

# California Prison Health Care Services

## Workforce Development



**LVN**  
As a key member of our health care team, you will find this challenging by improving the overall quality of care for the California prison inmate population. You will work in a changing environment that demands great customer and variety and fosters a clear sense of responsibility.

**PHARMACIST**  
We are accepting the standards of care for 175,000 California prison inmates. And as the only pharmacist work you have done the state of California's most demanding and most challenging environment.

**NURSE EXECUTIVE**  
Ensuring the quality of care for the State of California's inmate population is a noble mission - one that is also right in scope. And you will take a leading role in helping us achieve this mission.

**CHIEF EXECUTIVE OFFICER - HEALTH CARE**  
If the exciting challenge of leading your career portfolio is to lead, leadership in health care is not just a job title, it's a mindset. And as the only person in the state of California who has led a health care organization for 175,000 inmates and approximately 100,000 other inmates, you will be a leader in your own right.

**SUPERVISING NURSE**  
Ensuring the standards of care for 175,000 inmates, yet essentially providing care to the historical opportunity that is waiting for you at California Prison Health Care Services. As a key member of our health care team, you will take on this challenge while leading in a demanding, fast-paced, and ever-changing environment.

**SPECIALTY NURSING**  
Ensuring the standards of care for 175,000 inmates, yet essentially providing care to the historical opportunity that is waiting for you at California Prison Health Care Services. As a key member of our health care team, you will take on this challenge while leading in a demanding, fast-paced, and ever-changing environment.

**PHYSICIAN (INTERNAL MEDICINE/FAMILY PRACTICE)**  
Ensuring the quality of care for the State of California's inmate population is a noble mission - one that is also right in scope. And you will take a leading role in helping us achieve this mission.

**CHIEF PHYSICIAN**  
Ensuring the standards of care for 175,000 inmates, yet essentially providing care to the historical opportunity that is waiting for you at California Prison Health Care Services.

**REGISTERED NURSE**  
Ensuring the standards of care for 175,000 inmates, yet essentially providing care to the historical opportunity that is waiting for you at California Prison Health Care Services. As a key member of our health care team, you will take on this challenge in a demanding, fast-paced, and ever-changing environment.

**PHYSICIAN (INTERNAL MEDICINE/FAMILY PRACTICE)**  
Ensuring the quality of care for the State of California's inmate population is a noble mission - one that is also right in scope. And you will take a leading role in helping us achieve this mission.

**PSYCHIATRIC TECHNICIAN**  
We are seeking a highly motivated and detail-oriented individual to join our team as a Psychiatric Technician. This role is essential in providing care to the inmate population of California's most demanding and most challenging environment.

**MEDICAL EXECUTIVE**  
Ensuring the standards of care for 175,000 inmates, yet essentially providing care to the historical opportunity that is waiting for you at California Prison Health Care Services.

Putting the *Human* in Human Resources

*Strategic Plan  
July 2010 – June 2011*

# California Prison Health Care Services

## Workforce Development

### Strategic Plan

July 2010 – June 2011

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## *Executive Summary*

CALIFORNIA PRISON HEALTH CARE SERVICES continues the profound journey that began February 14, 2006. A great deal of energy and creativity has gone into building this organization, and those involved should be proud of their accomplishments—we have come a long way towards meeting the Receiver’s *Turnaround Plan of Action*, and in so doing meeting the Constitutional rights of a population under our care.

Like many complex systems undergoing radical change, early improvements came quickly. Incompetent practitioners were fired, wages were revised upwards to reflect real-world competitive needs, and focused recruitment produced qualitative and quantitative improvements to the health care team serving our 33 adult correctional facilities.

By July 1, 2008, the Receivership was not only managing human resources, it was fully immersed in an \$8 billion building plan that would construct 10,000 beds in seven skilled nursing facilities. These seven facilities would be the capstone of the Receivership.

While managing the on-going health care staffing goals at our existing institutions, we began to focus our recruitment planning on the challenges that were headed our way.

But *the best laid plans of mice and men often go astray*, and the Receivership proved to be no exception. The first shoe to drop was the political backlash that attacked the plan as unnecessarily costly. In some ways we were being undermined by our own success, as the facts were showing measurable improvements in overall care, along with a reduction in morbidity rates.

The second shoe dropped in fall 2008 when the global economic crisis would shake everyone’s confidence. With foreboding headlines everywhere, and the state paralyzed by a severe cash shortage, the Receiver’s building plan was at first scaled back, and then put on hold.

AS WE REGROUP AROUND A REVISED CONSTRUCTION PLAN, we still face many hurdles to overcome if we are to continue our success. The pages that follow are divided into three major sections. Part 1. From *Plata to California Prison Health Care Services*, is a look at the many things that we have accomplished so far. Part 2. The Workforce Development Strategic Plan, reviews the coming challenges, and Part 3. The Metrics, is a detailed look at our recruiting and hiring results from 2008 to the present situation.

The chart on the next page highlights the many important tasks that are planned for the next year. The narrative and the data contained in the plan presents the rationale for why these tasks are key to our continued evolution.

Some may argue, perhaps quite correctly, that a particular goal is too ambitious or can't be done in the timeframe allotted. If that is the case, then *when* the goal needs to be accomplished should be adjusted. However, to say that any of these tasks should be eliminated is to risk the structural soundness of the organization as a whole.

We have much to do. The total health-care requirements in Stockton will be immense; the activation rate of new care sites in addition to the Stockton build is very aggressive; the reintegration of medical, mental health and dental is necessary but remains in transition; we have several competing systems trying to supply accurate data; and succession planning is more critical than ever.

### Major Tasks for FY 2010-2011

ID	Task Name	Start	Finish	Q3 10			Q4 10			Q1 11			Q2 11			Q3 11			Q4 11			
				Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1	Workforce Planning for Receiver's & CDCR statewide building plan How does the total build/remodel plan effect Workforce Development?	1/3/2011	3/1/2011																			
2	Workforce Development Recruitment Efforts – Ongoing Online & Print Advertising Events & Conferences Mass Mailers Other Candidate Recruitment Activities	7/1/2010	6/30/2011																			
3	Planning for HR Reintegration of Mental/Dental Making sure we are prepared Implementing major psychiatric recruitment effort	9/1/2010	12/31/2010																			
4	Stockton Plan – Update 1 Revise plan based on latest figures	12/1/2010	2/1/2011																			
5	Stockton Plan – Update 2 Tactical Model Create tactical Workforce Development & Recruitment plan to achieve staff goals	6/1/2011	9/1/2011																			
6	CEA Leveling Project – Phase 1 Analysis of executive positions Presentation to SPB & DPA	9/1/2010	1/31/2011																			
7	Centralized Hiring - RCEA Complete CEO Recruiting Medical & Nurse Executive Recruiting on-going	7/1/2010	6/30/2011																			
8	ATS – Eligibles vs. Employables Supplemental Data Enhance to filter eligibles into well-qualified pool	8/2/2010	4/1/2011																			
9	HIRE Software Influence design at earliest stage	7/1/2010	12/31/2010																			
10	BIS Tracking – Real Capabilities Understanding real data output	10/1/2010	12/31/2010																			
11	Advanced HR Tracking Software Concept Workforce Dev. vision for what we really need	8/2/2010	2/1/2011																			
12	Exams Annual Exam Plan Complete	7/26/2010	7/30/2010																			
13	On-Line Exams Add balance of 41 exams to on-line system	10/1/2010	4/1/2011																			
14	Training Annual Training Plan Complete	7/1/2010	7/15/2010																			
15	Continued Implementation of HCNEO Statewide	7/1/2010	6/30/2011																			
16	Resumption of Statewide Basic Supervision Training	9/15/2010	12/31/2010																			
17	Implement Block Training Programs	10/1/2010	6/30/2011																			
18	Clinical Rotations Secure RJD beyond pilot year	7/1/2010	9/1/2010																			
19	Clinical Rotations – Institutional Model Implement RJD model as template for broader use Review transition clinicals for RN grads	9/15/2010	1/14/2011																			
20	Exit Surveys – Refining & Tracking the Data	10/1/2010	3/1/2011																			
21	Employee Satisfaction Survey Implemented	1/3/2011	3/31/2011																			
22	Search Firm to Begin Aiding Recruitment Goals	7/1/2010	7/14/2010																			
23	Creation of Retention & Recognition Program On-boarding + tool kit to support supervisors	9/1/2010	12/31/2010																			
24	Succession Planning Implement Leadership Mentoring Program Further analyze additional succession needs	7/1/2010	6/1/2011																			

End of FY 2010-2011

## Part 1

### From *Plata* to *California Prison Health Care Services*

#### Where Have We Been?

##### ***Progress Report***

From the robust changes in prison health care at the beginning of the Receivership to the redirection of our energies in light of the fiscal crisis, we have been steadily building a Human Resources organization to support the mission of the Receiver's *Turnaround Plan of Action*.

Originally referred to as "Plata," after the named plaintiff in the class action lawsuit that brought about the receivership, California Prison Health Care Services (CPHCS) has set about building a new organization that will serve the health care mission within the California Department of Corrections and Rehabilitation (CDCR) for years to come.

Prior to the economic turndown, the rate of change at CPHCS (*nee* Plata) was breathtaking at times, with the energy and creativity of a start-up. New hires were being added at a rapid rate, and new policies, new procedures, and new major projects were undertaken on an ongoing basis. We were building a human resources organization from the ground up.

The ultimate measure of our success will be judged by how we fit various elements together to form a cohesive whole. We need to be focused on a sustaining, efficient organization that can meet current and distant challenges while avoiding the numbing drag of a deeply entrenched bureaucracy— duplication of efforts, poor communication, undependable data, and a lack of clarity— will only serve to diminish our effectiveness. Our goal is to put the *human* in Human Resources, for without dedicated, professional staff, our medical mission cannot be achieved.

##### ***Review of Key Human Resources Projects***

###### Health Care New Employee Orientation – HCNEO

HCNEO is, in many ways, our effort to plant the flag for California Prison Health Care Services. New health care workers, from certified nursing assistants (CNA) to physicians, were introduced to correctional health care from our own training experts. Rolled-out regionally in March 2008, HCNEO was building confidence and momentum with nearly 30 training sessions completed before February 2009, when HCNEO was put on hold due to restricted travel and related per diem costs.

With the execution of the tri-signature memo in October 2009 by Clark Kelso, Receiver; Suzan Hubbard, Director, Division of Adult Institutions; and Sharon Aungst, Chief Deputy Secretary, Division of Correctional Health Care Services, HCNEO was solidified

to replace the current In-Service Training (IST) NEO at the institutional level, thus preserving the orientation from a health care perspective.

Institution-based HCNEO began in January 2010, utilizing local IST staff and instructors, assisted by the newly established Health Care Training Coordinator. The curriculum is consistent from institution to institution, as CPHCS has developed and distributed the curriculum statewide. On-going webinar training sessions for IST staff help to preserve consistency. This is important, as we are a health-care unit serving the needs of a correctional environment, not custody employees providing care.

### Clinical Rotations Initiate First Cohort Class

In preparation for the Receiver's building plan, we began looking for ways to "grow our own." The especially critical classification is psychiatric technicians (Psych Techs). Using today's Stockton staffing estimates alone, there is a likely need for 440 Psych Techs over the coming two to three years, plus substantial needs throughout the system.

Based on available data, there is little hope of being able to recruit Psych Techs in the required numbers. This classification is likely to become increasingly difficult to recruit, as the limited number of educational providers is declining, and those remaining are reducing enrollment. Without exception, the contraction of this certification program is the result of the fiscal crisis and not a reduction in need.

The first step in any active training program is to establish clinical rotations at prison clinics. This is necessary so that schools can expand their educational programs, for without clinical sites, program size remains static. Graduation rates are further challenged because many schools are losing clinical rotation agreements with health care providers. Clinicals also give us the chance to expose students to correctional medicine during the formative teaching years, an important recruitment tool that gives us the chance to view newbies in action and select from the most appropriate candidates.

The 10,000 bed plan, before being sidelined, called for the first Receiver facility to be constructed in San Diego. Starting in November 2008 we began working towards developing a suitable contract for clinicals to take place in Chula Vista, a suburb of San Diego.

Working in conjunction with both medical and custody staff at Richard J. Donovan Correctional Facility (RJD) and Southwestern Community College (SWC), we approached the agreement with the idea that it could become a template for other institutions to use. The first cohort class of licensed vocational nursing students (LVNs) began rotations September 2009 at the locked unit of Alvarado Hospital. The first cohort class began clinicals at RJD in January 2010 and, by the end of April 2010, the first pilot year of the program had been completed.

The RJD-SWC clinical rotation program was very successful. The custody staff was pleased with the program, and the nursing staff at RJD not only adapted to having the students in the clinics, they enjoyed having the extra sets of helping hands.

New employee orientation was provided for all students and SWC faculty that would be on site. It is essential that students and faculty alike maintain a “custody awareness” at all times. Whether or not orientation needs to be a full five days is a matter being debated; some students and faculty thought that much of the information did not pertain to them, and that the orientation could be conducted in three or three and one-half days rather than a full five days. This change remains part of the ongoing review of the pilot program.

As a practical accomplishment, the students learned very quickly to get and stay organized, and how to present themselves in a professional and confident manner with inmate patients. This was an excellent outcome that is hard to achieve with first-semester nursing students.

From a direct recruiting perspective, clinicals for LVNs represent an incremental opportunity rather than a chance to hire graduates right out of school. At this moment in time we are not hiring new graduates since there is an abundant supply of experienced vocational and registered nurses seeking employment with us. As the economy changes and more and more nurses retire, the need to hire new grads will be more critical, and our ability to use clinicals to groom students to the special needs of correctional medicine will be a huge advantage.

Clinicals also present an intangible benefit that may be hard to quantify, but exists nonetheless. In the beginning, many students were ambivalent or completely disinclined towards a career in correctional medicine. But at the debriefing/evaluation meeting for each cohort group, the enthusiasm for a correctional medicine career had blossomed.

We managed by virtue of our actions to peel away some of the fear factor in terms of working in a prison, a very positive step for us. Furthermore, every time a student or faculty member experiences first hand the correctional environment, they spread the word among their friends and coworkers that a career with Corrections can be very rewarding and that the general population should not fear this necessary fact of life in a modern culture.

We need to view clinicals as an evolutionary process, and not something that we can start and stop like a machine tool. The goal is to make sure that everyone understands processes and procedures so that the experience will be of maximum benefit to all concerned with the least amount of disruption to staff services.

We are currently (June 2010) in the process of reviewing the pilot class of student nurses. We are highly desirous of the program continuing so that we can use it as a base for expanding clinicals to other institutions and schools.

### Grow Our Own – Part 2

In addition to our efforts to secure clinical rotations in correctional facilities on a routine, systematic basis, we also worked towards helping expand Psych Tech

educational capacity by participating in U.S. Department of Labor (DOL) and California Employment Development Department (EDD) grants. In two of three cases where the outcome is known, we were not successful in garnering any grant funding to further Psych Tech education. The third effort, a DOL grant proposal to expand San Joaquin Delta Community College, should have been decided in June 2010, but the exact outcome is still uncertain.

We may be fighting a perception that CDCR does not need or deserve grant funding when so many other worthy causes are competing for dollars. It could also be that the psychiatric technician classification is not well known outside of those public agencies that use Psych Techs—in fact, it is a recognized, licensed health care vocation in only four states. With the lack of recognition for the class, it is possible that we will continue having difficulty gaining traction with various funding sources.

With the schools themselves unable to fund program expansion on their own, some form of outside funding is going to be necessary if we are to meet our future staffing needs for Psych Techs.

#### Receiver's Career Executive Assignments – A New Model for Executive Leadership

Few programs better illustrate the vision of the Receiver to do things differently than the Receiver's Career Executive Assignment (RCEA) program, which was conceived as a structure for bringing in career health care executives into CPHCS without the requirement of having previous State or Corrections experience. This is nothing less than a seismic change for civil service and, in many ways, we were granted Department of Personnel Administration (DPA) approval for these classifications because the concept was seen as not likely to migrate to other departments or agencies.

The RCEA classification currently contains the following job titles: Medical Executive, Nurse Executive, Chief Executive Officer, and Clinical Executive. In addition, there are three Clinical Executive positions; one each for Imaging, Pharmacy, and Laboratory Services. RCEA appointments at the facility level report to the facility CEO (medical and nurse executives); those at regional or statewide levels report to the statewide RCEA at headquarters. Recruitment, selection and hiring for these positions is managed by the Centralized Hiring Unit, which is discussed on page 13.

Approved by the court as a new model for building executive leadership, RCEA appointees are two-year limited-term assignments, plus one year of probation. In effect, these executives are "at-will" employees for three years. (RCEA appointments who were State employees prior to appointment, but are terminated as an RCEA, are eligible for the classification they held previously.)

Further emphasizing the unique nature of the RCEA position, these classifications are the only competency-based specs in all of state civil service, potentially a giant step in the direction of being able to hire and retain the best health care executives from private industry.

Even the compensation plan is part of the progressive nature of the RCEA program. The plan is designed to award experiential and performance excellence. The former allows for additional base pay depending on experience guidelines, such as serving the under-served, controlling a budget at or above a certain level, and managing more than 100 employees for three years or more. Base pay would also be increased depending on degrees awarded, professional certifications, and board appointments. Pay could be increased depending on the institution or whether the assignment was a regional or statewide appointment. Exceptional candidates could be paid more, which should allow us to attract exceptional applicants.

Performance criteria is a method for awarding one-time annual payments (not added to base pay) for meeting or exceeding certain goals on a yearly basis.

Lastly, longevity pay would award the appointee with cumulative increases in pay based on one, three, five and ten years of service.

Implementing the pay plan does have its thorny issues. How appointees are reviewed is one issue, as well as risking another version of merit-less merit pay that simply increases staff costs without improving performance. Ideally, the pay scheme will enhance our recruitment and retention efforts with these high-value employees.

The pay plan is discretionary and subject to available funds. As such, we have not yet paid any incentive money to RCEA appointees because of budget constraints. When these incentives might be paid is a subject still under consideration.

The RCEA program is definitely an innovative classification for bringing in new talent from the outside. In practice, most of the facility CEOs have been external candidates. Medical executives have been almost all internal candidates, as the nature of this job has few external equivalents. Nurse executive recruitment has produced a number of external candidates, though several positions have been filled with internal hires thus far. A number of facility CEO appointments have not yet been made. Once they are in place, the medical and nurse executives that serve under the CEO will be filled.

The vision of the RCEA classification is another measure of our willingness to embrace innovative solutions. We are building the core executive staff that will guide us into the future. Some hires have probably been less than perfect and others have proven to be exceptional. What matters most is not the skills of any one individual, but the fact that we have a system *in place* that allows us to attract and hire very talented individuals.

### Online Exams Underway for Several Classifications

The CPHCS online exam system currently has 21 classifications automated, a major step forward in the continuing evolution of CPHCS Human Resources as an innovator. The value of this process can be measured in two distinct ways:

Internally, the online exams give us control over the process—the exams are created, edited, and processed by our staff members. This represents not only a streamlined

procedure for us, but a dramatic cost savings as well. Additionally, being able to revise and shape an exam internally allows us to be far more responsive to a changing employment environment than if we had to manage revisions through the State Personnel Board (SPB).

Perhaps more difficult to quantify, but equally important in terms of achieving our mission, is that new candidates exposed to civil service employment through our online system experience a contemporary, efficient process rather than a frustrating bureaucracy that can turn people off before they get started. The system provides exam results immediately, eliminates redundancy in completing forms and other requests for information, and modernizes the vetting process for checking licenses and credentials. You only get one chance to make a good first impression and online exams are definitely a good first impression. Our goal is to add the 41 remaining classifications to the system during the coming fiscal year.

### List Management and the Rule of Three Ranks

As the Receiver's Turnaround Plan was put into action, incompetent medical personnel were systematically terminated. This activity, along with the realization that we needed a large medical staff if we were to meet court requirements, put tremendous demand on the selection process to produce a bigger pool of eligibles in order to fill all authorized positions.

The Rule of Three Ranks states that only candidates within the top three ranks are reachable for recruitment and hiring. A counterbalancing civil service concept is called the Rule of the List, which means, in simplified terms, that if someone has met the minimum qualifications (MQ), passed an exam, and is duly licensed by an appropriate board, that candidate is "qualified" to be on the eligibles list. In other words, you are on the eligibles list if you met the MQs, passed the exam, and are licensed in your profession.

Selection Services resolved the conflicting needs of a large-enough pool of eligibles while maintaining the Rule of Three Ranks by limiting the list to only three ranks that included all successful candidates. In some respects it was a compromise based on the fidelity of the selection instruments being used and on the pragmatism of the Rule of the List for meeting our recruiting objectives for medical hires, especially the nurse classifications.

The Rule of Three Ranks remained intact and the Receiver's mission was attacked head on.

As we look more closely at numbers surrounding our activities (following section), we may find ourselves revisiting our list management criteria and our recruitment objectives. What's most troubling from a global perspective is that we still have institutional vacancies for certain health care positions, while at the same time having numerous eligibles for that classification willing to serve in that location. It begs the question: do we have eligibles who are not competitive? Stated another way, can we measure the difference between the "qualified" and "well qualified?" If not, the eligibles

list is not a particularly meaningful measure of our potential pool of new hires. We may also have institutional hiring practices that are cumbersome or overburdened with providing services, in which case we would want to consider revisions to hiring practices at the facility level.

### Exit Surveys – Learning About Retention From Those On The Way Out

If “Recruitment” has an evil twin, it has to be “Retention.” No matter how skillful Human Resources is at recruiting viable candidates, the loss of existing employees sets us back, which rekindles vacancy costs with added overtime and registry expenses.

From February 2009 through January 2010, an Employee Exit Survey was conducted. Medical supervisors and managers throughout the State provided the survey to departing employees and HR staff mailed a notice of the survey to employees who had permanently separated from the State.

During this 12-month period, 115 responses were received, though how many were distributed is unknown. Additionally, we know that there have been a total of 571 separations from state service over the same period, but not how many people left one state position for another one, whether as a promotion, a lateral transfer, or even a job outside of our department. Out of the 571 separations, 121 were retirements and four were disability retirements.

Even without a statistical measure of how many survey responses we got relative to those who left their jobs for any reason, we do have some meaningful qualitative data.

The top reasons respondents gave for leaving the organization were employment conditions, workplace culture and values, lack of recognition, relationship with supervisor, lack of leadership, and furlough pay cuts. Some replied that they might have stayed on with, among other things, promotional opportunities, respect, and assistance with education.

On the positive side, departing employees said they liked the challenge, work schedule, their colleagues, serving inmates, educating patients, and the autonomy of the job.

After this test period, it was determined that more detailed information would be needed in order to make specific changes that would help improve staff retention. HR staff worked with the Division of Correctional Health Care Services (DCHCS) to revise the exit survey to include Mental Health and Dental employees. The new survey was renamed Health Care Employees Exit Survey and disseminated to all Health Care supervisors and managers statewide. Results from the first few months of the revised survey are not yet available.

The overall significance of the survey should not be undervalued. Employees in various classifications have told us what they like and what they dislike. With experience, we may find ourselves asking more and different questions, and with each revision getting closer to a core understanding of why employees leave. But the fact is, a picture is now forming that should be used.

We need to listen closely to what people liked about their jobs and emphasize those features when we recruit. Likewise, we need to pay heed to the criticisms and see what adjustments we can make that might improve our retention rates. It is not a matter of hiding the negatives when we recruit, but fixing them. The process will become more and more valuable as we find ourselves once again competing for talent in a more robust economy.

### San Quentin Pilot Program

In early 2007, we launched a pilot program at San Quentin to revamp the organization of the health care department as part of our recruitment and retention of medical professionals.

The culture at San Quentin, as well as the other 32 institutions in California, was custody-centric and, as such, custody hiring took priority over hiring of health care staff. Medical professionals were simply not being hired in a timely fashion, which impacted patient care. Salary studies were conducted for difficult-to-recruit-and-retain-classifications and salaries were brought in line with the private sector. Self certifying and continuous filing with online exams helped ensure a ready and able candidate pool.

The pilot program also consisted of the Northern Region rolling in personnel transactions to the Sacramento Northern Regional office for medical, mental health, and dental staff. Two CPHCS analysts and one CPHCS office technician (OT) were hired at San Quentin as liaisons between headquarters and onsite staff and to assist the supervisors and managers in the recruitment and retention of health care professionals. The rolling in of the personnel transactions enabled CPHCS to provide consistent and accurate information to health care employees, a critical component that was missing.

The pilot has been successful in managing health care hires, especially with standardizing recruitment, retention, and personnel transactions.

### Centralized Hiring Aids in Filling Key Authorized Positions

In some respects, the Centralized Hiring Unit (CHU) is a companion of the San Quentin pilot program. By improving and streamlining the hiring process, we have been able to move towards our goal to reduce vacancies for doctors and similar classifications to 90 percent fill rate or better. It remains an imperfect world, and not all facilities have met this goal.

Classifications include Physicians & Surgeons, Physician Assistants, Pharmacists I & II, Pharmacy Services Managers, Nurse Practitioners, and Chief Medical Officers; as well as Receiver Career Executive Assignment (RCEA) candidates.

Logistically, the Centralized Hiring Unit divided the State into four regions, each focusing on scheduling interviews that lead to hiring commitments.

The process entails direct contact with potential candidates, review of curriculum vitae (CV) and resumes, checking credentialing and privileges, and coordinating with chief executive officers and medical and pharmacy executives to see which potential candidates are of interest to interview.

The CHU remains a coordinating point of contact throughout the hiring process, making sure that desirable candidates have final clearance prior to any appointment offer being made. Central Hiring provides a sense of continuity and consistent communication to the candidates, which contributes to a candidate's confidence in the system. Once a position number and start date for the candidate are established, a congratulations letter and final hiring documents are emailed to the new hire.

### The Applicant Tracking System – A Powerful Tool

In September 2008 we integrated an Applicant Tracking System (ATS) into our website *www.ChangingPrisonHealthCare.org*. ATS, developed, owned, and supported by Bernard Hodes, provides candidates with a means to create a personal profile, upload resumes, and register interests in specific medical careers. Recruiters can access information about these candidates and contact them via email.

Hundreds of medical professionals have logged onto our website and added themselves to our electronic database. Hundreds more have been added by our recruiters after visiting nursing schools, career fairs, and speaking with potential candidates over the phone.

By July 2009, we were also able to capture information needed on the standard state application, so candidates could apply electronically. Concurrently, HR recruiters developed an efficient method of collecting vacancy information from regional personnel offices. By posting vacancies on the website, candidates were able to take self-assessments and apply for actual positions rather than bouncing candidates back and forth between our website and the State Personnel Board (SPB) site.

In addition to posting vacancies on our site, we have the ability to cross-post these vacancies onto hundreds of other websites, including more than a dozen free career sites. This leverages the asset several times over. For example, instead of listing an average of 300 vacancies on our website alone, we are also posting these same vacancies on at least 10 other career websites. These additional sites refer thousands of medical professionals every month where they learn more about our benefits and our selection process. Candidates are encouraged to complete an appropriate online self-assessment or are directed to the appropriate paper application process; in either case they are added to our growing certification lists. As a result, the data base continues to expand.

Between February 1 and March 31 2009, 143 RNs were added to our ATS. During the same period this year, 737 RNs added themselves to our ATS. That's more than a 500 percent increase in a one-year timeframe. Some of this increase may be due to economic conditions, but we have to think that much of the growth is a result of a streamlined system that works well.

No other state agency has access to this system or anything like it. We have the power to store thousands of medical professionals in one place. It's an easy-to-learn tool with the ability to index and search for candidates based on their medical background and keywords stored in their resume. It is even linked to online exam results.

It only makes sense to continue to invest in what works. With ATS integrated into our overall recruitment strategies, we are taking a big step towards becoming a contemporary workforce development organization that is able to efficiently recruit the next generation of health care professionals for CPHCS.

### Central Fill and Centralized Medical Transcription

The Central Fill Pharmacy implemented Phase I of recruitment in Sacramento with the work force beginning April 2010. Phase II hiring is anticipated in November 2010. The new centralized system will blister pack inmate-patient's daily medication and then ship to the appropriate institution where it will be administered by institution staff to the patient. It is yet to be determined which classifications and positions will be redirected from the institutions pharmacies.

A centralized Medical Transcription Unit was established in Sacramento in October 2008. This program area replaces the need for transcribers at the institutional level and provides a central location for standardizing medical transcription processes and improves overall efficiency. Upon vacancy, institution Medical Transcriber positions are being redirected to the centralized unit. Positions are vacated slowly with a large portion of them still to be redirected.

### ***Economic Crisis Hits Home***

For all of our success in building a new organization, the financial crisis has led to some serious disruptions in the work place. The most obvious disruption to productivity was the three furlough days all staff members were required to take each month through June 2010.

Furloughs might well be 14 percent of the work month, but the loss is probably higher than that. For example, if an employee earning \$3,000 a month had \$600 in disposal income each month before the furlough program, their new adjusted income would be about \$450 less each month, or nearly 75 percent reduction in discretionary income!

Lost individual productivity, the loss of staff positions and, although harder to quantify, the loss of morale and staff direction, takes its toll in numerous ways. Are people willing to be as creative, as energetic, as resourceful as they once were? We have to assume that the reduction in standard of living that our team members have been forced to accept has produced some reduction in their work. Furloughs have pushed some employees into retirement that might well have stayed on had the loss of income not been a factor. By the end of the fiscal year, we simply had fewer oars in the water.

Constrained budgets also produced a kind of "hunkering down" mentality. While trying to build a new organization, we were finding ourselves resource shy. Loss of travel

budgets has reduced our presence in places where we need to be seen; the elimination of advertising budgets put us in front of far fewer eyeballs, and the loss of income has made it hard to recruit some classifications, as well as making retention problematic.

A big part of our workforce development message is that a career in correctional medicine is rewarding. But if we are not in front of prospective recruits on an on-going, relentless basis, that story gets lost in a competitive environment where numerous employers are seeking clinicians and allied health care employees.

On balance, we have navigated significant fiscal stress without tipping over and the management and rank and file staff coalesced around the mission of serving the goals of the Receiver's *Turnaround Plan of Action*. But stress has a cumulative effect, a fact that may well have greater impact in the year to come than we experienced in the past.

## Part 2

### Strategic Plan -- Workforce Development

July 1, 2010 through June 30, 2011

#### Where Are We Going?

The Strategic Plan for CPHCS Workforce Development should center on the intellectual commitment to evolve from a startup mindset to a mature, sustaining organization that can manage change, leadership succession, and system growth in a competent, resourceful manner.

As exhilarating as relentless change can be, the transition to a mature organization is complicated. While we need structural integrity for organizational stability, we also need to be mindful of how an excessively bureaucratic environment can cost us efficiency, creativity and innovation when we need it most.

Our goal is to continue to fill every authorized position at our institutions with the highest quality of medical professionals available. This is how we exceed the requirements of the *Turnaround Plan of Action*. This is our core responsibility. We need to be able to do this in an era of limited resources, with many competing social and infrastructure needs demanding funding. Efficiency is critical and, to achieve that, we need highly transparent communication and high-quality data.

#### **Reemergence of the Receiver's Building Plan**

With the re-emergence of the Receiver's building plan and the construction of the Stockton California Health Care Facility (CHCF), plus the DeWitt Nelson Conversion and the Northern California Reentry Facility, we will soon find ourselves needing to recruit as many as 1,700 health care workers for Stockton alone. Early indications point towards a high level of need for licensed psychiatric technicians, somewhere between 400 and 440. This is a huge requirement, a number that we could not fill from the local labor pool.

Additionally, we will need large numbers of psychiatrists, psychologists, physicians, numerous nursing and allied health classifications, many of which we will not be able to recruit locally or even statewide. To fill these facilities with quality, competent staff, we will need to think national recruitment.

Within the context of planning for the new facility, some inmate-patients requiring acute mental health care will be provided for by Department of Mental Health (DMH) employees. This means that the Stockton facilities will have DMH employees, CDCR employees managing custody, and CPHCS employees managing health care, an HR puzzle that we will need to better understand as we move forward.

In addition to the new construction, we also face the conflict of aligning inmates at existing prisons based on health care requirements versus segregating them based on

security risks. Any realignment of where inmate patients are placed realigns custody requirements *and* health care staffing needs.

### The Stockton Plan

The *Stockton Workforce Analysis Plan* has been produced, which will help us understand the recruiting challenges that lie ahead. It is also helpful for educating local leaders on the staffing issues that we are all facing, both pro (many new jobs) and con (a competitive hiring environment).

Job classifications were broken down into seven employment clusters rather than by agency divisions—Custody; Physicians, Mental Health Providers and Pharmacists; Nurses (all classes) and Psych Techs; Dental; Allied Health; Physical Plant Management; and Executive and Administrative. This breakdown allows us to compare our needs with the local community workforce in terms of typical wages and numbers employed. This should aid in recruitment planning and public understanding of the jobs that will eventually be located in Stockton.

Since this report will continue to evolve, it was created to allow staffing changes to be easily reintegrated into the plan. [See *Stockton Workforce Analysis Plan*, Lifeline Intranet home page, “Stockton Workforce Analysis Plan now available,” or direct link: <http://lifeline/LinkClick.aspx?fileticket=URcnc7chlw%3d&tabid=38>]

Workforce Development will revisit the Stockton Plan at the end of the calendar year, and again towards the end of the fiscal year (June 30, 2011). The objective is to devise a concrete, tactical plan for recruiting and staffing the Stockton facilities in tune with the completion of construction and activation schedules. To drill into the plan too deeply now may prove to be a waste of effort, as things are still very fluid in terms of staffing configurations and dates. Likewise, to wait too long before completing our tactical plan runs the risk that we are not able to recruit the workforce in a timely manner. Should this occur, the facilities’ activation plans would be delayed because of a lack of qualified staff. We do not want these rocks falling on our heads.

### **Identifying the Big Challenges Ahead**

In terms of big strategic challenges that await us, four key issues stand out:

1. Validating the data used to make decisions is profoundly important. “Do we have the right number of authorized positions?” “Are all, most or only some of our eligibles truly competitive?” “How do we combat the huge cost of registry without a full grasp of these issues?” “How reliable is our Position Management and Recruitment and Retention data to begin with?”
2. Reintegration of medical, mental, and dental under a single consolidated health care organization. It ripples through everything that we do. Staff size, organizational structure, the parsing out of recruiting and retention goals, are all driven by this situation. We are integrating some HR functions soon and this will be a major focus during the coming fiscal year.

3. Training is the commitment to the future. From HCNEO to on-going employee training as new systems come online to basic and advanced supervision requirements, a great organization is constantly teaching and updating its team members. Without training we risk becoming a kennel full of old dogs with old tricks.
4. Strategic succession planning and knowledge transfer must be front-and-center in both our thinking and our actions, as senior management, technical, administrative and medical staff are all moving quickly towards retirement. Identifying and preparing junior people for senior roles, experienced management for leadership positions, and medical, technical and administrative ranks for the jobs that lie ahead, is a huge challenge—this 800 pound gorilla is in the room and we need to acknowledge her.

### **Validating Data Needs**

Napoleon famously said an army marches on its stomach. Clearly military personnel need to eat well, but what Napoleon was really getting at was the importance of the supply line.

Our supply line is data. Without good data we end up marching in circles, which is repetitive, costly, and very inefficient.

In terms of this discussion, the elephant in the room is the Business Information System (BIS) and whether or not it will deliver as promised. Based on our understanding of BIS, and a second system called HIRE in a redesign phase, we can then contemplate the needs for an Advanced HR tracking system.

At the very least, we are in an environment with multiple competing systems, each of them with a legacy that makes them difficult to manage, yet impossible to abandon.

### **Business Information System**

The Business Information System is a real-time software system conceived to track and report up-to-date enterprise matters. It has been a work-in-progress for more than seven years. BIS was initiated by CDCR in response to growing frustration with our inability to provide accurate or timely information.

Historically, costs have been spent in a vacuum of antiquated reporting systems that were not able to provide real-time data. Add in the fact that 19 bargaining units have representation within the system, with each contract having different contractual obligations, and the ability to obtain accurate, real-time data becomes even more difficult.

BIS development began before the Receivership was created, but the tool, when implemented, could provide a reporting system for CPHCS.

The core Human Resources functional modules are:

- ✓ Organization Management
- ✓ Personnel Administration
- ✓ Training & Continuing Education
- ✓ Workers Comp / Disability
- ✓ Equal Employment Opportunity (EEO)
- Time Management
- Shift Scheduling
- Personnel Cost Planning

Modules shown with a checkmark [ ✓ ] have been completed and are in use state wide.

Modules shown with an open circle [ ○ ] have not yet been deployed. Although officially these modules were scheduled for deployment in July-August timeframe, the projected deployment schedule is more likely January-February 2011.

The goals of BIS are accurate time management, scheduling, compliance for all bargaining unit contracts, a clear delineation of all the positions in place and where, and the dollars spent on registry costs. At the highest level, it becomes an enforcement mechanism to make sure we are doing everything correctly according to the rules and regulations governing our staff, along with a method for tracking procurement costs from outside vendors, including the dreaded registry costs.

BIS is a huge undertaking, well in excess of \$100 million in total investment to date. As the name implies, enterprise software is designed to touch every area of an organization. In its ideal deployment, everyone from supervisors to senior leadership would have total visibility—what's going on at any moment in time. With that level of visibility, the decision-making process should have fewer errors based on bad data and an implied efficiency would be achieved over using other data sources that are more fragmentary and not available in real time.

Right now 6,900 CPHCS employees are in the BIS system and 65,000 total CDCR employees have been inputted, with the latter number inclusive of CPHCS employees.

As a practical matter, even the deployed and in-use modules are not fully integrated into our day-to-day use. Like any big project, there is much training and fine tuning that needs to be done before its value is apparent. For the un-deployed modules, which would be very useful to us, we are several months away from seeing any realizing any operational utility.

From a Human Resources perspective, especially in terms of position management, recruitment needs, training, and registry cost containment, the question remains: is BIS going to provide us with the data we need in order to perform our job at the highest possible level of efficiency?

Frankly, that question cannot be answered at this moment in time. As such, we need to take a proactive stance by being fully engaged with the developers and integrationists so that we can let them know what we need, and they can tell us truthfully what we are likely to get.

### HIRE -- Hire Tracking Data Base

An alternative solution to some of our HR needs may be met with a program redesign that is in progress now called HIRE. Based on meeting with some key developers, it is safe to say that HIRE is a work-in-progress that is some time from deployment. As such, we may be able to shape its functionality to meet some of our needs; to do so, we will need to stay involved with the development process on an on-going basis.

### An Advanced HR Tracking System Concept

If we are to successfully manage recruitment and retention for medical, mental health, and dental professionals (a reality that is soon approaching), we are going to need a system to deal with an eventual 12,000 or more authorized health care positions.

*An HR Position, Skills Inventory, and Hiring Process Management Tool* would ideally give us a real-time view of every authorized position, including those filled and vacant, at all facilities, including regional offices and headquarters. All 33 prisons must have access to the system and Workforce Development must be able to monitor and track the entire system on an on-going basis. A robust system of this nature is essential.

Core system requirements are to track all positions and every step of the hiring process, including exam results and eligibles. At the time of appointment it would track the candidate's immediate and future training needs, maintain a skills inventory for each employee, and keep pertinent file data (anniversary dates, vacation and other paid time off, and probation /performance reports, etc) that would allow us to view the emerging talent within each position. As employees are promoted, their personal inventory follows them and the vacated position is refreshed, following the hiring process anew until filled with the next appointee.

The primary question that has to be resolved is what is the likely functionality of BIS/HIRE to provide the core data. BIS not only should provide core position management information, but anniversary dates, vacation time, probation, training needs, and other similar requirements. Core data has been the stumbling block in the past.

Regardless of the pending efficacy of the enterprise-wide application, or the smaller HIRE system, we still must have or generate core data in order to make our own system work. Until this gate is open, we're stuck for want of the information.

In terms of managing our own strategic resources over the coming fiscal year, it really is two-pronged. One, we have to stay in the BIS/HIRE kitchen and find out what's really cooking. It doesn't do us any good to make plans on expectations that are unlikely to be realized. Our laser-like focus must be on the genuine accessibility of core

position data. That is our Rosetta Stone and without this we are merely stumbling along rather than purposefully moving forward.

Secondly, we should use this investigative period to develop process descriptions for the ideal system that we need. It needs to be highly defined, with a rational scope of work.

This is an absolutely essential process that we must undertake if we are to succeed. Over fiscal year 2010/2011 we should concentrate on what developers call the “Happy Path.” We shouldn’t even imagine that we will be able to get into a development cycle this coming fiscal year. We won’t prototype, we won’t test, and we won’t deploy any software of our own over the coming 12 months. What we can be is prepared for these steps.

In spite of the name, the Happy Path is a thoughtful, step-by-step outline of what we want, with all the ins and outs carefully considered. The problem with software development is that it often starts out with very broad brush strokes that have little thought given to the details that must be addressed at the beginning.

The flaw in the grand vision approach is that the developers march off toward the horizon like the Seven Dwarfs singing “*Hi ho, hi ho, it’s off to work we go,*” when in fact they have little idea of what we genuinely need. By devoting some staff time, perhaps an ad hoc committee assembled for this purpose, we can delineate step-by-step-by-step what our needs are. Think of it like a dress rehearsal, where we sit in front of a computer and imagine what we need, and how we will get there, key stroke by key stroke.

With this clear understanding of what we need and what is real with the other systems, we will have a better idea of where we go from there. Depending on what BIS/HIRE delivers, we would begin with their underlying data collection capabilities and layer on our specific functional needs. Development requirements from that point will be much easier to define, budget, and forecast.

#### Applicant Tracking System – An Under-Utilized Asset

While other systems seem to be more vaporware than software, the Applicant Tracking System (ATS) is likely a genuine asset that we can further leverage without a costly development cycle. ATS may be particularly useful in helping us understand the relationship between the number of eligibles on various lists, and the actual number of “well-qualified candidates” represented by this pool.

We have reached the point where the swollen number of eligibles is not helping our efforts to reduce vacancies to zero; rather, the numbers are so large that hiring authorities are not willing or able to sort through the pool to find the employable candidates. Managers should not be asked to sort through a blizzard of eligibles in order to find the best fit for the job.

We can sometimes fall into a mindset that thinks of a personnel year (PY) as an interchangeable authorized position that can be filled easily from a pool of eligible

applicants, but this is not the case. Individual skills, experience, leadership capabilities, tolerance for various environments (the team approach versus the autonomous worker, as an example) has enormous impact on the likelihood of success for any candidate hired in any classification.

In a time of surplus candidates, it stands to reason that selection criteria will exceed minimum qualifications. This is not a bad thing for us if we can manage the pool, but it becomes self defeating if we don't subdivide the larger numbers into more practical groups.

What we need is job-related filtering of the eligibles pool. This allows us to flag candidates whom we deem particularly well-suited to one job or another. In essence, we manage the list so that we can discriminate between the qualified and the well-qualified candidate.

The Selection Services Unit has begun the process of contracting with Hodes to program enhancements to ATS. Contracting should be completed in July 2010 (subject to fiscal issues) and, within the first quarter, we should have functionality of some of the enhancements. Implementation will follow and should be up and running in some classifications by the end of the fiscal year.

The plan calls for the ability to sort by certifications, licenses, and other measurable differences, typically via polling in the beginning and, once refined, by modifying the original online exams to account for these additional factors.

Eventually it will allow us to rank candidates based on some of these selection enhancements. In other cases, the filtering will not influence rank, but will be a flagged element that we can use as a sorting tool.

In order to determine what additional factors should be measured, Selection Services will conduct limited focus groups with various hiring authorities that meet as many of the individual facility differences as possible without involving everyone at the beginning. The results of the initial focus groups will be compiled and shared with everyone so that the enhancements to ATS are as complete as possible when implementation is started.

At issue is discovering what is the threshold between an eligible candidate who has met the MQs and a competitive candidate who is a good fit based on job-specific filtering. If we do this correctly, we can effectively shrink the eligibles pool to a more manageable employables pool. Then the applicants that we send to the hiring managers are genuinely desirable and the likelihood of a good hire taking place will go up proportionate to the filtering process. At the very least, we will learn a lot about the nature of the eligibles lists and what these numbers actually represent.

This is not a static shift in eligibles versus employables, but a method of adjusting the recruiting and hiring process to more closely match the ebb and flow of the economy. Likely as not, the relationship will shift again as the economy improves and we should be prepared to adjust the supplemental forms accordingly.

## SROA / Surplus – Dealing with Changes to the Recruitment Picture

Within the data category is our need to accommodate certain rehiring requirements. Layoffs have occurred because of the state fiscal crisis and, to assist employees, the state utilizes the following two processes:

1. Surplus: A surplus employee is in jeopardy of being laid off or demoted in lieu of layoff. Surplus employees are notified that their particular job classification is being reduced within their department and if their position is selected, they could be laid off unless they find a job with another department.
2. State Restriction of Appointment (SROA): Each surplus employee automatically has SROA status. SROA status means the employee's name has been placed on SROA hiring certification lists for the employee's current class and current work location and is in danger of being laid off if they are not hired with another department.

The SROA/Surplus situation is a new reality for recruitment. Although SROA and Surplus are different designations, employees in either category have equal rights when applying for a state civil service job. In essence, we now have a prioritizing process that adds a layer of complexity and confusion to both centralized hiring positions and those positions filled at the institution level.

Further confusion has resulted because SROA designees are on a list, but there is no list for surplus employees. Only when a surplus employee submits an application for a vacant position, along with their surplus letter, is the hiring authority aware of this person and their "preferential status."

From a global perspective, the hiring process must now filter potential hiring decisions through the SROA and Surplus eligibilities, as well as the usual eligibles lists and possibly even reemployment lists. Except for reemployment lists, candidates on either SROA or Surplus status get first consideration unless they waive their interest for that *specific job*. If the employee chooses to waive their interest, they have the possibility of losing their SROA/surplus status. The DPA will investigate the reason for waiving and determine if the criteria is met. If the reason is not valid, DPA can choose to remove the employee from the surplus list. Should the employee choose not to respond to an inquiry, there will be no penalty and their name will remain on the list for 120 days or until they are hired in a different department.

The hiring authority may elect to pass over an SROA/Surplus candidate in favor of another potential employee, but they must substantiate the grounds for not wanting to hire a particular person. This letter is ultimately forwarded to DPA, which makes the final ruling on hiring for this candidate for this position. Rarely do they sustain the rejection. However, there are exceptions that do not require DPA approval.

Workforce Development staff must be keenly aware of these candidates—the goal, obviously, is to relocate unemployed state workers at a position that allows their civil service to resume—but we are also committed to filling authorized positions with capable, competent candidates. Making the system even more cumbersome is the fact that SROA/Surplus individuals have a global status, so waiver letters are sent to hundreds of candidates over and over again regardless of where they live or where they may be willing to work. A remedy for this situation would have SROA/Surplus individuals select locations and other preferences so that waiver letters can go to a directed pool of potential hires. This would be far less expensive to manage and would likely produce better results for all concerned.

As the pool of candidates grows, a likely condition over the coming year, we have to accept that the hiring process will become more labor intensive, thus more time consuming, and that the likelihood of illegal hires taking place will be elevated. Additionally, we must be certain that nothing is blocking a candidate's opportunity for hire. We don't want to be in the position of rescinding offers that have been made prior to clearing all potential options.

Lastly, we also have to accept a slower hiring process in general, and remain absolutely focused on clearing-for-hire all eligible candidates prior to any employment offer being made. It simply takes time to do it right.

### **Reintegration of Mental Health and Dental**

If data is our critical supply line, it might be fair to say that the reintegration process will define our force strength and our mission requirements.

From a strategic point of view, few activities could be more important to us than adding mental health and dental classifications to our workforce development and recruiting tasks. Currently some HR functions that are being put in place, with numerous other steps to be resolved in time.

Preparing the tactical implementation of reintegration is something that senior leadership should be discussing and, prior to the blending of these units, we should have in place the likely organization charts that will be used at the beginning. We should be prepared for some rocky cultural moments, and be flexible enough to review and revise the organization as it gels.

### **Training the Workforce to Meet the Challenge**

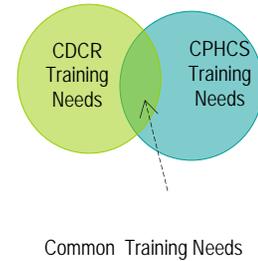
Training is an essential activity that senior organizational leadership know we need, yet they often seem to become detached from the importance of it. We might speculate that during fiscally constrained times training is an easy target when searching for budget cuts. Training is also how we will manage succession planning, a topic covered below.

We need to view training as the mortar that holds the bricks together. When we invest in training, our collective functionality goes up; when we cut our training budgets, we pay dearly. Recruitment, retention, and consultant costs go up; our ability to do critical

tasks internally goes down; and we end up with redundant hires and a reliance on expensive consultants and retired annuitants to do work we somehow don't know how to do for ourselves. (The Annual Training Plan should be complete July 2010.)

Our training activities have several core tasks that we are addressing on an on-going basis. HCNEO is a core task and that activity should continue to evolve and progress over the coming year (See page 6).

A second, and equally important, core training activity is Basic and Advanced Supervision for all new managers and supervisors. Basic is required by state code and Advanced is a CDCR commitment. Combined, the instruction entails 40 hours of formal training (structured, classroom instruction) and 40 hours of informal, or on-the-job training (OJT), to enhance the formal activities. Sadly, since 2008 no Basic or Advanced Supervisor Training has been conducted because of resource issues. We are hoping that this training will resume in September 2010 depending on the new budget.



CPHCS would benefit from attacking head-on the overlapping training needs that exist between CDCR and CPHCS employees who are located in our institutions. Across disciplines there are a lot of common training needs even though the core competencies are so different. Ideally, common training needs would be taught together—overall agency training costs would be reduced, and employees with different missions bond together when trained together. With strained budgets and cancelled classes, there is a training backlog that will have to be managed this year and beyond.

In an effort to increase our training capacity, we are looking more and more toward Internet connectivity as a tool that can spread the gospel without travel or per diem expenses. The webinar, or web-based seminar, is becoming a tactical tool that our training staff is using to overcome some of the budget constraints we have in terms of moving students and/or instructors around the state.

The web is a powerful tool that we will learn to use better every day. But there still is no substitute for the physical classroom experience and all of the dynamics that occur within that environment. We also lack the hardware and suitable learning environments in many locations for web-based training to work effectively.

Lastly, the addition (or expansion) of the use of computer-based training CDs and DVDs as part of the lesson delivery system should be encouraged. Permanent media can be used at any time of the day by individuals working a three-shift environment, it allows students to easily review material several times, and key lessons become a consistent message that everyone will see and hear in exactly the same way.

### Commitment to Clinicals

Within the sphere of training, we need to include our commitment to providing clinical rotations at suitable prisons for health care education. The initial success of our pilot

year at RJD should be viewed as our first step in a multi-step process of institutionalizing clinicals as a key part of our training initiatives.

In order to advance the program, we need buy-in at the facility level and from senior management of CPHCS and DCHCS. At the prison level, we need to make the case one by one with the CEO, nurse executive, and DON—the key players at the local level. Senior leadership at headquarters needs to champion clinicals not only as a part of our workforce development initiatives, but as a positive link to the community that advances health care education for all of us

Furthermore, we need to commit to streamlining the contracting process for all clinicals at suitable institutions. We can do this by distributing contract templates to every institution and encourage CEOs, medical, and nurse executives to include clinicals in their planning. We should be the point of contact when institutions have questions and perform in an ombudsman-like role to help solve problems that arise in the contracting process.

### Transition-to-Practice Programs

Newly graduated RNs are having difficulty finding work. This condition is the result of two off-setting forces. Since 2004, we have increased the capacity of California nursing programs by 66 percent, adding 31 new nursing programs in the state. By 2009, we graduated 4,400 more nurses than we did just five years prior. This should be viewed as a great success.

However, while expanding capacity, our economy shrank at a frightening level, forcing part-time nurses into full-time positions, and keeping nurses who were planning on retiring on the payrolls much longer than expected. As a result, new graduates are finding it very difficult to secure their first professional job since they are competing with very experienced nurses for a limited number of positions. This mirrors our own hiring practices.

The California Institute for Nursing and Health Care (CINHC), after conducting numerous regional forums to address this issue, is recommending that employers consider what they are calling “community-based transition-to-practice programs” (internships) for new graduates. These programs would further develop skills, competence, and confidence. Running from 12 to 18 weeks in length, they would provide specialty training based on the skills that the employer most needed. Students would be given college credit and an industry-recognized certificate of completion. Health care employers would benefit from the program by helping to prepare a new generation for practice, but would have no specific commitment to hire any participating nurses, nor would they need to pay the student-nurse during the transition-to-practice period.

As we look at our needs toward a more distant horizon, this type of program could be very beneficial to us and recent graduates. As such, we should investigate how we might set up such a program and consider a pilot effort to test the efficacy.

## **Leadership Success – Succession Planning – Employee Recognition**

No matter how skillfully we manage recruitment and retention, the fact remains we all get older and we will all eventually retire or separate from state service. Perhaps more frightening than any other fact is the stark realization that the more senior the leadership, the closer the individual is to retirement.

One of the strengths that helped build CPHCS from the ground up was the creation of a senior staff with notably long (and successful) careers. With only a few exceptions, the entire senior staff is within a whisper of being able to retire.

The RCEA program has also allowed us to recruit talented people into these roles who still need to be groomed if they are to be successful. Otherwise, we risk an outcome where talented people fail because we haven't prepared them for success.

On the institutional health care front, succession is an equally big issue, one that we should not be distracted from because of the current economic climate. That will change in due course.

### Succession Planning for Nurses

Early succession planning for registered nurses started with statistical surveying rather than implementing a succession plan. The focus on RNs was based on the fact that they are both a key classification in total numbers *and* have the skill sets that we use to deliver care to our patients. Although the research is slightly dated (and has not been revised), the results are still a good starting point. About 40 percent of our RN population is 51 years old or older, with 22 percent over the age of 55. In both cases, these ratios are better than the national averages, but that may well be the result of having so many new hires over the past three years. Based on recruiting success and the overall number of eligibles, no succession plan for nurses was created or implemented.

In recognition that nurse managers take time to grow, we are in the process of revising the specifications for SRN I, II, and III. This revision will create a more defined career ladder for the nurses, which should encourage overall retention and the development of skilled nurse-managers. This is a worthwhile effort. The special features of our prison environments require that managers gain a good portion of their experience in our employment, rather than simply transferring similar management skills from a more traditional health care situation. Spec revisions should be completed this year.

### Civil Service Instability

Where historically civil service has been a very stable employment choice, we now have conditions that required us to look closely at the potential of losing employees to an unstable environment. Some key things we have learned so far are that furloughs, which ended June 2010, accelerated the rate of separation for some employees who would make more retired than fully employed. This issue should end by the start of the

new fiscal year (July 1, 2010) but still unresolved are issues of cuts in pay or benefits, which may end with us being less competitive in the near future.

If retirement benefits are reduced for new hires or the vesting age is raised, or the individual contribution to retirement is raised beyond current limits, we may well find that we need to compete on less tangible planes, such as autonomy in the workplace and very rewarding clinical work. Devising a recruiting plan with more emphasis on intangibles—the desire to serve an underserved population, the sense of mission as opposed to having a job—may well be worth our while.

### Leadership Mentoring – Planning for RCEA Success

An old marketing truism states that the best audience to market to is existing customers. In our case, we should invest in the success of our new RCEAs, since we have invested so much to get them. This is a talented group of new hires who fall into one of two categories. One, they come into our system with health-care leadership experience, but without any corrections or civil service background; or two, they have lots of internal experience, but have developmental needs for leadership skills. In either case, we have talented individuals who need early support to ensure maximum potential for success.

We should develop a plan where we support these two archetypes—giving the former outsider the mentoring she needs in CDCR processes and procedures, and civil service requirements—so that good decision making follows. Provide the experienced civil servant with leadership mentoring so that the years of internal experience are leveraged with good executive skills. Within this process, we should find some opportunities for cross pollination, where the mentor becomes the student and the student becomes the mentor.

As part of this task, we should look for a method to create a database of this talent pool—skills, experience, education, background. This group is likely to become much of the core senior management over time and we should be able to search this pool using various criteria.

### Retention Often is as Simple as Recognition

Building a great staff is a recruitment challenge. Maintaining a great staff is an organic process that involves the utilization of numerous activities on an on-going basis. In much the same way that routine car maintenance is far cheaper than repairs, it is far more cost effective to nurture our existing staff than it is to replace it.

One such activity that has a low resource commitment and the potential for good results is a simple recognition program where staff members can be acknowledged for their contributions.

Why an Employee Recognition program? Because time and time again research has shown that employees respond to intangible benefits that highlight and support our inherent need to be acknowledged as a valuable human being.

Over the coming year we should develop the tool kit that will facilitate employee recognition. This would most likely be an Intranet-based resource with guidelines, tools, templates, and other related materials that allow the recognition process to be implemented easily, yet still be personal and meaningful for the recipient.

## **The Role of HR – Conclusion**

What this strategic plan attempted to do was to focus on key issues that face CPHCS Human Resources and provide suggestions along the way on how we might tackle some of these challenges in creative and resourceful ways.

Based on observation, the fiscal crisis has bogged us down. What might have been viewed last year as a temporary storm that we will survive is looking more and more like a long-term period of reassessment in the value and cost of civil service. At the most global level, we will need to embrace efficiency and not simply pay lip service to it. At the tactical level, productivity remains a challenge as the organization grows in size and bureaucratic layering.

Our Governor has been routinely derided for wanting to “blow up the boxes,” but the sentiment is legitimate if he meant that we need to do things differently. The world is changing very rapidly and, as such, we will not endure, and certainly not prosper, if we persist in approaching every challenge with the same old ways of doing business.

A core weakness is the opacity of our data—do we really see all that we need to see at any moment in time? Probably not. We conveniently insist that our system is so very complicated with 33 institutions (all overcrowded), 19 bargaining units, and a 24/7/365 operation that we accept the fact that we can’t be expected to know what’s really going on. That explanation is nothing more than an excuse, for many organizations of our scale function on three, four, and even five continents, subject to language issues, local customs and culture, and numerous governmental entities all having different jurisdictions.

Although our data collection can seem clumsy on occasion, a complicating problem is not the lack of data, but that one unit knows something that would be valuable to others but the data gets stored out of sight. Others who could benefit from it are not aware that it exists and end up duplicating efforts by recreating something that already exists.

In creating this report, however flawed it might be, one truth stands out—very few people from group to group know what’s going on in any context other than their own responsibilities. We all have to function with a particular focus on our jobs; in some ways it seems that we are all reading one chapter of the same book and writing our report based solely on that limited view of the whole. Razing the silos is not the answer, for concentrated knowledge is essential. What we all need is a genuine interconnectivity and visibility of what others are doing if our jobs are to make better sense to us. Productivity is not an anchor, it’s a sail. The propelling breeze comes from everyone knowing what’s going on.

We also have a particular burden in that the work we do is unloved by the community at large, yet it is important work that serves public health by providing essential services to an incarcerated population. Our leadership, here and at the institutions, must embrace our efforts at health care education, be it clinicals, grow our own efforts, or transition-to-practice programs for graduates in need of clinical experience. These efforts are not just recruitment tools, but our way of giving something back to the people of California by nurturing a new generation of medical professionals who will serve us all, one patient at a time. Every time students experience correctional medicine, at whatever level of skill they are trying to perfect, we have one more set of hands that push back against the tide eroding our efforts to meet the goals of the *Turnaround Plan of Action*.

It's not news that HR departments are viewed as somehow less important than other groups, a backwater place where the minutiae of resume vetting and number of sick days is tracked, but not a place where the real work gets done. There may well be some truth to this in other situations, but it does not have to be so in ours.

We should see ourselves as designing and building a great organization that will accomplish many things and not just gatekeepers at the moat's edge. We need to embrace change or it will come at us from other sources. We should remember that very rarely does one get the chance to be a part of something new, where their ideas and their actions shape both the present outcomes and the future success as well. This is our heartbeat.

## Part 3

### The Metrics

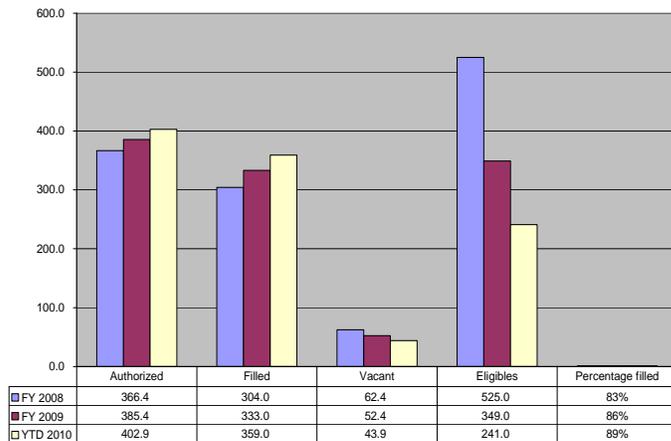
#### Recruitment Goals and the Data Used to Make Decisions

The following series of charts illustrate three reporting periods (FY 2008, FY 2009, YTD FY 2010) for Physicians, Mid-Levels, Nurses, and Pharmacy. This gives us a global look at positions, vacancies, eligibles, and percent filled for the key medical classifications that we are currently responsible for.

Following the global view, we will look at the institutions and how they are fairing in meeting their recruitment challenges.

Lastly, we will try to draw some conclusions based on the numbers.

#### Physicians – Global View



The chart at the left compares authorized, filled, vacant, and eligibles over three reporting periods.

We can see that the authorized and filled positions grew each year, while the number of vacancies declined. The eligibles declined by roughly half.

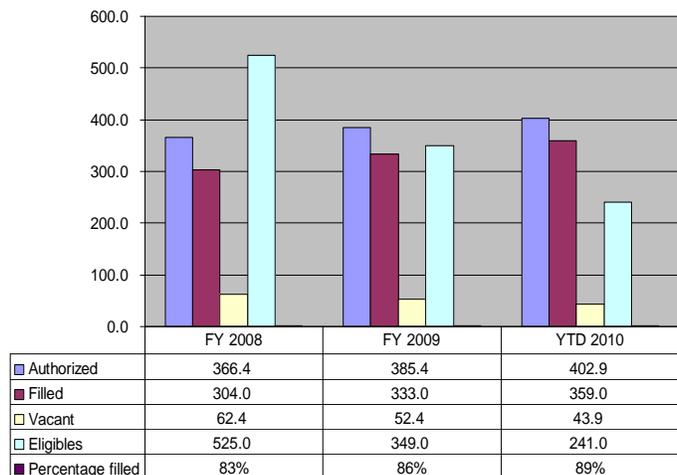
Percent filled improved each year, from 83% to 86% to 89%.

The view at the right segregates the same four data categories and groups them by fiscal year.

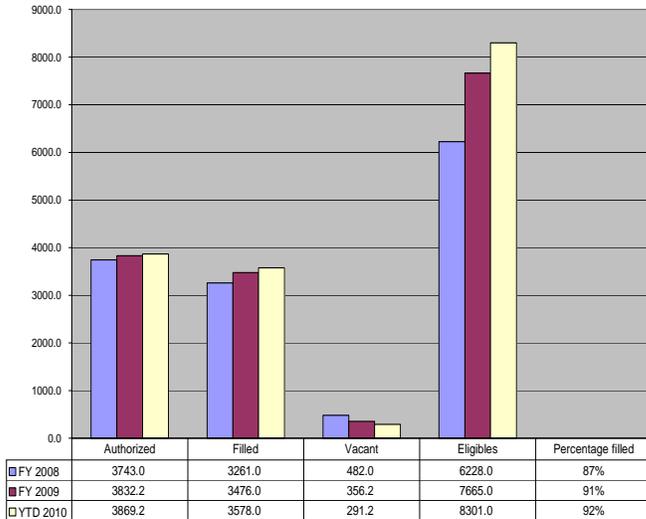
The relationship between authorized and filled is easily visualized (first two bars of each fiscal year).

We can also see the steady decline in vacant positions and the steep decline in eligibles (bars three and four).

In FY '08 we had 8.41 eligibles for every vacancy; FY '09 the ratio was 6.6 to 1; YTD FY '10 is 5.48 to 1.



## Nurses – Global View



We can see that the authorized and filled positions grew each year, while the number of vacancies declined.

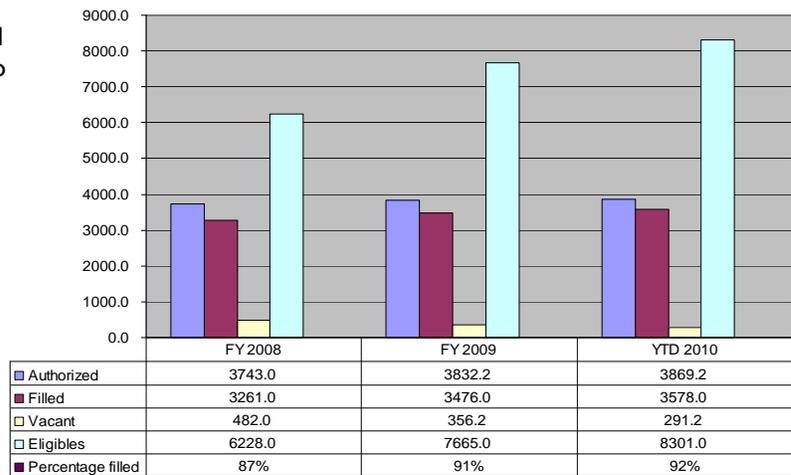
The eligibles increased by 2,073 to a current 8,301, or an increase of just over 25%.

Percent filled improved each year, from 87% to 91% to 92%.

The relationship between authorized and filled is easily visualized (first two bars each FY).

We can also see that vacancies declined slightly each year, while eligibles rose significantly.

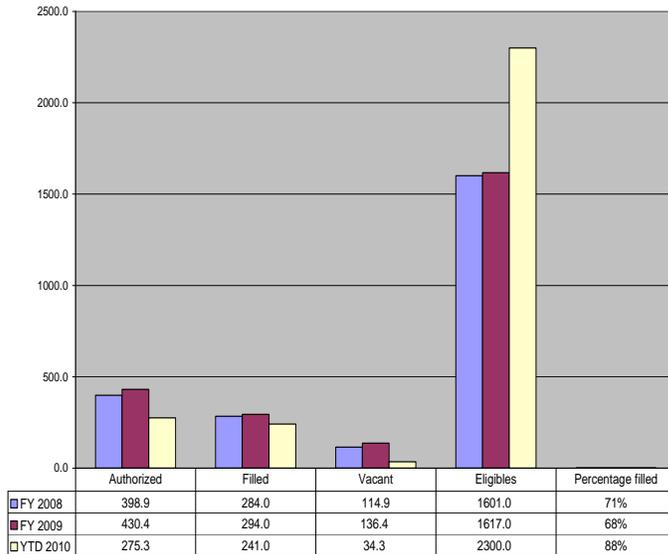
In FY '08 we had 12.9 eligibles for every vacancy; FY '09 the ratio was 25.5 to 1; YTD FY '10 is 28.5 to 1.



The most glaring difference between physicians and nurses is the ratio of eligibles to vacancies. We improved the filled rate for doctors by six percent and the filled rate for nurses by five percent—in the scheme of things, a fairly small differential. However, the ratio of eligibles to vacancies went in completely opposite directions over the three reporting periods. Physicians went from 8.41 eligibles for every vacancy to only 5.48; by historic measures, this is below where we ideally want to be. Nurses, however, went from a very healthy 12.92 eligibles for every vacancy to a whopping 28.5. It is worth considering, Why did doctor eligibles decline while nurse eligibles increased? Perhaps, due to fiscal constraints, we significantly curtailed recruitment efforts; we also curtailed statewide recruiting since vacancies were mostly found in the central valley, where there was little interest in those openings. Could also be that after our initial aggressive recruiting of physicians, interest declined proportionate to our recruiting efforts.

Regardless of why the discrepancy between doctor and nurse eligibles, we are still left with an important question, With such a high ratio of eligibles to vacancies for nurses, why do we have any nurse vacancies at all? And of those many eligibles, what percent are really competitive?

## Pharmacy – Global View



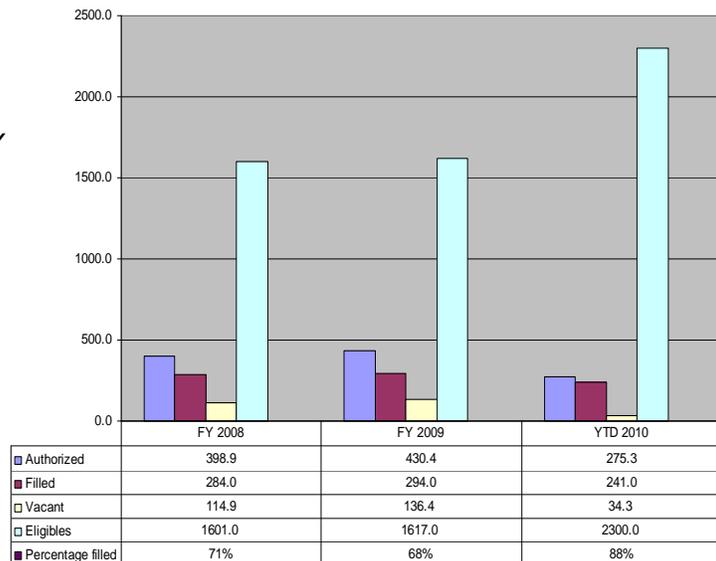
We can see that the authorized grew from FY '08 to FY '09, then dropped substantially in YTD FY '10; the number of vacancies declined by 102.1 from FY '09 to current, but the number of authorized positions declined by 155.1.

Percent filled went from 71% to 68% to 88%, but any sense of improvement is skewed by the reductions in authorized .

The relationship between authorized and filled is easily visualized (first two bars each FY).

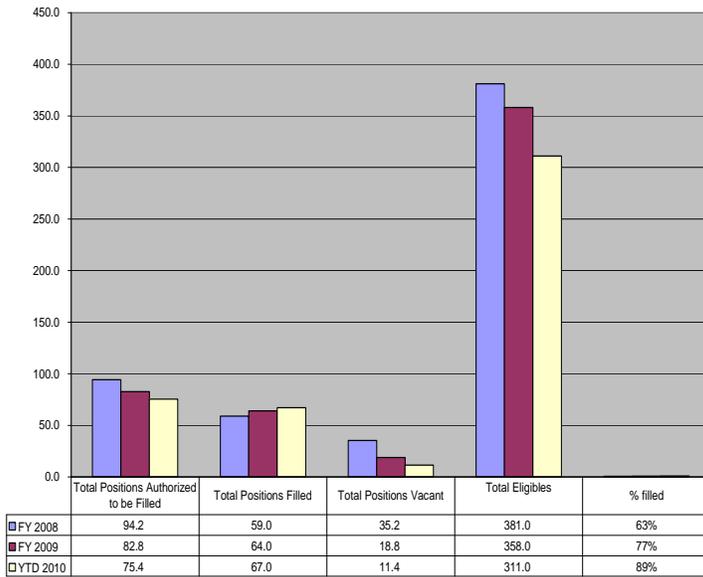
Vacancies increased from FY '08 to FY '09, then declined dramatically; eligibles were flat for the first two periods, then rose YTD FY '10.

In FY '08 we had 13.9 eligibles for every vacancy; FY '09 the ratio was 11.85 to1; YTD FY '10 is 67 to1.



Pharmacy presents its own interesting picture, namely the decrease in authorized positions and the dramatic increase in eligibles; not only as a ratio of authorized to eligibles, but in raw numbers as well. Although we decreased the number of positions we wanted to fill by 155.1, those who wanted to work for us grew by 700. Further changes in pharmacy may change this picture again as central fill comes fully online.

## Mid Levels – Global View



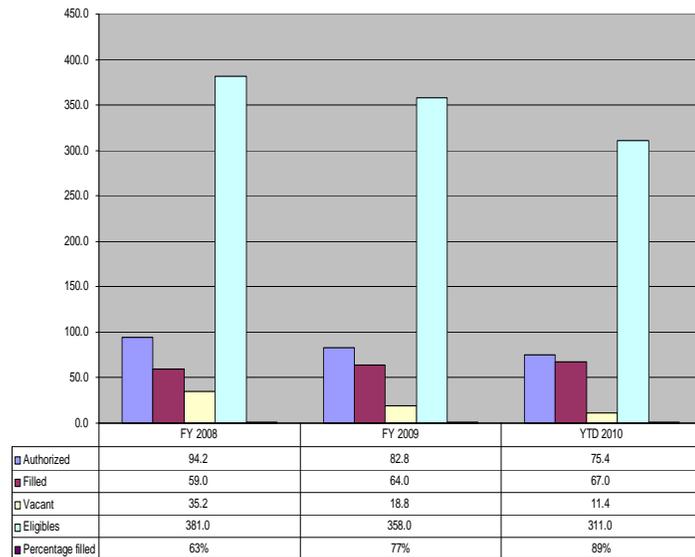
We can see that the authorized declined each reporting period from 94.2 to 75.4; the number of vacancies declined each year as well; we had an overall reduction in authorized of 18.8 and a reduction in vacancies of 17.4.

Percent filled improved from 63% FY '08 to 77% FY '09 to 89% YTD FY '10, but the improvement is largely a matter of reductions in authorized positions.

The relationship between authorized and filled is easily visualized (first two bars each FY).

Vacancies and eligibles decreased each year, although the ratio of eligibles per vacancy increased substantially.

In FY '08 we had 10.82 eligibles for every vacancy; FY '09 the ratio was 19.04 to 1; YTD FY '10 is 27.28 to 1.



Over the three reporting periods we have seen the number of authorized positions for Mid Level classifications decrease, the number of filled positions increase, and the number of vacancies (relative to the number of authorized for that reporting period) go down. Total eligibles have dropped in number as well.

Eligibles verses Employables – Show Me the Money

For each of the four key classifications that we have reviewed above, the ratio of eligibles to vacancies (and the underlying question of why do we have any vacancies at all) has focused on whether eligibles are actually competitive—employable, to put it bluntly. In all of the classifications, except physicians, the ratio of eligibles to vacancies has gone up, in some cases dramatically.

We may well have a case of where eligibles are not actively pursuing a civil service career because the pay scale is not competitive with private employers. Where we had suggested that we might use the Applicant Tracking System to gather supplemental experiential data (who is really an employable candidate for hire), we may want to use ATS to see if, or where, pay rates are the issue from the candidates perspective. While we are segregating the pool based on experience, some potential employees who are on the list may be declining opportunities once the pay rate is fully understood, but remain on the list because they simply aren't taking the time to remove themselves.

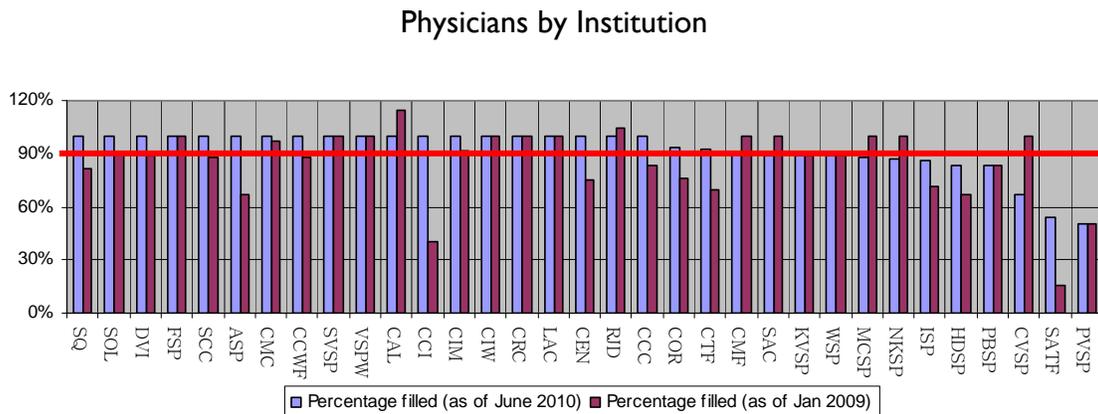
Within this same vein, the new instability in state civil service employment and what the actual benefit package will look like for new hires may be another stumbling block towards our goal of achieving 100 percent filled for all authorized positions. This is a subject that remains so fluid at this moment in time that devising a means for determining the effects is hard to visualize, other than polling eligibles to see what they are thinking in terms of shifting from a private sector employer to CPHCS.

Institutional View

Apart from the global view, we can now look at our success rate in filling the various classifications on an institutional basis. In each of the four major classes, we have stack ranked our percentage of authorized positions that have been filled from highest to lowest, reading from left to right.

The red line superimposed on each chart represents the 90 percent filled threshold that we initially used to measure our effectiveness based on the goals of the *Turnaround Plan of Action*.

Blue bars represent our current status; purple bars as of January 2009.

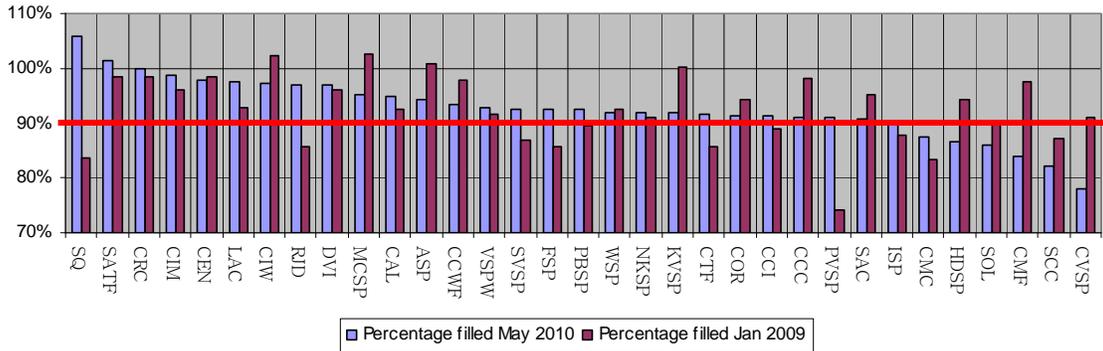


Eight institutions are less than 90 percent authorized physician positions filled. Listed in declining order from best to worst of those with less than 90 percent, they are: MCSP, NKSP, ISP, HDSP, PBSP, CVSP, SATF, and PVSP. (See institutional abbreviation chart at the back of section.)

Of those institutions below 100 percent authorized filled, five institutions saw a decline in percentage filled when comparing current figures to January 2009. Those institutions are: CMF, SAC, MCSP, NKSP, and CVSP. The last three are also below 90 percent.

Lastly, six institutions saw enough improvement from January 2009 to current to meet or exceed the 90 percent threshold. These are: ASP, CCI, CEN, CCC, COR, and CTF.

Nurses by Institution



Six institutions are below 90 percent filled. These are: CMC, HDSP, SOL, CMF, SCC, and CVSP. Of those six, only CMF saw an improvement from 2009 to current; the remaining five all declined in terms of percent of authorized positions filled.

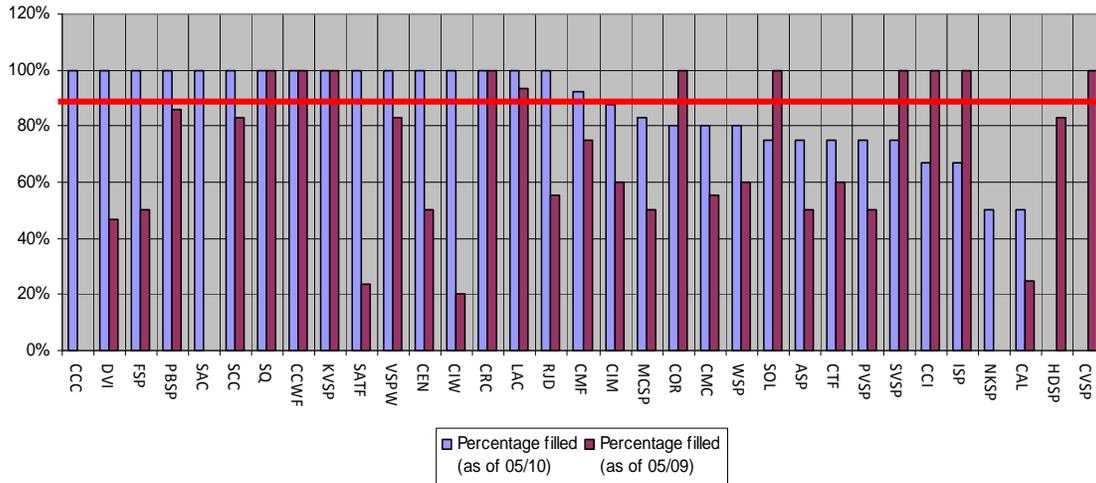
Only three institutions currently are at 100 percent filled (SQ, SATF, and CRC). In January 2009 there were four other institutions that were at or above 100 percent that are now below that threshold. These are: CIW, MCSP, ASP, and KVSP.

Perhaps the most startling outcome of all is that 15 institutions have current percentages filled that are lower today than they were in January 2009. Those institutions are: CEN, CIW, MCSP, ASP, CCWF, WSP, KVSP, COR, CCC, SAC, HDSP, SOL, CMF, SCC, and CVSP. *In other words, 45.5 percent of our institutions have a lower filled rate today than in January 2009.*

Can we discern a pattern in the decline of filled nursing positions and can we attribute it to any one thing? This would be an important condition to understand, especially in terms of our strategic planning. Is this an anomaly that is not likely to reoccur or is this a pattern that could accelerate if we don't make some course corrections? With over 45

percent of our institutions showing decline over a 16-month time-frame, this is too significant to overlook.

Pharmacy by Institution

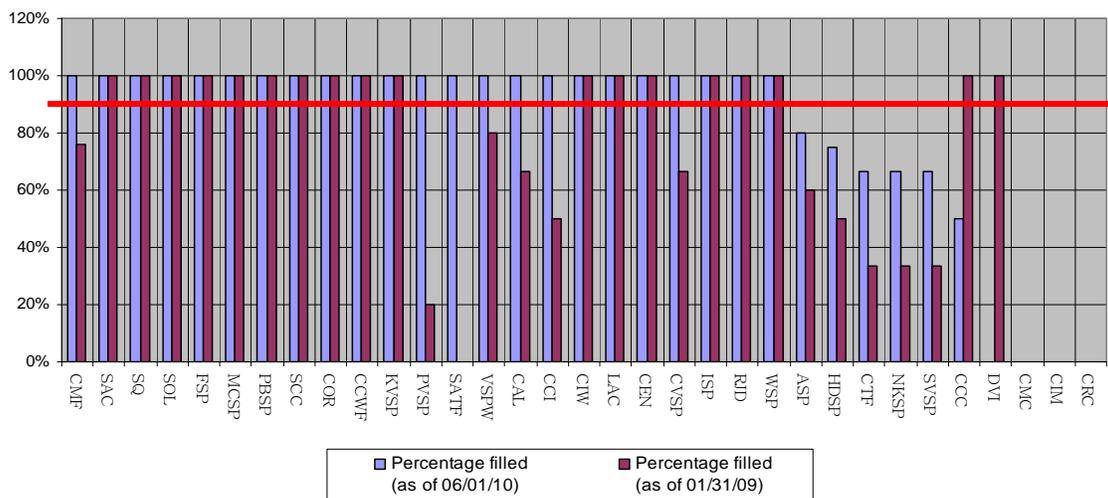


Pharmacy does not have a 90 percent filled target in the *Turnaround Plan of Action*, but a red line indicating 90 percent has been added as a point of reference. Sixteen institutions are not at 90 percent filled or greater. Those below 90 percent filled are: CIM, MCSP, COR, CMC, WSP, SOL, ASP, CTF, PVSP, SVSP, CCI, ISP, NKSP, CAL, HDSP, and CVSP. The last two have no blue bars as all authorized positions are vacant.

Sixteen institutions are at 100 percent filled. These are CCC, DVI, FSP, PBSP, SAC, SCC, SQ, CCWF, KVSP, SATF, VSPW, CEN, CIW, CRC, LAC, and RJD. One institution, CMF, is above 90 percent.

Pharmacy presents its own unique circumstances since we are in the process of instituting centralized fill, which will undoubtedly shift some of the institutional demands for pharmacy PYs. As that program evolves, those changes should take place.

### Mid Levels by Institution\*

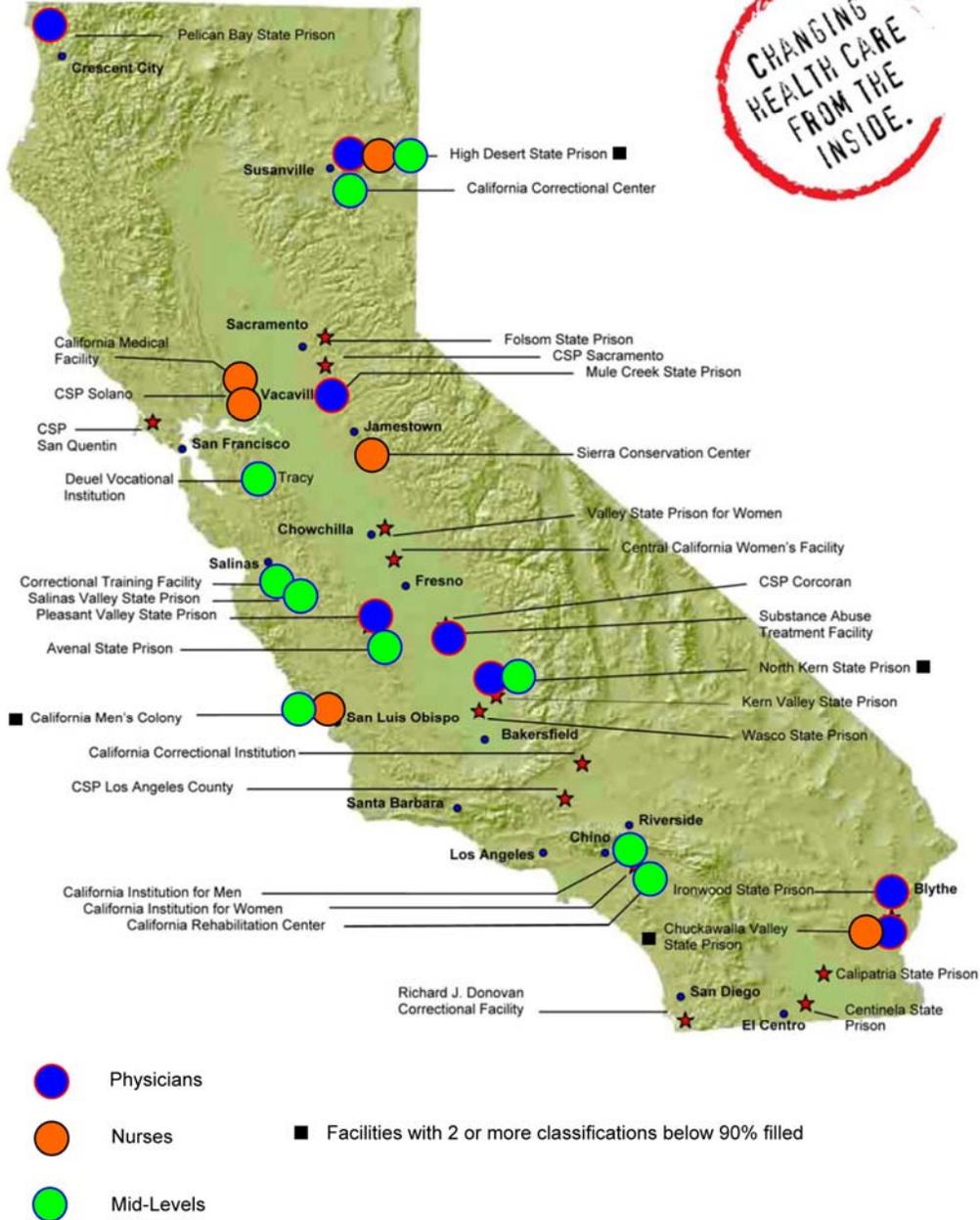


Mid Levels, like Pharmacy, do not have the targeted 90 percent filled in the *Turnaround Plan of Action*. In the case of Mid Levels, all but seven institutions are at 100 percent filled. Those below that level are: ASP, HDSP, CTF, NKSP, SVSP, CCC, and DVI. DVI, which shows no filled PYs for YTD FY 2010, has only one authorized position which is not currently filled; thus they are technically at zero percent filled. CMC, CIM, and CRC have zero authorized PYs.

In all other cases, we have either improved to or maintained a 100 percent filled rate.

\* Note: Mid Levels for SQ were reported as being at 300 percent as of Jan 31, 2009 in the Recruitment and Retention Report, but the figure was reduced to 100 percent here. This was done in order to scale the chart for a more meaningful presentation of all the data.

# Institutions where Authorized Positions\* are Filled Below 90 Percent



Created 6/30/10

\* Pharmacy is not included because of the transition to central fill. Currently 16 facilities are less than 90% filled

## **Institution Names and Abbreviations**

**ASP**

Avenal State Prison

**CAL**

Calipatria State Prison

**CCC**

CA Correctional Center

**CCI**

CA Correctional Institution

**CCWF**

Central CA Women's Facility

**CEN**

Centinela State Prison

**CIM**

CA Institute for Men

**CIW**

CA Institute for Women

**CMC**

CA Men's Colony

**CMF**

CA Medical Facility

**COR**

CA State Prison Corcoran

**CRC**

CA Rehabilitation Center

**CTF**

Correctional Training Facility

**CVSP**

Chuckawalla Valley State Prison

**DVI**

Deuel Vocational Institution

**FSP**

Folsom State Prison

**HDSP**

High Desert State Prison

**ISP**

Ironwood State Prison

**KVSP**

Kern Valley State Prison

**LAC**

CA State Prison Los Angeles County

**MCSP**

Mule Creek State Prison

**NKSP**

North Kern State Prison

**PBSP**

Pelican Bay State Prison

**PVSP**

Pleasant Valley State Prison

**RJD**

Richard J. Donovan Correctional Facility

**SAC**

CA State Prison Sacramento

**SATF**

CA Substance Abuse Treatment Facility

**SCC**

Sierra Conservation Center

**SOL**

CA State Prison Solano

**SQ**

CA State Prison San Quentin

**SVSP**

Salinas Valley State Prison

**VSPW**

Valley State Prison for Women

**WSP**

Wasco State Prison

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