbalance
- *Pharmacy Workforce* - changing practice patterns, statewide shortages
- *Selected Certified, Technical and other Licensed Allied Health Workforce* - specific issues and shortages
- *Dentistry Workforce* - geographic maldistribution; rural shortages
- *Hospital Executives* - high turnover

### Case studies

Ten of California's open door providers (five hospitals and five clinics) were toured and high level administrators and leaders were interviewed to collect information about staffing challenges, issues and solutions. Site visits and interviews were conducted at Arrowhead Regional Medical Center, Colton; San Francisco General Hospital; Martin Luther King/Drew Medical Center, Los Angeles; Contra Costa Regional Medical Center, Martinez; Community Medical Center — Fresno; Sacramento County Primary Care Clinic; North County Health Services, San Marcos Health Center; Venice Family Clinic; Humboldt Open Door Clinic, Arcata; and Salud Para La Gente, Watsonville. The information gathered provides insight into the particular workforce concerns facing open door providers and their capacity to address those concerns. In addition, examples of best practices and models of success for improving recruitment and retention of health care workers were identified. These include:

- A state-of-the-art facility designed with staff input (see page 37)
- Outstanding volunteer clinician programs (see pages 69 and 81)
- A dental unit with new equipment and bilingual dentists (see page 93)
- Educational programs to facilitate community recruitment and staff retention (see page 61)
- Excellent staff retention and longevity (see pages 43 and 49)
- An in-house per diem system that works (see page 55)

### Findings

California's open door health care institutions — public hospitals and health systems, and community and free clinics with missions or mandates to serve anyone regardless of ability to pay — represent vital health care resources for emergency care, the uninsured, and residents of geographically isolated areas. Not surprisingly, these open door providers share many of the workforce challenges that are now confronting all of health care in California and the nation. In addition, there are distinctive workforce challenges and opportunities for open door providers.

**F1** California's open door providers share some workforce challenges with other delivery sites in the state including:

- Hiring and retaining nurses, pharmacy personnel, some physician specialties, and radiology personnel;

- The need for racial and ethnic diversity, cultural competence, and bilingual skills among workers;
- The need for flexible practice and professional models for the delivery of care services, and
- Recruiting and retaining health care practitioners in rural areas.

**F2** In addition to common workforce challenges that health care delivery sites share, California's open door providers reported particular challenges in the areas of:

- Finding physicians who will accept referrals for Medi-Cal or uninsured patients;
- Dentistry workforce shortages;
- Public health nurse shortages; and
- Hiring and retaining clerical workers.

**F3** Some global characteristics of open door providers can mitigate workforce challenges, making the site attractive to potential employees and improving retention rates. These characteristics include:

- *Service mission* An orientation or mandate to serve all patients regardless of their ability to pay. A stated and demonstrated mission to serve the underserved helps create strong teams, a sense of family, and dedication to the job. Places that "work well" have clear mission statements that are posted, known and referenced regularly by staff.
- *Comprehensive clinical services*. Open door providers often offer a full range of health care, often including trauma and other special unit care not available at other sites.
- *Strong benefits packages and stability*. Public hospitals and health systems in particular can often offer generous benefits packages (including well-funded retirement plans) and long-term employment stability.

**F4** Some characteristics of open door providers exacerbate workforce challenges, making it more difficult for them to secure an adequate workforce. These characteristics include:

- *Lower salaries and wages*. Due to budget constraints and unstable funding sources, many open door providers can only offer salaries and wages that are lower than those of competitors. Some clinics rely on volunteer clinicians to provide care and must find enough of them willing to work to cover open hours.
- *Bureaucracy and competition*. Public hospitals in particular are subject to layers of bureaucracy that limit the ability to act quickly or independently on personnel issues, including hiring, adjusting salaries, and changing job titles or descriptions.

Where aspects of job posting, examinations, or hiring are centralized at the county level, county hospitals and clinics may lose potential hires to other sites and may not have easy access to information collected about the workforce.

- *Unattractive reputations*. Some open door providers suffer from unfounded myths regarding run-down facilities or less-than-optimal quality of care.

**F5** For some professions (e.g. general medicine), open door providers' positive characteristics may be sufficient to outweigh the negative characteristics, as evidenced by workforce needs generally being met. For other professions (e.g. radiology technicians and clerical workers) the positive characteristics may be insufficient to counter-balance extreme pay differentials.

**F6** Compared to other variables, location is often the most important factor in workforce issues. Aside from inability to act quickly, most open door providers had more or less the same workforce challenges (or lack thereof) as other providers in the same geographic area. Local collaborations among delivery sites or between delivery sites and educational institutions have shown success in addressing workforce issues in those areas.

**F7** Each community clinic and public hospital has a distinctive set of challenges, constraints and resources.

- Several of California's open door providers, pushed by necessity to be creative with their approaches to staffing, hiring, recruiting and retaining the right number of quality workers, have implemented innovative solutions and "best practices" that can serve as models.
- Many institutions have worked within local constraints and limited resources to develop coping mechanisms for their problems and challenges.
- Often a winning idea or strategy was the work of one individual leader or manager, without whom the program would likely fail. This phenomenon sometimes led to a patchwork of distinct, unrelated programs and projects with designated funding that could not be shifted to other needs.
- The unique character of institutions and communities may make blanket policy proposals irrelevant to many sites.

**F8** Populations served by open door providers directly affect workforce issues, including:

- Dictating essential characteristics, such as bilingual and bicultural skills, necessary for the health care workforce at a particular site;

- Creating a pool of potential health care workers from those served who are committed to the organization and to "paying back" the community with service; and,
- Producing site-specific epidemiological challenges (e.g. rates of tuberculosis) that forecast the need for particular programs, departments and professionals.

**F9** An 18–24 month window was reported by many open door providers to be a critical employment period. Workers who stayed beyond this point would often stay for an entire career; by this time, they were committed to the work and the site. Those who would leave because of the environment would likely leave within the first two years.

**F10** There are perceived tensions between groups of workers at some open door provider institutions that affect staffing.

- The perceived generation gap between younger and older health professionals may be exaggerated at open door providers. Older workers who entered health care generally, and public hospitals or community clinics specifically, because of a personal commitment that mirrored broader social movements to serve those in need, are unsure about the social, career and economic values of their younger co-workers.
- A gap between workers who were committed to the open door provider mission and those who were there for the job, or to run the business, was perceived at some sites. Leaders at some sites felt able to use this tension constructively and balance the different values, goals and strategies to provide high quality care in a cost-effective manner to all patients.

**F11** Open door providers generally operate on extremely limited and unpredictable budgets that affect ability to hire and retain staff. In particular, when the economy slows and demand increases for public health services, and the staff needed to provide them, public program budgets are cut.

**F12** Good leadership and management are of cardinal importance for successful implementation of workforce policies and strategies. However, open door provider leaders and managers have limited access to resources for their own professional development.

**F13** The physical buildings, floor plans and equipment at each site have significant impacts on many workforce issues including unit staffing, employee satisfaction, worker safety and efficiency, access for patients and workers, and types of providers hired.

Like all delivery sites, these issues are critical but open door providers often face significant budget limitations for building and renovation. Community and free clinics are notably crowded and operating in space not originally built for health care services.

**F14** Leaders at open door provider institutions must rely on good information to address staffing problems. Necessary information, however, is often lacking or unavailable to open door providers. Such information includes:

- Meaningful data on the workforce, including demographics, educational background, and reasons for choosing, remaining at, and leaving a job.
- Research on the impact of various staffing, teaming and utilization models on quality of care, patient satisfaction, employee satisfaction, and personnel costs.

### Recommendations

To improve the hiring, training, management and retention of staff at California's open door provider institutions, a number of recommendations are offered. These are directed to a number of different audiences including county officials, institutional administration, state and local policymakers, union leaders, educators, researchers, and health care professionals. In many instances, collaborative efforts among several of these groups will be required for successful reform.

**R1** Share *best practices* — Some of the best and most creative workforce innovations encountered in the study were low cost adaptations to common challenges. While heavily dependent on the work of individuals and somewhat site specific, these workforce innovations nonetheless could be adapted to other settings. Forums might include workshops, conferences, electronic exchanges and websites.

**R2** Build on distinctive *centers of excellence*. Every site need not provide all services to all populations. By identifying their own outstanding clinical competencies or best practice models for addressing the needs of particular populations, open door institutions can focus on developing centers of excellence. Such strategies should allow open door providers to secure additional resources that can assist them in workplace redesign.

**R3** Create *collaborative partnerships* between delivery organizations and labor unions representing workers — Such partnerships can improve understanding, create a common political agenda, redesign work and job function and make more effective use of limited resources.

**R4** Streamline *bureaucracy* — This issue is most significant in the public setting and provides an arena where immediate action could be taken. Not having enough workers to deliver care may provide the motivation to make the necessary changes at the county level. Strategies driven by employees, unions and line managers (rather than top-down) may be the most important issues on which to focus. Until bureaucracy can be streamlined, support and training could be provided to managers to work in this environment.

**R5** Change *practice and professional delivery models* — Many workforce shortages exist only because of and within the constraints of a model of care delivery that has built-in but outdated assumptions. Use current challenges of care and staffing as a way to raise issues of work redesign, personnel substitution, and technological substitution.

**R6** Build and improve *leadership and management resources* — Individuals who are designing and implementing innovations throughout the system in California should be encouraged to share their managerial and leadership vision, skills and success with wider audiences. Reward those who become innovators.

**R7** Create workable *career ladders and education support* — Career ladders throughout health care organizations improve quality of work life and make employment more attractive and sustainable. They can also target previously untapped pools of potential workers and help individuals from those pools enter professions experiencing critical shortages.

**R8** Ensure *diversity and cultural competence in workforce* — Latino and African American workers are underrepresented in most health occupations in California. Most open door providers serve a higher percentage of these populations. Improving the match between populations served and workers needed will create new employment opportunity, improve health outcomes and build stronger ties between community and health care organizations. Continue and expand efforts to recruit and retain health care staff with the language skills and cultural competence to care for populations served.[1]

[1] Cultural competence resources can be found, among other places, at the UCSF Center for the Health Professions and the California Association of Public Hospitals and Health Systems.

**R9** Incorporate *data collection and tracking* strategies into overall institutional information strategy — Over the next decade all health systems will make improvements in their data infrastructure. Human resources and management leadership should be clear about the types of information they could use to address workforce challenges organizations will confront. Additional qualitative research about, for example, the pivotal two-year window for employees, could also help institutional leaders better plan workforce needs.

**R10** Ensure *adequate funding and financial management* for open door providers to meet their mandates to provide care to anyone regardless of ability to pay.

**R11** Develop and implement plans to *better inform* policymakers and the public about open door providers, the work that they do, the workforce needs they have and the job opportunities they offer.

**R12** Recognize *new patterns of work; changing work values and shifting demographics*—More than any factor in the future these three realities together are creating new opportunities and challenges for all health care organizations. By understanding and anticipating new patterns of work, open door providers can use them to their advantage when plotting strategic directions. For example, older people with means may serve as volunteers and the service-oriented values of younger workers may prove an asset for open door institutions.