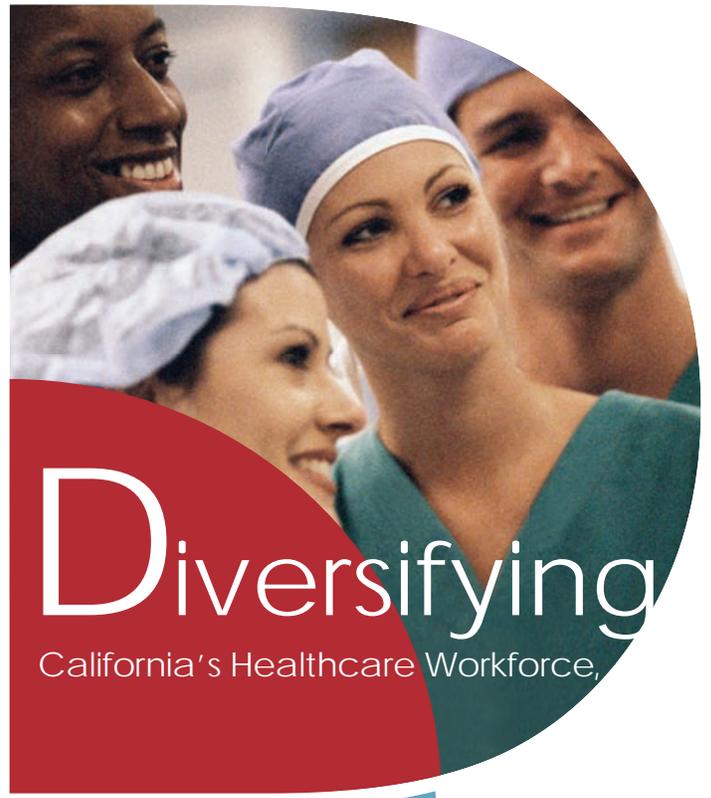


Healthcare Workforce
Diversity Advisory Council



Diversifying
California's Healthcare Workforce,

an Opportunity

to Address California's Health
Workforce Shortages

About the Healthcare Workforce Diversity Advisory Council

The Office of Statewide Health Planning and Development (Office) received a grant from The California Wellness Foundation to establish and convene the Healthcare Workforce Diversity Advisory Council (Council). The Council serves in an advisory capacity to Governor Arnold Schwarzenegger's Administration. The Council was charged with developing policy recommendations to address California's health professional shortages especially among populations that are underrepresented in the health professions. Council leadership represents health policy/advocacy, health employer, health professions pipeline, workforce investment, professional, student, research, labor and ethnic health organizations and associations.

Linda Nguy, Chairperson, *Latino Coalition for a Healthy California*
Denise Adams-Simms, MPH, *California Black Health Network*
Joubin Afshar, *American Medical Student Association*
Kevin Barnett, DrPH, MCP, *Public Health Institute*
Carmela Castellano-Garcia, *California Primary Care Association*
James Crouch, MPH, *California Rural Indian Health Board*
Katherine Flores, MD, *California Health Professions Consortium*
Christine Gonzalez, PHD, MD, MBA, *California Latino Medical Association*
Priscilla Gonzalez-Leiva, RN, *California Institute for Nursing and Health Care*
Kevin Grumbach, MD, *UCSF Center for Health Professions*
Susan Hogeland, CAE, *California Academy of Family Physicians*
Allen Miller, *COPE Health Solutions*
Bob Montoya, MD, MPH
Sonia Moseley, RNP, *National Union of Hospital & Health Care Employees*
Desiree Rose, *California State Rural Health Association*
Ho Luong Tran, MD, *Asian Pacific Islander Health Forum*
Peggy Broussard Wheeler, MPH, *California Hospital Association*

Other Contributors to the Council

Gail Blanchard-Saiger, *California Hospital Association*
Lisa Folberg, *California Medical Association*
David Ford, *California Medical Association*
Serena Kirk, *California Primary Care Association*
Catherine Martin, *California State Rural Health Association*
Kara Odom, MD, MPH, *Robert Wood Johnson Clinical Scholar*
Jesus Oliva, *COPE Health Solutions*
Jeff Oxendine, MBA, MPH, Associate Dean for Public Health Practice, *UC Berkeley*
Tom Riley, *California Association of Family Physicians*

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Executive Summary

In 2007, the Administration, with the assistance of a grant from The California Wellness Foundation, convened the Healthcare Workforce Diversity Advisory Council (Council) housed within the Office of Statewide Health Planning and Development (Office) and chaired by the Latino Coalition for a Healthy California (LCHC). Comprised of health policy advocates, health professions pipeline programs, workforce investment, health student and professional associations, research, labor and industry, the Council was charged with developing recommendations to address California's health professional shortages, especially among underrepresented groups. Public input from hundreds of key stakeholders gathered through regional hearings guided the Council in identifying and prioritizing recommendations.

The Council focused the development of its report "Diversifying California's Health Workforce: an Opportunity to Address Health Workforce Shortages" on two important issues that impact the delivery of health services to Californians.

First, there is a mismatch between California providers and consumers. California's health professions workforce does not reflect the state's demographics with respect to racial and ethnic composition and language proficiency. For example:

- Latinos comprise over a third of the state's population, but they make up 5.7% of nurses, 5.2% of physicians, and 7.6% of psychologists in California.
- African-Americans comprise 5.9% of the state's population but make up 4.5% of nurses and 3.2% of physicians.
- Current estimates indicate that roughly 9 out of every 10 physicians, dentists, and pharmacists in California is either White or Asian.

Second, California is facing looming health professional shortages:

- By 2014 the projected demand will exceed supply for pharmacy technicians by 119%, for dental hygienists by 122%, for physical therapist assistants by 178%, and for clinical laboratory scientists by 559%.
- There will be an estimated need of 47,600 additional nurses by 2010 and 5,000-17,000 physicians by 2015.

The underrepresentation of racial and ethnic groups in California's health workforce is an acute problem. These communities are less likely to have an adequate supply of health providers. Underrepresented communities also experience reduced access to health care and poorer health compared to communities populated by non-Latino Whites. Considerable research documents that underrepresented health professionals are more likely to serve in underserved communities and serve disadvantaged patients such as the uninsured and those insured by Medicaid. Thus, diversifying California's health workforce has profound implications for reducing racial and ethnic disparities in healthcare access and outcomes as well as addressing California's health workforce shortages.

The Council's recommendations fall into three broad categories: overarching, higher education, and the existing healthcare workforce. Overarching recommendations span the three content categories, and focus on building the evidence base and infrastructure that support the design, implementation, and evaluation of health workforce policies. The recommendations can be implemented immediately to produce measurable impacts within the next two years and are as follows:

Overarching Recommendations

- Develop a comprehensive, multi-year strategy and implementation plan to advance health workforce and diversity in California;
- Conduct a gap analysis to identify immediate opportunities to enhance workforce diversity;
- Facilitate the effective implementation of the Healthcare Workforce Clearinghouse Program by building the capacity of departments, institutions, and agencies involved in the collection and reporting of health workforce and education data;
- Institutionalize the Healthcare Workforce Diversity Advisory Council.

Higher Education Recommendations

- Support local, regional, federal, and statewide public/private partnerships that matriculate, retain, and graduate underrepresented students such as Health Career Opportunity Programs (HCOP), Centers of Excellence (COE), and Area Health Education Centers (AHEC), and work collaboratively with regional consortia to increase the matriculation of underrepresented students in undergraduate and graduate programs;
- Require health professions educational institutions to submit an annual report, as part of their annual budget report, regarding the admissions, retention, and attrition of underrepresented students and faculty, as well as formal plans and resource allocation to increase diversity and create a diverse learning environment;
- Create incentives for health professions education institutions to recruit and retain faculty whose research focuses on health disparities and/or communities with disproportionate unmet health needs and/or health workforce development.

Workforce Recommendations

- Pursue public/private partnerships to increase loan repayment availability for students and faculty;
- Pursue public/private partnerships to increase resident and clinical placements in rural and urban/inner city areas with disproportionate unmet health needs.

The Council's policy recommendations have been designed to facilitate better acquisition of resources; the establishment of health workforce priorities that increase diversity; and enable the identification and sharing of best practices and strategies that may be replicated statewide, regionally or nationally. The report highlights the recommendations, the problem the recommendation attempts to address and the actions required by both the public and private sector.

Preamble

To fulfill its charge of developing policy recommendations to address California's health professional shortages especially among populations underrepresented in the health professions, the Council operated from the following framework:

- California's health professions workforce does not reflect the state's demographics of racial and ethnic composition and language proficiency.
- California lacks an overarching plan for increasing the diversity of the health professions workforce.
- California faces looming current and projected shortages in the health professions.
- California requires the commitment of a variety of stakeholders including federal, state and local governments, K-12 education, academic and research institutions, private industry, professional associations, philanthropy and others to increase health workforce diversity.
- Underrepresented students face social, educational, and financial barriers that often preclude their ability to pursue health professions education and health careers.
- Health providers from underrepresented backgrounds provide a disproportionate amount of care in underserved areas.
- Strategies must be developed and implemented to reduce and eliminate disparities in the healthcare delivered to racial and ethnic minorities that are in many cases associated with worse health outcomes.¹
- Underrepresented faculty play a significant role in shaping California's future health professions workforce and in eliminating racial and ethnic health disparities.
- Underrepresented populations participation in the health professions align with the building blocks of healthcare reform:
 - *Promote health, prevent disease and deliver wellness.*
 - *Contain healthcare costs/support affordability and meet the demands associated with coverage for all.*

This framework provided the context needed by the Council to develop policy recommendations that facilitate better leveraging of resources; the establishment of health workforce priorities that increase diversity; and enable the identification and sharing of best practices and strategies that may be replicated statewide, regionally or nationally.

Methods

Key Terms and Definitions

The following operating definitions were adopted throughout Council meetings, regional hearings and this report:

- *Higher Education*: California Community Colleges, California State Universities (CSU), the University of California (UC), and Private Postsecondary Institutions.
- *Underrepresented (UR) populations, students or faculty*: African-American, Latino, Native American, certain Southeast Asian and other populations whose participation in the health profession does not reflect California's demographics.
- *Underserved areas*: urban/inner city and rural areas that lack sufficient numbers of health providers to meet the population's needs.
- *Short-term recommendations*: actions that can be implemented immediately to produce measurable impacts within two years.
- *Long-Term recommendations* are captured within the overarching recommendations and typically take two or more years for impacts to be realized.

Process for Input

The Office of Statewide Health Planning and Development (Office) received a grant from The California Wellness Foundation in December 2006 to establish and convene the Healthcare Workforce Diversity Advisory Council (Council). The Council serves in an advisory capacity to Governor Arnold Schwarzenegger's Administration. The Council was charged with developing policy recommendations to address California's health professional shortages especially among populations that are underrepresented in the health professions. The Council is a group of seventeen leaders representing health policy/advocacy, health employer, health professions pipeline, workforce investment, professional, student, research, labor and ethnic health organizations and associations.

From July through August 2007, the Council held three regional hearings in Oakland, Burbank, and Fresno, California to gather public input to aid the Council with developing policy recommendations to address health workforce shortages in California. The regional hearings gathered input from over 117 individuals representing California Community Colleges, California State Universities, University of California, Private Higher Education, K-12 Education, health pipeline, students, policy/advocacy, professional associations, labor, corporate, community, local government, state government and foundations (see Appendix A).

Hearing recommendations generally fell into three broad categories: higher education, the existing healthcare workforce, and overarching recommendations. Overarching recommendations span the three content categories, and focus on building the evidence base and infrastructure that support the design, implementation, and evaluation of health workforce policies.

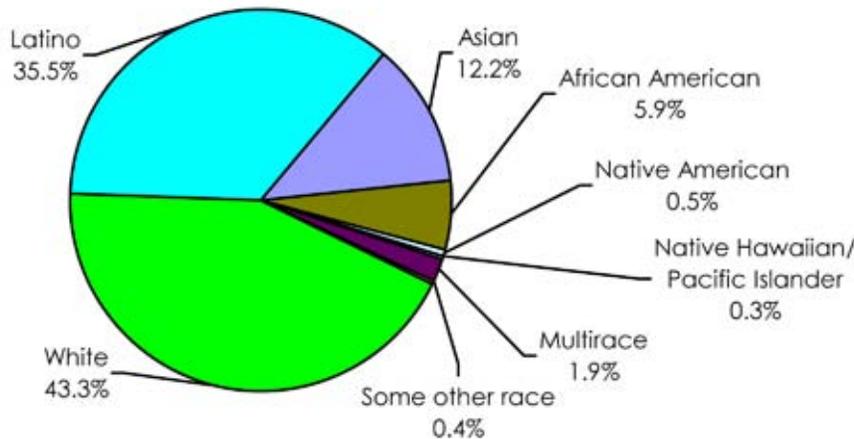
After considering all of the recommendations, the Council met several times to prioritize and finalize the recommendations. The Council with assistance from staff of the Office conducted a literature review to develop the case for support of the recommendations. Short-term recommendations, along with a problem statement, the action required to implement the recommendation, and the anticipated impact are provided in this report. Due to California's fiscal situation and the need to implement recommendations that are immediate and actionable, specific long-term recommendations are not included in the report but will be informed by the overarching recommendations. In addition, a complete list of recommendations received throughout the hearing process is included in Appendix B.

Problem Identification

California's population is among the most racially and ethnically diverse in the U.S as seen in Figure 1, yet California's health workforce does not reflect its diversity. Specifically, California's 2005 population was 35.5% Latino, 5.9% African-American, 12.2% Asian/Pacific Islander, 0.9% Native American and 43.3% White. The state's demographics are rapidly changing with dramatic increases in Latino and Asian/Pacific Islander populations as well as the aged.

These demographic shifts are already causing gaps between workforce supply and demand. By 2014 the projected demand will exceed supply for pharmacy technicians by 119%, for dental hygienists by 122%, for physical therapist assistants by 178%, and for clinical laboratory scientists by 559%.² There is also an estimated need of 47,600 additional nurses by 2010 and 5,000-17,000 physicians by 2015.³ Additionally, California ranks 43rd in the nation in the number of pharmacists per capita (66:100,000).⁴ To meet current and future health workforce needs and address looming shortages, California must develop strategies that tap into the growing pool of underrepresented talent that will enter the labor force. By 2030 it is projected that nearly 60% of California's population under the age of 18 will be Latino,⁵ so developing California's workforce will require diversification as the current health workforce does not represent changing demographics.

Figure 1: 2005 California General Population by Race and Ethnicity



Source: 2005 American Community Survey Public Use Micro Data Sample

As seen in Figure 2, there is a severe imbalance in the composition of the state's health profession workforce. Latinos comprise over a third of the state's population, yet they make up 5.7% of nurses, 5.2% of physicians, and 7.6% of psychologists in California. African-Americans comprise 5.9% of the population but make up 4.5% of nurses and 3.2% of physicians. Asian-Americans comprise 12.2% of the population, and make-up 22.5% of nurses, 26.4% of physicians, and 29.2% of dentists. Note Asian-American data is reported in the aggregate and can be misleading especially among South/Southeast Asian sub-groups.⁶ Current estimates indicate that roughly 9 out every 10 physicians, dentists, and pharmacists in California are either White or Asian although entry-level, lower-wage health professions tend to be more diverse.

In addition to meeting looming shortages, diversifying the health workforce will also help mitigate increasing healthcare costs. The Sullivan Commission states the lack of a diverse workforce results in a "loss of productivity, higher absenteeism, and greater employee healthcare costs...[resulting] in millions of dollars lost to companies as the result of chronic conditions left untreated" (2004).⁷ Workforce expenditures comprise 60% of the total cost of care, so having a more demographically representative health workforce will ensure that supply and demand are matched in an efficient manner.⁸ Economic productivity loss is exemplified by language barriers which cause less efficiency in the utilization of institutional resources.

**Figure 2: Current Composition of Selected Health Professions
in California by Race, Ethnicity**

Profession	White (%)	Asian (%)	Latino (%)	African Am. (%)	Native Am. (%)	Other Race (%)
California Population	43.3	12.2	35.5	5.9	0.5	--
Physicians/Surgeons	61.7	26.4	5.2	3.2	0.6	2.9
Registered Nurses	64.3	22.5	5.7	4.5	0.3	2.7
Dentists	61.4	29.2	--	--	--	9.4
Pharmacists	47.8	44.5	--	--	--	7.7
Psychologists	84.0	--	7.6	--	--	8.4
Social Workers	67.8	8.4	13.5	8.1	--	2.2
Respiratory Therapists	58.0	--	--	--	--	42.0
Diagnostic-related Technologists & Technicians	56.7	12.6	22.9	--	--	7.8
Healthcare Support Occupations	34.1	17.5	34.8	9.8	--	3.9

Source: 2005 American Community Survey, Public Use Microdata Sample for California; California Medical Board Re-licensing Survey; Board of Registered Nursing 2006

In addition to meeting workforce shortages and mitigating increasing healthcare costs, having a demographically representative health workforce can increase access and reduce health disparities as underrepresented health professionals are more likely to serve in low-income and medically underserved communities.⁹ According to a 2003 study by the Institute of Medicine (IOM), communities of color suffer higher levels of sickness, disability, and premature death than Whites. "The fact that the state's health professions have not kept pace with the changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for millions of Americans."¹⁰

Recommendations

After considering the recommendations made by the Council and regional hearing attendees, the Council along with staff of the Office reviewed relevant literature and research to develop the case for support of the *overarching, higher education* and *workforce* recommendations. Short-term recommendations, along with a problem statement, the action required to implement the recommendation, and the anticipated impact are provided in this report. Due to the need to implement cost-effective recommendations that are immediate and actionable, specific long-term recommendations are not included in the report and will be informed by the overarching recommendations.

Overarching Recommendations

Overarching recommendations focus on building the evidence base and infrastructure that support the design, implementation, and evaluation of health workforce policies. The Council proposes four overarching short-term recommendations for consideration.

1. Mandate the development of a comprehensive, multi-year strategy and implementation plan to advance health workforce and diversity in California.

California's population is aging, growing, and increasing in diversity, but California's health workforce is ill-equipped to respond to these new pressures on the healthcare system. The University of California (UC) projects the state will face a shortfall of approximately 47,600 nurses by 2010, and shortfalls of 116,000 nurses and nearly 17,000 doctors by 2015. Such shortages, driven primarily by market forces, exacerbate quality of care, availability of specialty care, mal-distribution of providers and negative health outcomes. Unfortunately, California does not have a long-term, statewide and/or regional plan that includes the varying professions to address these looming workforce shortages. California is missing the needed vision, strategy, action plan and infrastructure to coordinate efforts and be accountable for maximizing efficiency and impact. While many individual, organizational, and institutional forces are converging to address the lack of diversity in the health workforce, coordination is limited among these efforts and other key stakeholders who have similar objectives. Although well intended, the lack of coordination is causing missed opportunities to identify allies, synergies and lessons learned, as well as a duplication of efforts and inefficient use of limited resources.

An effective overarching plan with short and long-term components includes a gap analysis of the various public and private programs and their ability to meet the looming workforce shortages; addresses forecasted demand barriers; identifies problems for key professions, strategies and actions for implementation, and tools to monitor progress and outcomes. Further, the plan's multi-level approach will include policy, profession, region-specific and institutional strategies. Thus, the plan will include input from key stakeholders as well as identify the needs of and provide roles for various sectors such as: health professions, health organizations, business and labor, educational institutions, state government, workforce

boards, philanthropic organizations, regional leadership and consumers. The plan will incorporate ongoing dialogue from K-12, community college, California State Universities (CSU), UC, and private postsecondary colleges. In addition, the plan should link to existing opportunities such as the Governor's Nursing Workforce Initiative and the Mental Health Services Act. For example, the Governor's Nursing Workforce Initiative is addressing the nursing shortage by investing in a five-year \$90 million public-private partnership to provide funding for nursing education. Lastly, the plan should address and focus on issues that impact the health of all Californians such as increasing the number of primary care providers, focusing on health promotion and disease prevention, and ensuring a sufficient workforce for safety net providers in rural and urban underserved communities.

Iowa and Wisconsin have begun to develop comprehensive health workforce plans, but California has the opportunity to nationally pioneer efforts in the development of a health workforce master plan, which will result in a multi-level and multi-sector approach to an overarching vision, action plan, and infrastructure to coordinate efforts in order to maximize efficiency and impact.

2. Conduct a gap analysis to identify immediate opportunities to enhance workforce diversity and to develop a comprehensive plan to achieve health workforce diversity in California.

To develop a comprehensive plan to address health workforce shortages and diversity in California, a gap analysis should be conducted that evaluates the impact and effectiveness of existing programs, identifies service gaps related to education and training infrastructure, and assesses scale and cost. For example, many of the public programs fall under the California Health and Human Services Agency and within the Office of Statewide Health Planning and Development. However, others including the Labor and Workforce Agency, the Department of Education and the private sector offer additional programs designed to address health workforce and diversity issues. Unfortunately these programs are not coordinated with each other, so there is no consistent form of evaluating their merit, scope and potential ability to address current and future workforce demands. Staffing and funding limitations preclude some programs from any evaluation.

A policy directive that requires a gap analysis to assess programmatic and fiscal impact, review capacity and effectiveness of existing programs relative to needs at the regional and statewide level would include the following indicators: geographic location, race and ethnicity, languages spoken, income levels, and age distribution. This gap analysis could also identify and prioritize unmet data collection and reporting needs as well as state, federal and private funds committed to health workforce diversity.

Producing this gap analysis supports the development of statewide, regional and profession-specific indicators and provides numerous benefits and opportunities to:

- leverage funding resources and form new partnerships;
- foster shared learning across various sectors;
- identify and institutionalize best practices;

- document areas that are not being addressed;
- identify workforce issues that need further exploration and strategy development;
- assess how resources are being distributed; and
- minimize duplication of effort.¹¹

3. Facilitate the effective implementation of the Health Care Workforce Clearinghouse Program by building the capacity of departments, institutions, and agencies involved in the collection and reporting of health workforce and education data.

To support health workforce policy and development initiatives, the Governor signed legislation creating the Health Care Workforce Clearinghouse Program within the Office of Statewide Health Planning and Development (Office) to serve as the central source of health workforce and educational data in the state (SB 139 (Scott), Chapter 522, Statutes of 2007). The Clearinghouse creates a much needed database to document and monitor the state's healthcare workforce by assessing workforce supply and demand to influence and shape health workforce policy. The Clearinghouse requires the Office to work with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect data (to the extent available), by specialty, including but not limited to existing supply, geographic distribution, race, ethnicity, and languages spoken.

To administer the Clearinghouse, gather information and data from multiple sources, perform data analysis, and prepare regular reports, the Office and Clearinghouse data partners will need more access to existing data collected by State bodies. For example, some data providers may not collect or have authority to share or transfer data needed to meet Clearinghouse reporting requirements. Further, the majority of health licensing entities do not collect demographic data on their licensees, such as race/ethnicity, language proficiency, geographic location and population served. Without this information, the Clearinghouse will be limited in its ability to develop and respond to demographic and geographic shifts in provider needs. In fact, the only state licensing boards that collect the aforementioned data include the Medical and Dental Boards of California and the California Board of Registered Nursing.

At a minimum, the State should require all health licensing entities to collect, disaggregate and report on the demographic profiles of their licensees; allow the sharing and transfer of confidential data; and secure additional resources to support data collection efforts. These legislative, regulatory and administrative actions would enhance the Clearinghouse's ability to prepare comprehensive annual reports that identify education and employment trends in the health professions; illustrate the current supply and demand for healthcare workers in California and identify gaps in the educational pipeline producing workers in specific occupations and geographic areas.

Clearinghouse reports and data products will aid in the development of a statewide health workforce master plan as well as public policies to address the health workforce shortage,

distribution, and access exacerbated by the lack of health workforce diversity. The reports and data products will also enhance California consumers' ability to understand the complexity of California's healthcare delivery infrastructure relative to health workforce supply and demand.

4. Institutionalize the Healthcare Workforce Diversity Advisory Council.

The Healthcare Workforce Diversity Advisory Council (Council) was established by a one-year grant from The California Wellness Foundation to the California Office of Statewide Health Planning and Development (Office). The purpose of the Council is to provide the Office and Administration with short-term, strategic recommendations to address the lack of diversity in the health workforce. The convenings and subsequent regional hearings have initiated discussion among a diverse group of stakeholders who are pivotal to the development of health policy that positively affects health workforce diversity in California. The Council's role and the public input process it has embraced highlight the need for ongoing planning, coordination and implementation of health workforce diversity initiatives that can be funded through public-private partnerships.

Although the state hosts a variety of healthcare related advisory groups, there is currently no advisory group charged with providing counsel on the overall health workforce. There are a number of individual groups working on workforce issues throughout the state, however the long-term commitment of a diverse group of key stakeholders assembling to discuss health workforce issues and inform health policy benefits the state's healthcare reform efforts and identifies critical health workforce needs. The Council's role should be expanded with dedicated staff to convene, coordinate, and communicate health workforce development initiatives statewide. As a broker of information, the Council should also serve as a forum, catalyst, communicator and resource for best practices and monitor efforts to develop a health workforce that is reflective of the state's demographics. Specifically, the Council will be instrumental in leveraging resources in the development of a statewide master plan and could provide counsel during the development of the gap analysis and data clearinghouse.

The State should support the permanency of the Council by continuing to provide in-kind support in the form of regular Council meetings, meeting space and dedicated staff over the next five years. The private sector should provide funding for coordination, including forums, convenings and resource dissemination. Convening and staffing the Council beyond the period for which grant funding has been received will demonstrate the State's commitment to health workforce diversity.

Higher Education Recommendations

Three higher education recommendations are proposed that can be adopted by the Administration, the State Legislature and higher education institutions. In general, the recommendations aim to increase the admission, support and retention of underrepresented (UR) students and faculty in health professions education institutions.

1. The State shall support local, regional, and statewide public/private partnerships:

- **Advocate for programs that support retention and graduation of underrepresented undergraduate and graduate students such as**
 - **Health Career Opportunity Programs (HCOP),**
 - **Center's of Excellence (COE), and**
 - **Area Health Education Centers (AHEC), and**
- **Work collaboratively with regional consortia to increase the matriculation of underrepresented (UR) students in undergraduate and graduate programs**

Traditionally authorized by Title VII of the Public Health Service Act and federally funded, HCOP, COE and AHEC diversify the health workforce by: developing a more competitive applicant pool to build health professions diversity; supporting programs of excellence in health professions education for underrepresented individuals; and offering recruitment, health career awareness, and educational enhancement activities targeted towards UR students. Federal cuts have rendered many of these programs inoperable. HCOP was cut 88.8%, from \$35.3 million in Fiscal Year (FY) 2005 to \$4 million in FY 2006 and FY 2007. The COE program was cut 64.3%, from \$33.6 million to \$12 million in FY 2006 and FY 2007.¹² These cuts have resulted in the complete elimination of federal funding for HCOP and COE in California despite demonstrated success in diversifying health professions.*

To increase opportunities oriented toward directing, encouraging, and retaining existing and future UR students in pursuit of healthcare careers, the state should seek restoration of funding for Title VII programs and support student support services through federal advocacy and state funding. Most California health professions education programs do not focus on diversity recruitment due to state funding limitations. Other states such as North Carolina and Florida have AHEC's that fund statewide educational initiatives focused on health workforce diversity. A sustainable source of funding in California for public/private partnerships that increase the matriculation, retention, and graduation of UR students in undergraduate and graduate health professions education programs will enhance California's ability to produce a healthcare workforce that reflects the population and can meet the state's cultural and linguistic healthcare needs. For example, the University of California, San Francisco found that disadvantaged students who participated in post-baccalaureate programs were three times more likely to secure health professional education opportunities (e.g. gaining admission into medical schools) than students who did not participate in such programs.¹³

Funding student support services is insufficient without coordinated regional engagement. Regional consortia that include academic, community, and industry partnerships and are responsive to State and local needs advance efforts in increasing the diversity of the workforce. For example, Sutter Health Sacramento Sierra Region, Catholic Healthcare

* A Robert Graham Center study reveals that schools receiving Title VII funding showed 15.8% graduates in family practice, compared with 10.2% in schools without Title VII funding. 10.5% of Title VII-supported graduates practiced in primary care health personnel shortage areas compared with 1.2%; 12.7% of graduates practiced in rural areas, compared with 9.5% in non-Title VII schools. Title VII is the only federal program that has increased the production of primary care physicians who serve medically vulnerable populations.

West, U.C. Davis Medical Center, Kaiser Permanente, Los Rios Community College District, Sacramento City Unified School District and California State University, Sacramento are working with the Regional Health Occupations Resource Centers (RHORCs) to create a regional workforce collaborative to address local health workforce needs.¹⁴ Along with the Healthy Communities Forum \$3 million contribution to expand American River College (ARC) Nursing Associate Degree program, Sutter has donated millions in student scholarships and in-kind support, demonstrating the effectiveness regional collaboratives have in leveraging resources.

2. Health professions educational institutions shall submit an annual report as part of their annual budget report regarding the admissions, retention, and attrition of underrepresented (UR) students and faculty, as well as formal plans, progress and resource allocation to increase diversity and create a diverse learning environment.

The student and faculty population of health professions education institutions does not reflect California's population demographics. Currently, California lacks a reporting process to monitor or document why underrepresented (UR) students and faculty are missing from health professions education institutions or what is being done. UR students are far less likely to apply, gain admission, matriculate and graduate from health profession educational institutions than their counterparts.¹⁵ College level health professions programs face a feeder educational pipeline characterized by high rates of high school dropout for African American (double that for Whites) and Latinos (four times greater than those for non-Latino Whites).¹⁶

State data suggest little change in the proportion of UR faculty at college campuses despite changes in population demographics. For example, between 1993 and 2003, the percentage of UR faculty grew from 6.8% to 7.2% within the University of California (UC) system and from 9.8% to 12.1% within the California State University (CSU) system.¹⁷ A twenty-eight campus study of independent colleges and universities in California funded by The James Irvine Foundation revealed that there is a revolving door that undercuts the proactive work required to diversify the faculty ranks in terms of race/ethnicity, suggesting that UR faculty retention requires as much attention as recruitment.

The Legislature and other relevant legislative committees can monitor health professions education institutions and their ability to educate and train a health workforce that represents California's diversity through annual reports. Monitoring activities include:

- Results of outreach support, admission, matriculation, and graduation of UR students from communities within the immediate region.
- Results of functional and ongoing links between UC-CSU-Community College campuses.
- Results of progress to create an institutional climate that ensures the accrual of the benefits of diversity.

- Results of partnerships with health professions employers, community leaders and other key stakeholders at the local and regional level.
- Evidence of dollars invested in infrastructure to support and sustain institutional commitment.

Annual reports hold health professions education institutions accountable for meeting the diverse needs of Californians and could substantiate incentives for increased activity and state-line item budget investments. A diverse student body also impacts attributes of the institutional climate: stronger commitment to multiculturalism, greater faculty emphasis on racial and gender issues in their research and in the classroom, and more frequent student involvement in cultural awareness workshops and ethnic studies courses.¹⁸ These same environmental characteristics also have positive impacts on student retention, overall college satisfaction, college GPA, intellectual self-confidence, and social self-confidence.

3. The State shall create incentives for public and private health professions education institutions to recruit and retain faculty whose research focuses on health disparities and/or communities with disproportionate unmet health needs and health workforce development.

California's health profession workforce does not reflect the state's demographics, which is especially evident among health profession faculty. For example, only 6.1% of the University of California (UC) medical school faculty in 2004 came from underrepresented (UR) backgrounds despite composing 42.7% of Californians.¹⁹ Additionally, the California Board of Registered Nursing 2006-2007 Annual School Report reveals that 13.6% of nursing faculty is from UR backgrounds and 70.4% are White. The absence of UR faculty limits an institution's ability to attract UR students as they serve as both role models and mentors for UR students.²⁰ UR faculty typically undertake research agendas that explore previously neglected areas of investigation that are pertinent to racial and ethnic minority communities and underserved populations, further attracting UR students as research assistants.²¹

One campus-level initiative example is the Berkeley Diversity Research Initiative (BDRI), an inter-disciplinary initiative sponsored by the UC Berkeley Chancellor. The BDRI hired six full-time faculty members to lead three tracks of research: diversity and democracy; diversity and health disparities; and educational policy collaboration. All six faculty are integrated into the annual UC Berkeley budget to ensure sustainability.

Another campus-based initiative where institutional leadership recognized the community health needs and tailored its medical school curricula to meet that need is the UC Irvine Program in Medical Education focused on the Latino Community (PRIME-LC). PRIME-LC is a national model for meeting the healthcare needs of the growing Latino population by training Spanish-speaking students the standard medical curriculum with a specific focus on health issues impacting Latinos. PRIME-LC is training an additional 43 medical students since its 2004 inception and has been successful in securing over \$660,000 from private foundations and industry leaders as well as permanent state funding.²²

The State along with private funding entities including foundations and corporations, should increase funding for research on racial disparities in healthcare and health status, including but not limited to: research on culturally competent care, how to measure and eliminate racial bias and stereotyping, strategies for eliminating health disparities, and increasing positive health behaviors among racial and ethnic groups.

The Legislature should annually allocate funds to provide awards to 2-3 campuses. Award selection should include the following at a minimum:

- Level of internal funds committed at the program and campus level;
- Sustainability of internal financial commitment;
- Attention to support and mentorship for junior faculty;
- Engagement and support of senior faculty who serve as mentors;
- Clarity and relevance of research agenda to priority health needs in diverse California communities; and
- Inclusion of UR students in the research.

State support to public and private health professions education institutions that recruit and retain faculty whose research focuses on health disparities and/or communities with disproportionate unmet health needs and health workforce development could help the state: reduce health disparities; enhance the training of all students by including relevant cultural and social issues in the academic and clinical curriculum; and identify barriers to UR student health professions education program entry and completion.²³

Workforce Recommendations

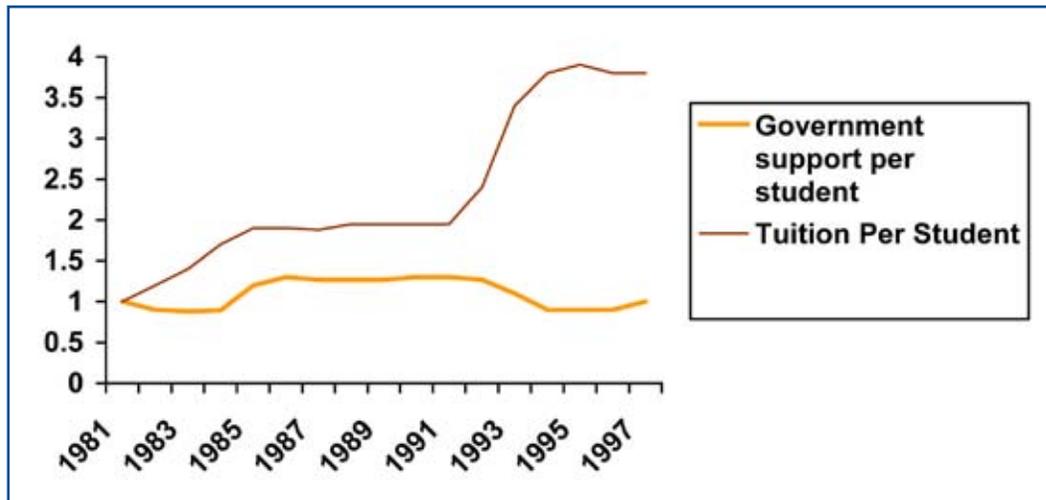
Two workforce recommendations are proposed to target California's current workforce including licensed or certified health professionals. The workforce recommendations acknowledge underrepresented (UR) health providers' role in increasing access to healthcare in underserved areas and to UR populations.

1. The state shall pursue public/private partnerships to increase loan repayment availability for students and faculty.

Students

California's rising cost of higher education is outpacing other economic indicators such as growth in household income and inflation. Tuition and other non-fee related expenses like housing, transportation and textbooks have made it challenging for individuals to pursue their professional and personal dreams. For example, for the decade from 1993-94 to 2003-04, the State's median household income rose by 13%, student fees at California State Universities (CSUs) and University of California (UCs) also rose by 13% but non-related fees rose by 32% at UCs and 21% at CSUs.²⁴ Further, the aggregate level of student indebtedness has increased by 66% from 1995-96 to 2003-04. Students attending vocational proprietary schools are

particularly at risk due to higher costs of education, higher average levels of indebtedness and thus, higher default rates and lower abilities to repay educational loans.²⁵ Loan forgiveness programs have been proven to increase the supply of educated and trained individuals as well as attract qualified candidates to particular medically underserved areas.



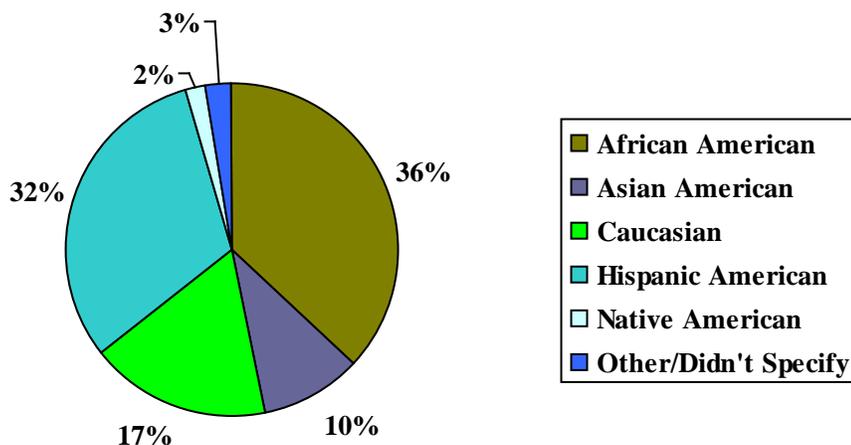
In 1981, government support covered all but 5% of student costs. By the late 1990s tuition was four times higher than it had been two decades earlier.

Source: *Keeping College Affordable in California A Report of the Special Panel on Affordability to the California Postsecondary Education Commission, December 2006.*

Increasing loan repayments will aid current and future health professionals who come from financially disadvantaged backgrounds conquer what is often viewed as an overwhelming and insurmountable barrier. The 2006 American Community Survey indicated that the median income for White families was 30% higher than that of African-Americans and 39% higher than that of Latinos. The majority of health professionals who utilize loan repayment programs come from UR backgrounds and/or underserved communities. Failure to address the cost problem will only increase the growing diversity gap between health professionals and the populations they serve.

California's Health Professions Education Foundation (Foundation) offers several loan repayment and scholarship programs targeting physicians, nurses, mental health providers, vocational nurses, nurse practitioners, physician assistants, dental health providers and nursing educators and provides over \$5 million in annual awards. Recipients – practicing in 51 of 58 counties – are required to practice a minimum of two to three years in rural and urban underserved areas or as nursing faculty. Further, the Foundation's program applicants and recipients (Figure 3) represent California's racial and ethnic diversity.

Figure 3: Race/Ethnicity of Award Recipients



Source: Health Professions Education Foundation

These programs are primarily funded by health professional licensure fees, foundations, and corporate donations but remain woefully under-funded. Licensing boards that contribute to loan repayment programs via their licensure fee have been effective in developing sustainable, long-term funding for these programs. Unfortunately, not all health licensing boards contribute from their licensure fees thereby creating a greater demand for loan repayments than the funding availability. In fact, these programs receive 35-45% more eligible applications than can be funded. As existing and new loan repayment programs are developed, the State should partner with the respective health licensing boards to develop a required contribution fee to support program awards and operations. This funding strategy would require minimal General Fund support and build long-term sustainable funding.

Fully funding the Foundation's programs will have a significant impact on the geographic distribution and diversity of the state's health professionals. Loan repayments are highly effective in attracting physicians and nurses to work in disadvantaged or underserved communities and increasing access to care in health centers. In fact, a 2000 study of the National Health Service Corps, found that 15 years after the start of their service obligations, more than 50% of providers were still practicing in communities where they were sent. Retention rates were as high as 60% to 70% one year to two years after obligated service ended.²⁶

Faculty

Increasing loan repayment availability for health professions education faculty could have multiple impacts—address the education capacity constraints that limit enrollment expansion and increase opportunities for recruitment and retention of a diverse student body. A report following the work of the Sullivan Commission recognizes that UR health professionals account for only 4.2% of medical school faculties, less than 10% of the baccalaureate and graduate nursing school faculties, and 8.6% of dental faculties in the United States, emphasizing the urgent need for a diverse pool of leaders and mentors.²⁷ In fact, a 2002 report from the

federal Inspector General documents the support for continuing faculty loan repayment programs that target faculty from disadvantaged backgrounds.²⁸

Faculty that is reflective of the population's demographics provides a key element in retaining UR students by creating a system of social support via mentorship as well as curriculum and programmatic development. Further, faculty loan repayment programs can instigate a chain reaction in the higher education realm by increasing the number of faculty members available to teach, admissions slots, program enrollments, and the number of UR health professional graduates.

2. The State shall pursue public/private partnerships to increase resident and clinical placements in rural and urban/inner city areas with disproportionate needs.

There is a significant shortage of health professionals practicing in underserved areas in California. Nearly 4.2 million Californians live in a Primary Care Health Professional Shortage Area (HPSA); over 1.7 million live in a Dental HPSA; and over 3.9 million reside in a Mental Health HPSA.²⁹ These areas have high concentrations of uninsured, underinsured, and publicly insured residents and tend to be ethnically and culturally diverse.

A recent study of the University of California, Charles R. Drew University Medical Education Programs suggests that physicians who receive their clinical training in underserved communities are more likely to practice in these areas, and that physicians from populations that are underrepresented (UR) in the health professions are more likely to return to underserved communities to practice after completion of their degree.³⁰ Additionally, awardees of the Song-Brown Healthcare Workforce Training Act Program indicate that 54% of their Family Practice Residents, 63% of Family Nurse Practitioner and Physician Assistant graduates, and 42% of Registered Nurse graduates practice in underserved areas upon completion of their training or education.

To address the current and forecasted deficit of providers practicing in underserved areas and enhance access to healthcare, creative financing mechanisms are needed to increase clinical placements. Resources are needed to build the training capacity of community hospitals and community health centers that serve these communities, and revenue sharing arrangements between hospitals and community health centers are needed to cover the ongoing marginal costs of the training process. Possible capacity building strategies include, but are not limited to tax credits and other incentives for health professions employers such as health plans, biotechnology and pharmaceutical companies to invest in hospital and community health centers, required investments by new programs (e.g., UCR School of Medicine), and public-private sector matching grants.

For ongoing marginal costs (particularly for community health centers who do not receive clinical training subsidies), an analysis of federal and state funding streams is needed to examine possible revenue sharing arrangements. A current pilot program involving the placement of trainees from the five California dental schools for rotations in community

health centers** suggests that revenue sharing arrangements can yield significant benefits for all parties. Preliminary results indicate a dramatic increase in access to care for residents in underserved communities and an increase in the number of graduates who choose to practice in these areas after graduation.

*** This dental pipeline program is funded by The California Endowment and the Robert Wood Johnson Foundation. A funding proposal to examine options and formalize revenue sharing arrangements was submitted to the federal Health Resources and Services Administration and approved, but funds have not been appropriated to date.*

Conclusion

The lack of racial and ethnic diversity among California's health workforce is a complex problem fueled by systemic, education and workforce barriers that undermine California's ability to address health workforce shortages and disparities. Implementation of the recommendations cited in this report will require multi-level and cross-sector communication and partnerships to leverage limited financial resources and elevate California's urgent need for health workforce diversity.

There are many individual and organizational efforts underway to address health workforce diversity including the efforts of the California Health Professions Consortium, the Latino Coalition for a Healthy California, the California Institute for Nursing and Health Care, The California Wellness Foundation's, "Make It In Scrubs Campaign" and The California Endowment's "Connecting the Dots Initiative." As such, the need for ongoing monitoring, coordination and dialogue among these and other health workforce partners will be integral to the implementation of the recommendations proposed.

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APPENDIX A

Healthcare Workforce Diversity Advisory Council Regional Hearing Participants

American Medical Student Association	Central Valley Health Policy Institute
Asian Pacific Islander American Health Forum (APIAHF)	Cerritos College
California Association of Alcohol and Drug Program Executives, Inc (CAADPE)	College of Osteopathic Medicine
California Dental Association Foundation (CDA Foundation)	COPE Health Solutions
California Department of Public Health: STD Control Branch	David Geffen School of Medicine at University of California, Los Angeles
The California Endowment	Fresno Center for New Americans (FCNA)
California Hospital Association	Fresno Interdenominational Refugee Ministries
California Immigration Policy Center	Golden West College
California Institute for Mental Health (CIMH)	Greenlining Institute
California Institute for Nursing & Health Care (CINHC)	Hartnell College
California Medical Association	HealthCare Resource Center (HCRC)
California Optometric Association	Healthcare Workforce Development Program
California Primary Care Association	HealthNet
California Rural Indian Health Board	Health Professions Education Foundation
California State Rural Health Association	Hospital Association of Southern California
California State University, Sacramento	Hospital Council of Northern and Central California
California State University, Fresno	Inland Coalition Advancing Diversity and Education in the Health Careers
The California Wellness Foundation	Kaiser Permanente
California Workforce Investment Board	Latino Care Management
Center for Student Success	

Latino Coalition for a Healthy California
(LCHC)

Latino Health Collaborative

Latino Issues Forum

Latino Medical Student Association

Livingston Medical Group

Los Angeles Health Action

Medical Board of California

Milken Institute

Mt. San Antonio College

National Registered Nurses Professional
Association

National Union of Hospital and Health Care
Employees

Palomar Pomerado Health Development

Public Health Institute

Reach Out West End

Regional Health Occupations Resource
Center

S. Reyes & Associates

San Diego Welcome Back Center

San Francisco Community Clinic Consortium

San Joaquin Valley Health Consortium

Santa Ana College

Sonoma Developmental Center

Southeast Asia Resource Action Center
(SEARAC)

United Nurses Associations of California/
Union of Health Care Professionals
(UNAC/UHCP)

University of California, Davis

University of California, Merced

University of California, Riverside

University of California, San Francisco

University of California, San Francisco:
Latino Center

University of Southern California: Keck
School of Medicine

Western University of Health Sciences,
Doctor of Osteopathic Medicine Program

APPENDIX B

Plausible Solutions to Address Health Workforce Diversity

Throughout the hearing process, hearing attendees offered the following academic and training, administrative and/or policy solutions for consideration by the Council:

Academic and Training

- Increase funding to expand health professions education capacity
- Increase permanent funding for post baccalaureate and re-applicant program support and reduce reliance on foundation grants
- Increase student support services for students coming from deficient educational backgrounds
- Regional recruitment of students
- Recruit underrepresented faculty from community colleges
- Provide cultural competency training for students and faculty
- Broaden admissions policies and the definition of what a “qualified student” means
- Expand admission qualifications beyond GPA and test scores and consider other options—interviews versus test scores
- Increase accountability for college admissions—look at the applicant's values in relationship to the institutional mission; determine the applicant's willingness to serve in underserved areas
- Institutionalize diversity and services to vulnerable populations—more holistic admissions criteria; and standardize cultural competency curriculum
- Provide budget augmentations for bridge programs
- Provide full-time/paid advisors to educate students about healthcare careers
- Increase state funding for UC Programs in Medical Education (PRIME); specific to diverse students
- Increase funding for Regional Occupation Programs (ROP's) and vocational schools
- Expand vocational programs in health professional/allied health fields
- Increase focus on sciences and math in middle school and grade school
- Create more magnet health academies at lower grades and gather data of their effectiveness
- Increase the number of health professional academies in rural and underserved areas
- Make the A-G college preparation curriculum the default curriculum and let the deviation from the college prep curriculum be the students' choice

- Increase the number of teachers and counselors in K-12 and provide incentives for to participate in additional learning opportunities for students; increase time spent in classroom; and ensure more diversity to better educate parents and mentors
- Provide funding for counselors, mentors and faculty salary increases
- Have diversity in schools and graduation rates parallel the community
- Revisit pre-baccalaureate programs
- Reward/provide incentives for faculty that participate in student support services examples include credits toward tenure
- Extend pipeline programs through college and health professions and also extend down to grade school levels
- Develop career-focused statewide initiative to ensure linkages among programs and enhance portability
- Expand clinical training sites
- Include safety nets (community health centers and clinics) in rotations
- Increase flexibility of class offerings—more off-hour, weekend classes for science courses and simulation classes
- Increase distance learning opportunities
- Increase access to telemedicine training

Administrative Actions for State Government

- Adopt health professions diversity as a statewide priority; make it an initiative
- Institutionalize the Healthcare Workforce Diversity Advisory Council
- Create a taskforce for diversity in the health professions and charge the taskforce with the development of a strategic plan; connecting the dots with people in the field and policymakers, and public relations
- Create a committee to revisit the master plan of education—including hiring practices in schools for faculty with involvement from labor unions and the legislature
- Explore/restore the use of Employment Training Funds to support health workforce development and training opportunities
- Adopt a strong policy statement about the importance of new medical schools proposed at UC Riverside and UC Merced
- Establish quarterly meetings of stakeholders including the Employment Development Department, Workforce Investment Board, Department of Education, Office of Statewide Health Planning and Development, Licensing and Education Institutions
- Increase funding formulas for health professions education programs
- Statewide and Regional/Regulatory Boards should be representative of California's demographics

Administrative Actions for Employers

- Enhance retirement programs for healthcare professionals
- Make the business case that employers can influence health premium dollars by demanding access to culturally and linguistically responsive care for employees
- Adopt a policy statement that recognizes and embraces diversity as an important priority
- Redirect recruitment dollars to training current employees
- Encourage on the job training in healthcare settings
- Offer tuition reimbursement to existing employees
- Increase pay for bi/trilingual workers
- Expand 20/20 programs and/or provide stipends
- Implement more Continuing Education Units for the existing workforce and focus on cultural competency
- Encourage hospitals and providers to create a strategic initiative to receive, retain and support the development of diversity
- Statewide and Regional/Regulatory Boards should be representative of California's demographics

Policy

- Create a Commission for accountability and sustainability and require health professions education institutions to publish an annual diversity profile
- Provide loan forgiveness for physicians, nurses, pharmacy technicians, and other health professionals
- Develop more health professions schools and expand
- Provide consistent, long term (more than 3 years) and seamless funding
- Increase loan repayment as a method to create incentives for individuals and educational institutions
- Increase scholarship availability
- Encourage primary care provider versus specialty training through financial incentives, including loan repayment
- Statewide and Regional/Regulatory Boards should be representative of California's demographics
- Recruit RNs from the Universidad Nacional Autonoma de Mexico (UNAM) and speed up the licensing process or provide more resources to the Board of Registered Nursing
- Target scholarships and loan repayment in a way that would benefit underrepresented populations using proxies such as low income or residence in a health professional shortage area

- Provide tax credits to health professionals—MD's, RN's etc. to stay and practice in California
- Provide state funding for Health Career Opportunity Programs, Center's of Excellence, Area Health Education Centers and other pipeline programs
- Require comprehensive data collection of all healthcare providers and allied health providers (location, race/ethnicity, language, practice information, hours in practice, and public program participation)
- Increase Song Brown Healthcare Workforce Training Act funds
- Mandate physician contributions to support the Steven M. Thompson Physician Corps Loan Repayment Program
- Mandate partnerships between colleges, high schools and middle schools
- Increase access to International Medical Graduates in residency programs
- Develop standards for foreign trained professionals to undergo residencies which can lead to licensure
- Increase Medicare and Medi-Cal reimbursement
- Make mentoring a form of Medicare reimbursement or a continuing education requirement
- Implement reporting requirements and identify areas of underemployment
- Revisit or Repeal Proposition 209
- Look at issues and track adverse effects of Proposition 209, especially as they relate to healthcare professions diversity
- Leverage role of 500 new school based health centers and make the health center's a priority beyond primary school
- Provide grants for healthcare providers to establish practices in underserved areas
- Institute a community investment program/healthy enterprise zone
- Establish user fees for health equipment companies, similar to fees assessed to telephone and cable companies and allocate a portion of the revenue to support scholarships and loan repayments
- Bridge gaps and develop incentives for public/private partnerships
- Endow existing agency like the Department of Public Health to regulate community investment components that fund workforce development and health workforce diversity projects

Opportunities for Partnership and Collaboration

- Create funding partnerships with the Employment Development Department, the California Department of Education and the Department of Mental Health to increase education capacity

- Involve the business community—manufacturers associations, chambers of commerce, biotechnology and engineering companies
- Involve and encouraging parents to become “Parent Promotores,” and talk to other parents about their children’s education, financial aid opportunities and the importance of parental involvement
- Involve the media and developing a statewide public education campaign for community outreach to increase awareness and interest in health professional/allied health careers at the junior high, high school and collegiate level
- Involve Hollywood

Healthcare Workforce Development Division
Office of Statewide Health
Planning and Development
400 R Street, Suite 330
Sacramento, CA 95811
(916) 326-3700
HWDD@oshpd.ca.gov