Building an Inclusive Health Workforce in California:
A Statewide Policy Agenda

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Executive Summary

The American health-care system as we know it is changing. Demographic, market, epidemiological, and policy drivers are steering job growth and fundamental shifts in how health services are delivered and financed. To remain viable, the health-care industry will need an additional 4.6 million health workers to support the growing demand for services.[1] In California—the sixth-largest economy in the world and where the demographic shift toward a majority people-of-color population is already a reality—this translates to 450,000 health workers who need to be trained and recruited by 2020.[2] However, a significant portion of the fastest-growing, high-demand positions will be entry-level, low-wage jobs with poor prospects for career mobility. Additionally, the state's current education and health workforce development systems suffer from long-standing fragmentation and persistent inequities in the recruiting, training, and preparing of students and trainees of color for the health-care jobs of the future.

Thus, critical questions emerge: **Who stands to benefit from emerging health workforce training and job opportunities in California? Who still faces the largest barriers? And, what can the state do to remove barriers and foster an equitable, inclusive health workforce in California that is adept at responding to the changing landscape of health-care delivery?** An equitable and inclusive health-care workforce in California—one that reflects the state's racial, ethnic, and linguistic diversity and offers all Californians a chance at a meaningful, dignified job—is not only a moral obligation, but also an urgent health and economic imperative. A diverse workforce—made up of providers with similar and lived experiences to the state's patient population—is a critical strategy for increasing access to culturally and linguistically appropriate services, eliminating racial and ethnic health inequities and, in turn, improving quality care and reducing preventable costs. When centered on equity and inclusion, the health-care sector can serve as an important pathway to improving health and economic outcomes for low-income people, immigrant communities, communities of color, and others facing barriers to employment. It can offer quality jobs, family sustaining wages, and opportunities for economic mobility to hundreds of thousands of Californians.

This report aims to explore these pressing questions by describing the significant drivers that are transforming the health workforce landscape; identifying critical challenges and promising strategies to link vulnerable communities to education, training, and hiring systems; and offering policy recommendations that the state can use to advance equitable opportunity and inclusive health workforce systems. California is well positioned to strengthen its commitment to equitable inclusion by enacting policy and systems changes at the state level, which can serve as a model across the country. The state should remain a bold leader in defending equity gains while continuing to transform its health-care system.

The Changing Health Workforce Landscape: Drivers of Demand

Research has confirmed three major drivers that create significant labor demand and, in turn, job growth for key occupations in the sector.

- **Demographic and epidemiological changes,** attributed to 60 percent of overall job growth, are changing the profile of patient populations and the health workforce.[3] Population growth, an aging population, growing racial and ethnic diversity, and the shift from management of acute diseases to complex chronic conditions are changing the type of services needed and positions that must be filled. Allied health and support positions, such as nursing and physician assistants, health technicians, and home health aides, make up over half of all health workers in the state and will experience higher than average job growth—one-third of all new jobs. Driven by demand for long-term care, home health aides and personal care attendants or aides are estimated to experience the highest net job growth rates at 70 percent and 69 percent, respectively.[4]
- **Public policy, notably federal and state health-care reform through the 2010 Patient Protection and Affordable Care Act (ACA),** has led to the largest overhaul of the health-care system in decades. The ACA produced investments and regulatory mechanisms that expand access

to health insurance, improve quality of care, incentivize prevention and care coordination, and expand health workforce training and education. The influx of millions more health insurance enrollees, most of whom are low-income people of color, has increased demand for services. Since ACA was enacted, over 367,000 health-care jobs have been added in the state, and over 4 million Californians have gained coverage through Medi-Cal expansion or through products purchased through the state's Covered California health insurance exchange.[5] However, these gains are being threatened by legislative proposals to repeal and replace ACA, a rollback that would disproportionately impact rural and low-income communities of color.

- **Changing industry and institutional practices** are continuing to take place in response to these population and policy shifts. This has resulted in changes to the very nature of care delivery, payment, and workforce systems as they adapt to better meet the "triple aim" goals of reducing unnecessary and preventable health-care cost, improving patient care experiences and quality, and improving overall population health outcomes.[6] Key characteristics of this emerging paradigm of care include: shifting priority from individual to population-level interventions, coordination of care through interdisciplinary team-based care models, value-based payment and financial accountability, and expanded care settings to include outpatient, home, and community settings. Place-based health institutions such as hospital systems and universities are also adopting "anchor missions" to support local development through their business investments, procurement decisions, and community benefit activities, as well as ensuring inclusive hiring and workforce strategies toward a diverse health workforce.[7]

In summary, the health-care sector in California—like the nation as a whole—will continue to experience significant labor demand, with continued job growth in key occupations. Despite the current period of transition and uncertainty around ACA, demographic change remains a powerful driver of the growing demand for health-care services as populations become older and more diverse—and with it, the number and types of jobs needed in response. However, the current health workforce development and training systems in place do not have the capacity to keep pace with the growing and evolving demand for diverse and skilled workers across the state. An overhaul of health workforce education, training, employment, and incumbent worker investments will be needed to effectively recruit, prepare, hire, and retain workers, particularly low-income, immigrant, and other workers of color, with skills needed for the health-care jobs of the future.

Equity Challenges along California's Health Workforce Pathway

A robust, accessible, and coordinated health workforce pathway—a network of institutions, policies, practices, and investments that collectively facilitate the training and recruitment of workers—is needed to prepare students, trainees, and current workers seeking advancement to take on emerging health jobs. A range of players shape the pathway, including workforce intermediaries, community-based organizations, financial and regulatory entities, education institutions, employers, as well as students, trainees, and employees.

While the benefits of a diverse and inclusive health workforce are well documented, critical equity challenges remain in the education, training, and hiring systems that make up the health workforce pathway. Low to modest barriers to entry and growing employment opportunities make certain entry-level jobs in the health sector initially attractive for low-income people, residents of color, recently arrived immigrants, or those facing barriers to other jobs. However, the resources and supports of a structured pathway for advancement are out of reach for many of those in low-wage positions. Fragmented and underfunded pre-college education and job training systems in low-income communities and communities of color have created an uneven playing field for students. With the pathway currently in place, it is projected that people of color will continue to account for only one-third of workers in the health-care industry,[8] despite their being a majority of the population. These challenges are further exacerbated within California's rural communities, who face a severe lack of culturally competent providers, training opportunities, and workforce development infrastructure.

Six core systems challenges include:

- **Limited capacity of public education and training institutions.** Inequitable distribution of resources within the K-16 education systems, along with other structural, environmental, and cultural factors, have created a system that largely fails in preparing students of color and students from low-income families with the skills needed to succeed not only in school but in advanced training programs and the workplace. Community colleges also face distinct capacity and resource challenges in meeting high student demand for courses and program slots for resource-intensive fields such as health care, as well as meeting the need for basic skills training and remedial education.

- **Lack of alignment and coordination between education/training entities and employers.** As the health-care landscape evolves, employers are requiring new and different sets of skills from workers. The education and workforce training system has not developed the appropriate changes in training and education that are culturally relevant to diverse students' experiences and meet patient and employer needs.
- **Proliferation of for-profit institutions.** This trend has driven the increase in associate degrees and postsecondary certificates awarded for entry-level health occupations, particularly for students of color who are unable to pursue training through the community college system. However, for-profit entities charge higher fees, offer subpar curricula, and produce inadequate labor market returns. Federal legislative and executive actions have been introduced to strengthen regulation of this sector and protect vulnerable students.
- **Limited wraparound supports and infrastructure to support stability across the pathway.** Many health-care training programs are not equipped to navigate nor have the financial resources to address the full array of social services needed to support an individual in transition toward stability and self-sufficiency. Lack of stable income, affordable housing, transportation, and other challenges may impede successful participation in these programs. Without access to steady wages, current low-wage workers who seek to build additional skills face many barriers to completing traditional training programs and/or succeeding in the workplace.
- **Discriminatory hiring practices.** Low-income people and individuals of color, particularly young men of color, women of color, formerly incarcerated people, and undocumented or recently arrived immigrants, continue to face substantial hurdles when accessing employment in the sector. Some of these challenges are regulatory, while others are tied to institutional practices and embedded negative implicit bias.
- **Limited worker protections, career ladder, and job quality issues.** These factors plague low-wage occupations that also represent the fastest growth jobs in health care—allied health jobs, support and technician jobs, and home health and personal care aides. Overall, positions that involve "feeding, moving, cleaning, and caring for patients" are generally part-time and offer fewer benefits.[9]

An Inclusive Health Workforce Agenda: Policy Opportunities and Recommendations

The California state government has an important role to advance equity in regional and statewide health workforce development systems. A comprehensive set of policy solutions is needed to ensure that students and trainees of color, individuals facing barriers to employment, and formerly incarcerated people can access growing health jobs in the state. The state can also lead in eliminating the barriers to entering and succeeding in the health workforce pathway for those facing the most challenges to economic stability and mobility. We offer eight policy actions across four main categories that state regulatory and budget policymaking entities can take to improve the health, economic, and employment outcomes in vulnerable communities.

Remove Barriers and Target Investments in Training and Hiring

- **Establish targeted training and hiring criteria for public workforce dollars.** State agencies that provide funding for health workforce development activities should develop clear and consistent language within health workforce grant program eligibility criteria and application/review processes to prioritize training and targeted hiring of priority individuals from disadvantaged communities, and high-need regions such as rural communities, and those facing barriers to employment. These funding opportunities should also promote local and regional coordination with community-based partners and require applicants to outline activities for targeted outreach and engagement.
- **Provide adequate preparation and wraparound support services for vulnerable populations.** State education and workforce agencies should increase funding for culturally competent strategies and contextualized, work-based learning opportunities that build basic employment, literacy, and financial skills among trainees and students; improve cross-agency, community-based, and education sector alignment to provide critical supports such as affordable housing, child care, counseling, mental health services, case management, transportation, and income stability during training; and remove legal and human resource barriers for vulnerable populations.

Increase Funding Mechanisms for Community-Based Training and Career Ladder Opportunities

- **Support a wider array of community-based training strategies.** The state should expand training opportunities in community-based settings that offer prevention and primary care for vulnerable patients, such as federally qualified health centers (FQHC), community health centers, school-based health centers, rural and tribal clinics, and other safety net institutions. This includes expanding funding and reimbursement mechanisms to support roles critical to a team-based care model, as well as funding programs that facilitate partnerships between community-based organizations and workforce entities. The Office of Statewide Health Planning and Development and other agencies should also expand scholarship, loan forgiveness, and loan repayment programs to include allied health positions in these settings, as well as encourage targeted training and recruitment of vulnerable populations within funded health workforce activities and stronger employer partnerships to inform curriculum design. The state legislature and governor's office should allocate funding for innovative workforce programs that prioritize vulnerable individuals with multiple barriers to employment and facilitate workforce-community partnerships, such as the Breaking Barriers to Employment Initiative (BBEI) established by AB 1111 (Eduardo Garcia). The California Department of Education should also establish and fund an Office of School-Based Health to expand training opportunities in school-based health centers, prioritizing resources for low-income schools.
- **Increase incentives and resources for advanced career ladder training.** The state should offer incentives and additional resources for employers to invest in career ladder and advanced training programs that build skills for entry-level allied health workers to transition into higher-paying, middle and advanced skilled jobs. Programs through the California Employment Development Department, California Workforce Development Board, Employment Training Panel, and other agencies should prioritize funding for workplace training programs targeting incumbent entry-level workers and individuals with barriers to employment, and also increase resources for technical assistance and training for employers to develop robust career ladder programs. Hospital community benefit plan requirements can also be strengthened to include information on targeted hiring and health workforce development investments.

Enact Stronger Worker Protections

- **Ensure quality jobs for entry-level health workers.** The state should enact robust and comprehensive workforce protections for vulnerable workers and ensure that employers are held accountable for labor law violations. These protections include the right to overtime compensation, comprehensive health and medical benefits, paid sick leave, meal and rest breaks, flexible work hours without punishment or retaliation, safe working conditions, and protection from harassment and discrimination.
- **Raise the wage floor for entry-level and care-coordination workers.** The state should adopt labor policies that ensure family sustaining wages and salaries for allied health and entry-level positions that focus on improving care coordination and integration of primary, preventive, and community-based services. This includes enforcing the minimum wage for long-term internships and license or credential-related training experiences, and requiring employers to offer additional work hours and opportunities to existing part-time employees before hiring a new employee. Expanding financial incentives, funding streams, and reimbursement models can incentivize employers to appropriately compensate positions engaged in primary care, prevention, and care coordination in diverse care settings.

Improve State and Regional Infrastructure and Data Systems

- **Invest in a regional training pathway infrastructure and alignment of support systems.** Agencies such as the California Workforce Development Board, in partnership with other relevant agencies—education, labor, and industry—should align infrastructure and guidelines to foster coordination of training and education activities across regions. This infrastructure should be robust and align with state workforce goals, yet remain responsive to, and adapted to fit, regional needs.
- **Strengthen data collection quality, coordination, and transparency.** High-quality workforce data collection and analysis that can support regional and state-wide planning, coordination, and alignment is needed. This includes timely, accessible, longitudinal information about the sector, including data on student, trainee, and employee demographics (by race/ethnicity, gender, language capacity, age, immigration status, etc.), occupation, education, training, or career ladder program participation and success rates, retention rates, median wage and job quality indicators, and geographic distribution. Investing in a longitudinal K-12 education data system would inform future planning and bolster more equitable health workforce policy and budget decisions.

Health-care employers, workers, patients, educators, advocates, and policymakers have a collective stake in ensuring that current and future workers are provided equitable access to meaningful education, training, and employment opportunities. While the current demographic, policy, and system shifts in the sector present challenges, they are not insurmountable. Building on past efforts and current momentum, the State of California should bring about the policy and systems change strategies that will create a skilled and diverse health workforce, well-organized career pathway systems, and ultimately, a more inclusive economy. The recommendations offered here serve as a path to strengthen the state's capacity and translate these aspirations into reality—improving the health and economic outcomes for those most left behind, and in doing do, paving the way for all Californians to thrive.

Introduction

The American health-care system is undergoing rapid, transformative growth. Despite the Great Recession and the current period of political transition, this $3 trillion industry still accounts for one-sixth of the United States' gross domestic product[10] and employs 18 million workers nationwide. According to the Bureau of Labor Statistics, health occupations are projected to experience significant job growth over the next decade, with the sector poised to add more jobs than any other occupational group in the next decade.[11] Moreover, demographic, market, epidemiological, and policy drivers—including the Affordable Care Act—are changing the health-care system as we know it, accelerating job growth in the sector by driving demand for particular types and configurations of jobs in the sector. Researchers estimate that an additional 4.6 million health-care workers will be needed, not only to provide the growing number of services but also to implement emerging systems of care delivery that are marked by increased focus on team- and values-based models, prevention, care coordination, and social determinants of health.[12]

The unique context of California illustrates how these powerful trends have manifested in the health-care sector, and also in the solutions needed to address the challenges ahead. As the sixth-largest economy in the world, California employs over 1.3 million health workers, and by 2020, the state is projected to need an additional 450,000 health workers.[13] And yet, far too many Californians continue to face compounded health and economic inequities. The projected national demographic shift toward a majority people-of-color population is already a reality in California. Residents living in low-income neighborhoods, communities of color, tribal communities, and rural areas experience poorer health outcomes and increased risk for chronic and preventable conditions. These same communities often face the burden of not only persistent health inequities, but also limited access to quality education, job training, meaningful employment, and career advancement opportunities in the health sector. Both sets of outcomes are similarly rooted in structural barriers resulting from long-term systemic marginalization and disenfranchisement.

The critical questions are:

- Who stands to benefit from emerging health workforce training and job opportunities in California?
- Who still faces the largest barriers?
- What can the state do to remove barriers and foster an inclusive workforce that is responsive to the changing landscape of health-care delivery?

An equitable and inclusive health-care workforce in California—one that reflects the state's racial, ethnic, and linguistic diversity and offers all Californians a chance at a meaningful, dignified job—is not only a moral obligation but also an urgent health and economic imperative. A workforce that reflects the state's patient population is critical for improving access to culturally and linguistically appropriate services, eliminating racial and ethnic health inequities, and reducing preventable health-care costs. Furthermore, access to a stable job, living wage, and a pathway for mobility remains one of the most potent social determinants of health. Where one lives, educational attainment, and an individual's income and employment continue to shape not just physical health outcomes, but overall quality of life and community well-being. Harnessing the creativity, potential, and participation of all community members is the only way to ensure a prosperous economy and a healthy, sustainable future for California.

This report explores these pressing issues first by describing the significant drivers that are increasing the demand for a well-trained health workforce and contributing to job growth trends in the sector. Next, we identify critical equity challenges and gaps in the education, workforce development, and hiring systems that are tasked with training a diverse health workforce equipped with the skills necessary for meeting real-time patient and health-care employer needs. We also point to a broad range of strategies within the health workforce development landscape that can better align workforce training systems with health-care delivery needs, and prioritize workforce investment toward vulnerable communities facing the largest hurdles in accessing meaningful job and training opportunities. Finally, we discuss the central role of the California legislature and state agencies to advance equity and

propose and implement policies to improve the health, economic, and employment outcomes among low-income communities, communities of color, and others facing barriers to employment. These include targeted investment in outreach, hiring, and recruiting; aligning systems of training and social supports; stronger protections for trainees of color and entry-level workers; and improved infrastructure and data systems.

When centered on equity and inclusion, the health-care sector can serve as an important pathway for low-income communities, communities of color, and others facing barriers to employment to access quality jobs, family sustaining wages, and opportunities for economic mobility. With a long history of advancing forward-thinking policies, California is well positioned to enact policy and systems changes at the state level that can serve as a model across the country. As the federal policy landscape around ACA continues to unfold, the state can and should remain a bold leader in defending equity gains while continuing to advance a transformative health-care system that ensures a thriving and healthy future for all Californians.

The Changing Health Workforce Landscape: Drivers of Demand

Research has pointed to several trends that are driving health-care demand, and in turn, shaping the significant rates of job growth projected for the sector. Three major drivers that we highlight here include: 1) demographic and epidemiological changes; 2) public policy, notably federal and state health-care reform through the 2010 Patient Protection and Affordable Care Act (ACA); and 3) market and industry shifts that are changing the nature of care delivery, payment, and workforce systems to respond to these population and policy changes.

Of the 4.6 million additional workers needed nationwide—and 450,000 in California alone—approximately 40 percent of this projected increase in jobs is attributed to growing demand for services linked to ACA provisions, including increased enrollment and utilization of services due to population-wide insurance expansion; the majority of overall job growth (60 percent), however, is due to increasing and shifting demand of health-care services as a result of a growing, aging, and increasingly diverse population.[14]

Key Drivers of Growing Health Workforce Demand

Demographic and Epidemiological Changes	Public Policy-Affordable Care Act	Changing Industry and Institutional Practices
• Population growth • Aging population and workforce • Growing racial and ethnic diversity • Shift from acute to chronic disease burden	• Increased need for services due to 30 million new enrollees or those with expanded coverage through ACA	• Fundamental shifts in health-care delivery and payment systems • Increased focus on values-based, population health prevention and primary care models, chronic care management, and team-based care delivery in nonclinical settings • Greater need for “soft skills,” along with technical expertise, among workers

Driver 1. Demographic and Epidemiological Shifts: A Changing Population and Workforce

Not only is the United States projected to become a majority people-of-color nation by 2044,[15] the country's population is growing and becoming older: by 2050, the number of adults over the age of 65 years will nearly double from 48 million to 88 million.[16] In California, where nearly 60 percent of the state's 40 million residents are people of color and a third of whom are Latinx,[17] the population over 65 years is growing and becoming increasingly diverse. Nearly half (45 percent) of California's population over the age of 65 will be non-White by 2025, compared to today's 40 percent.[18] The Latinx and Asian and Pacific Islander population ages 65 and over is estimated to grow by 85 percent and 66 percent, respectively, between 2014 and 2025.[19]

These larger demographic trends are also reflected in the health workforce as older workers begin to retire, creating unfilled positions. Of the projected 450,000 additional health-care workers needed in California by the next decade, approximately 200,000 are due to skilled workers retiring in the next decade whose positions will need to be filled.[20] Training entities and employers will need to consider strategies that not only retain but also better accommodate older workers who seek to remain in the workforce and who have invaluable experience and skills. As individuals in the health workforce grow older, age-specific considerations and conditions, including disabilities and chronic diseases, can affect their capacity to stay at work.[21] Employers also face the dual task of training new and current workers (of all ages) to fill the roles made vacant by retiring workers, as well as enabling the seamless transfer of institutional knowledge and workplace expertise.

As hospitals, clinics, and other health-care institutions begin to adapt to these changing health-care needs, epidemiological shifts are also changing the nature of service delivery. Over the last century, chronic conditions have begun to eclipse acute, infectious disease as the leading causes of mortality and morbidity. Advancements in medical knowledge and technology, availability of vaccinations and effective treatments, improved sanitation, and overall standard of living have increased average life expectancies in the US and many countries across the globe.[22] This epidemiological shift, along with a more diverse and aging population, have translated into the increasing dominance of care models that focus on management of chronic conditions and long-term care within community, home, or other nonclinical settings.[23] Health-care needs have also become more complex, as many patients with multiple, concurring health conditions require not only medical health services, but integration of mental health, behavioral health, dental and oral health, and other services.[24]

The industry's response to these shifts is already being reflected in the types of health-care jobs experiencing the largest projected job growth. In California, while nearly 45 percent of the state's health workforce is made up of nurses (22 percent), therapists (9 percent), doctors (7 percent), and other clinicians, the majority (55 percent) of the state's workers fall into the category often described as the "allied health" field. While definitions vary, in this paper we refer to the range of entry-level and middle-skill positions that provide general health-care support (33 percent) or technician and diagnostic support (22 percent), including nursing and psychiatric aides; medical assistants; licensed vocational nurses; community health workers (also known as promotoras or outreach workers); and diagnostic and other health support technicians.[25] Almost half of California's allied health workforce is made up of just four occupations alone—community health workers, medical assistants, certified nurse assistants, and home health aides—that are characterized by low wages, poor working conditions, and limited opportunities for advancement.[26] Allied health occupations in particular are expected to experience higher than average job growth—making up one-third of all new jobs. The aging population and corresponding demand for long-term care is driving much of the job growth in entry-level allied health positions such as home health aides and personal care attendants. These strenuous but low-pay positions, estimated to experience the highest net job growth rates of 70 percent and 69 percent, respectively,[27] are predominately held by immigrant workers. These communities will likely be negatively impacted by increasingly restrictive federal immigration policies, and the supply of available workers may be reduced. Appendix A provides additional information about the various systems of classifying, categorizing, and organizing what we refer to as the "health workforce."

Driver 2. Public Policy: The Affordable Care Act and Workforce Impacts

Eight years after the 2010 passage of the Patient Protection and Affordable Care Act (ACA), implementation is both underway and vulnerable to continuing threats in a new political landscape. The largest overhaul of the health-care system in decades, the ACA aims to strengthen existing programs and create new ones. The ACA produces investments and regulatory mechanisms that expand access to health insurance, improve quality of care, and control costs through an emphasis on prevention and coordinated care. Implementation of the law has led to the largest reductions in uninsured individuals in decades, benefiting millions who have since gained coverage or accessed expanded services. While a comprehensive inventory of ACA provisions falls outside the scope of this report and can be found elsewhere, key components of the current law that have direct impact and relevance on the health workforce include the following:

- **Expanded access to health insurance.** A focal feature of ACA is the universal mandate—all US citizens and residents are required to be covered under health insurance, or be subject to a tax. The law includes strategies to support formerly uninsured residents and working families transition into coverage, including the (optional) state expansion of Medicaid eligibility up to 138 percent of the federal poverty level, employer mandates to offer health insurance, and government subsidies for eligible individuals to purchase health insurance on state-run private health insurance exchange marketplaces. Additionally, young adults can remain covered under their parents' health insurance plans until age 26, and insurers are no longer able to bar coverage for pre-existing conditions. Nationally, nearly 30 million people gained or expanded coverage through a combination of these strategies.[28] Should ACA continue as currently established by law, researchers estimate that this increased enrollment will lead to a 2 to 3 percent increase in demand of services over the next few years nationwide due to expanded coverage.[29] In fact, researchers estimate that every 1 percent increase in health coverage translated into a 0.38 percent increase in health-care job growth,[30] suggesting that a significant proportion of new jobs in the sector are directly linked to increasing demand for services due to wide-scale insurance expansion.
- **Financial incentives toward values-based performance.** The ACA's focus on prevention, care coordinators, building the safety net infrastructure, and incentives for payment reform have paved the way for innovative delivery and payment models. To lower health-care spending, ACA signaled an important shift away from the traditional fee-for-service model that has dominated the industry. The law created financial incentives toward values-based performance and disincentives against volume-based care that promoted prevention and primary care. These financial incentives aim to achieve greater quality and more efficient care. In addition to expanding Medicaid reimbursement and requiring insurers to cover a basic set of preventive services, existing and new models such as medical homes, patient-centered health homes, accountable care organizations, and bundled payments are being piloted.[31] ACA has also spurred interest in systems that integrate technology in care delivery, including electronic health records, and virtual or application-based care delivery and communications platforms. These changing structures have implications on what types of health-care jobs will be needed, the composition of providers needed to deliver better quality and effective care, the skills workers will need on the job, and how workers are compensated. Appendix D provides a brief overview of these models and current research.
- **Direct investments in health workforce training and education.** ACA allocates funding for loan repayment, scholarship, fellowship, research, and health professions training grant programs focused on health workforce training and education, as well as building infrastructure for data collection, analysis, and planning. ACA also funded workforce planning, implementation, and assessment grants, and made infrastructure investments to expand community health centers, school-based health centers, and other safety net institutions.[32, a]

a However, of the 19 provisions that focused on health workforce, only 11 received full funding, and of these, only six received the full amount authorized by Congress. Authorized but still unfunded provisions include the National Health Care Workforce Commission, which was established to serve a national coordinating body to facilitate planning, investments, and implementation of national health workforce development efforts.

California has led the nation in its robust, comprehensive implementation of health-care reform and emphasis on prevention, primary care, health-care access, and improved care coordination. Since ACA was enacted in March 2010, over 367,000 health-care jobs have been added to the California economy.[33] Of the state's over 12 million enrolled in Medi-Cal, the state's Medicaid program, over 4.7 million predominantly low-income, of color or rural Californians have enrolled in Medi-Cal since 2010; approximately 3.8 million of those joined the program because of ACA's expansion of Medi-Cal eligibility.[34] An additional 1.4 million Californians purchased insurance through Covered California, 1.2 million of whom received some sort of federal subsidy.[35] The state's commitment to federal health-care reform implementation significantly reduced the state's uninsured rate from 20.9 percent in 2010 to less than 10 percent in 2015,[36] a reduction of nearly 50 percent since the law was passed. Low-income communities and communities of color experienced the greatest gains in coverage due to ACA—nationally, nearly 60 percent of individuals who gained coverage between 2010 and 2015 were of color, and this majority is reflected in California as well.[37]

However, legislative proposals that have been introduced to repeal and replace the ACA, such as the American Health Care Act (AHCA), Health Care Freedom Act, and the new tax law that would eliminate the health insurance mandate, would have significant, deleterious economic and health impacts on communities across the country.[b] Repeal of ACA would result in the loss of coverage for millions and undo progress around prevention and care coordination and exacerbate existing challenges to accessing quality, and affordable health care. Vulnerable communities who are at risk for losing coverage would be in limbo as services shift back toward emergency rooms, adding additional workplace strain and pressure among workers to meet the already complex health needs of patients impacted by ACA repeal. The previously introduced AHCA was estimated to lead to losses of 135,000 health-care jobs, more than $20.3 billion in lost gross domestic product (GDP), and $1.5 billion in lost state and local tax revenue in California, concentrated in rural counties with higher proportions of residents enrolled in Medi-Cal expansion.[38] Estimates for other subsequent replace-and-repeal legislation project similar deleterious impacts, particularly for many rural areas including the Central Valley. Since ACA was enacted, four counties alone—Fresno, Tulare, Kings, and Kern—gained coverage for 331,000 people and added 15,000 new health-care related jobs, which may potentially be lost with ACA repeal.[39]

b The Congressional Budget Office estimated that ACA repeal through the previously proposed American Health Care Act would have led to loss of coverage for 23 million individuals and nearly a million health-care jobs by 2026.

Driver 3. Changing Institutional Practice: A Shifting Paradigm of Care

The health-care system has long grappled with the challenges of fragmentation, accessibility, affordability, cultural and linguistic responsiveness, and health workforce diversity. These challenges, in conjunction with the drivers described earlier, are pushing the sector to adopt a new paradigm of care. Fundamental shifts in structure, payment, and delivery are needed to ensure that the health-care system remains responsive, sustainable, and effective in achieving the heralded "triple aim" goals: reduced health-care cost, improved care experience and quality, and improved population health.[40]

Key characteristics of this emerging paradigm of care include the following:

- **Shifting the priority** away from individual-level transactions and toward population health interventions. This includes a stronger focus on prevention, primary care, quality control, and chronic care and long-term care management, instead of acute and emergency care.
- **Coordination of care** delivered by inter-professional team-based models of care, made up of both clinical and nonclinical professionals. These teams are poised to more effectively integrate primary care with behavioral health, mental health, and other systems of support. This trend[c] includes expanding roles of medical assistants, physician assistants, and nurses to support coordination of care for an increased workload.
- **Values-based payment and financial accountability** through rewards, incentives, and penalties linked to cost efficiency, improved outcomes, and patient satisfaction measures. New data, health information, and technology systems, including electronic health reports, are being developed to better track outcomes in a team-based care model.

c While literature has pointed to a significant workforce shortage between the current supply and demand, particularly among primary care physicians, this shortfall is contested. While rural communities and medically underserved areas continue to face significant health workforce shortages, many care settings will likely experience shifting configurations of clinical and nonclinical teams, to effectively deliver different patterns of health-care utilization. For example, Edward Salsberg in his article "Is the Physician Shortage Real"? in *Academic Medicine* (2015) estimated that 75 percent of services provided by a physician can be provided by a nurse practitioner or medical assistant in many primary care settings. In 2017, Joanne Spetz et al. reported in an article at the Healthforce Center at the University of California, San Francisco, that by 2030, nurse practitioners and physician assistants will comprise half of California's primary care clinician Full Time Equivalent (FTE), in concordance with a projected decline of primary care physician supply from 2016 to 2030.

By the Numbers: California's Health Workforce

1.3 Million
current health-care workers

450,000
new health-care jobs needed by the next decade

- **250,000 new jobs stemming from increased demand for services**
- **200,000 jobs to replace retiring and aging workers**

367,000
health-care jobs added since ACA

135,000
health-care jobs projected to be lost in case of ACA repeal

- **Expanding care settings** beyond primarily clinic or hospital-based care to service delivery in outpatient, home, school, workplace, and other community-based settings, including the integration of technology platforms to deliver care.

Accordingly, across California, many place-based health institutions, such as Kaiser Permanente and Dignity Health, are adopting new approaches that embrace a broader social determinants of health framework that consider social, economic, and environmental factors that shape individual and community health outcomes—for example, access to quality and affordable housing, quality education, and good jobs. Hospitals and university systems are beginning to adopt what has come to be known as an "anchor mission," pursuing business investments, procurement decisions, community benefit[d] activities, as well as hiring and workforce strategies to demonstrate their commitment to the well-being of local communities.[41] Such shifts are beneficial from a business case as well: improved access to timely prevention and primary care for vulnerable patient populations, as well as improved community health and quality of care, can reduce unnecessary and costly health-care spending in emergency rooms.

Critical to achieving these goals is the effective recruitment and retention of a diverse health workforce, one that reflects the experiences of the state's diversity in terms of race/ethnicity, gender identity, language, ability, immigration status, geography, and other dimensions that shape the quality of patient care. The benefits of a diverse and culturally competent health workforce are well documented, ranging from better quality care, improved population health outcomes, and reduced health-care costs, to stronger local economies.[42]

What types of skills and competencies will be needed to meet the realities of an evolving health-care landscape? What kind of workforce will be needed to deliver these new approaches to care and serve the complex health-care needs of an increasingly diverse patient population in California? Who stands to benefit from growing workforce training and job opportunities in California? And who still faces the largest barriers to accessing quality, living-wage job and training opportunities in growing subsectors? While the sector's projected job growth points to the promise of economic opportunity, the reality is that the current health workforce development and training systems in place do not have the capacity to keep up with the growing and evolving demand for diverse and skilled workers across the state. An overhaul of health workforce education, training, employment, incumbent staff development infrastructure, investments, and coordination will be needed to effectively recruit, prepare, hire, and retain workers, particularly low-income, immigrant, and other workers of color, with the skills needed for the health-care jobs of the future. Health workers will require not only

d ACA mandates nonprofit hospitals to complete a minimum set of community benefit activities to maintain their nonprofit status. This includes conducting a regular community health needs assessment and reporting on community benefit activities and dollars. However, challenges exist to incentivizing health-care institutions, such as private entities, to adopt community benefit and other community prevention practices and activities.

clinical and technical capacities, but also "soft" skills such as teamwork, collaboration, critical thinking, cultural humility, communication, care management, data and health information technology proficiency, and leadership.[43] The trend toward team-based models offering long-term care in nonclinical settings will increasingly rely on community-based, entry-level, and allied health workers. Positions such as care coordinators, patient navigators, and community health workers are positioned to substitute, enhance, or extend services delivered by traditional nursing and physician providers, but offer poor wages and prospects for growth and lead to high turnover.[44] Yet, such positions are already experiencing the highest rates of job growth and will likely continue to expand as this shifting model of care matures. Employers will need to address important questions of appropriate provider mix, the scope of clinical and nonclinical roles, appropriate compensation, job conditions, and career advancement pathways to attract and retain workers.

In summary, the health-care sector in California—like the nation as a whole—will continue to experience significant labor demand, with continued job growth in key occupations. Demographic change remains a powerful driver of the growing demand for health-care services as populations become older and more diverse. The ACA not only facilitated an influx of new enrollees into the system, the law also accelerated and solidified already emerging shifts in industry and institutional practice. Health-care delivery and payment are continuing to evolve toward systems that can meet the growing need for higher quality and better-coordinated, long-term chronic care management in nonclinical settings. And these models of care delivery will increasingly rely on entry level, allied health, and community-based health occupations.

In the following sections, we examine the current health workforce system in place and identify important equity challenges and opportunities that can strengthen its capacity to effectively train and prepare the future health workers of California.

Equity Challenges along California's Health Workforce Pathway

What Is a Health Workforce Pathway?

A robust, accessible, and coordinated health workforce pathway is needed to prepare students, trainees, and current workers seeking advancement to take on the emerging health jobs. The figure summarizes key phases and decision points along an ideal health workforce pathway, made up of a network of institutions, policies, practices, and investments that collectively facilitate the engagement, education, training, hiring, retention, and advancement of workers. While this pathway differs for specific occupations, similarities exist in terms of the overall phases along which students, trainees, or current employees progress. A range of players are involved at various stages along this pathway. Workforce intermediaries play an important link between employers seeking to hire workers, and education/training institutions that prepare workers to meet employer needs. Community-based organizations in particular serve in this important intermediary role, often providing both basic needs and social support services, as well as workforce training preparation, for the most vulnerable residents seeking access to the more formal entities along the health workforce pathway. Also, a range of financial and regulatory entities shape how this pathway operates. These include government and public agencies charged with funding and implementing workforce development priorities, professional associations that establish practice standards and scope-of-law guidelines, as well as union representatives, and financial entities. Students, trainees, and workers themselves comprise an essential constituency that should have a voice in how the pathway operates and functions.[45]

Key Phases and Players along a Health Workforce Pathway

Source: Adapted from "Coordinated Health Workforce Pathway" by Jeff Oxendine of the California Health Workforce Alliance, (2010): http://caehc.org/wp-content/uploads/Jeffrey-Oxendine.pdf

Key Players Include:

- Education institutions: K-16, four-year institutions, advanced degree programs
- Employers, including human resources and administration/leadership
- Workforce intermediaries, including community-based organizations and training programs
- Local, state, federal regulatory and governing entities: State workforce investment boards, advisory boards, task forces, public agencies
- Professional associations
- Labor and unions
- Health insurance agencies
- Financial entities/payment and reimbursement systems
- Trainees and students
- Employees

Equity Challenges to Advancing a Diverse and Inclusive Health Workforce

Despite growing employment opportunities in the sector, the economic and health benefits of this increased economic activity are not distributed equitably across people and place. Considerable equity challenges exist, stemming from the current health workforce system's limited capacity to effectively prepare a new generation of diverse workers for the rapidly evolving health-care landscape, as well as the sector's reliance on a growing share of entry-level, low-wage positions that experience high turnover. Low to modest barriers to entry, growing employment opportunities, and easy to access wages make many entry-level jobs in the health sector initially attractive for low-income people, residents of color, recently arrived immigrants, or those facing barriers to entry in the industry. However, the benefits of resources and supports along a structured pathway—particularly opportunities for career advancement—are out of reach for many low-wage positions that are predominately held by workers of color. While the health sector offers some occupations a clear pathway to pursue training, employment, and advancement, such as nursing and medicine, this is not the case for the majority of the support positions that are experiencing the largest job growth. These positions, such as home health aides and personal care attendants, lack clear or accessible occupational pathways, if these exist, because they remain unstructured, unclear, and fragmented.

Furthermore, in California, and across the country, the composition of health workers does not reflect the racial, ethnic, and linguistic diversity of the state's population. While progress has been made in attracting more students of color to health careers—44.8 percent of health professional program graduates are of color[46]—these rates significantly drop with each progressive phase of the pathway.[47] Multiple barriers prevent potential health trainees and workers from accessing opportunity across the entire health workforce pathway—from initial exposure, education, and training, to licensure, hiring, and career advancement. Health workers of color are grossly underrepresented in occupations that require the highest levels of advanced training and education, such as primary care physicians—Latinx physicians comprise only 5 percent of the physician workforce, although they make up over a third of the state's population.[48] As a majority people-of-color state, developing a health workforce that reflects the state's racial/ethnic and linguistic diversity is imperative. The influx of many new enrollees—many accessing the formal health-care system for the first time outside of emergency rooms and acute care settings—requires a workforce equipped to provide culturally relevant services, share cultural affinity with patients, and that can coach and support patients with complex health conditions to navigate the system and avoid costly emergency room visits and preventable services. A diverse, culturally competent workforce enables the system as a whole to advance its goals to increase access to culturally and linguistically appropriate services, eliminate health inequities faced by medically underserved patient populations, improve quality of care, reduce unnecessary health-care costs, and improve overall population health.[49]

Training Health Workers in Rural California

Communities in rural regions face distinct, significant workforce challenges due to the unique interplay of geography, concentrated poverty and unemployment, and job recruitment and retention challenges. Nearly 77 percent of rural communities are designated primary care health profession shortage areas, leaving many residents with not only challenges to accessing quality and culturally appropriate care, but also limited opportunities for job training in the health sector.

These distinct challenges are shaped by a number of factors. Limited infrastructure and transportation investments, coupled with large geographic catchment areas, translate into limited numbers of health-care facilities that are available to serve patients, hire workers, and serve as training sites. And yet, rural clinics and hospitals serve disproportionately sicker and poorer patients—rural regions saw the greatest gains in coverage through Medi-Cal expansion in the state. According to a 2014 report by Kandis Driscoll and Chauntrece Washington, *Workforce Development in Healthcare Part II: An Overview of California,* of the 20 percent of Californians who live in a primary care health profession shortage area, the majority are concentrated in the rural regions of Northern California, Central Valley, and Inland Empire.

Limited economic opportunities in rural towns also drive population away from those areas, as students who are able to access professional education and training elsewhere do so by leaving home and seeking employment in metropolitan areas where opportunities are concentrated. Greater state and regional investment in training programs and incentives for rural health providers, as well as increased reimbursement rates for Medi-Cal and private payers, could help address these challenges.

These workforce challenges are the result of, in part, fragmented and underfunded pre-college education and job training systems within low-income communities and communities of color that have created an uneven playing field for students, trainees, and workers of color seeking to pursue careers in this field. Multigenerational poverty, underfunded schools, poor housing, historical and persistent racial/ethnic inequities in wages, wealth, and overall access to economic opportunity along the "cradle to career" pathway disproportionately impact the young people, students, and prospective workers who are the key to California's future. While most of the fastest-growing jobs in the health sector will require some college, but less than a bachelor's degree—such as an associate's degree, technical training, or certification—communities of color continue to be hardest hit by the reality of this "skills gap."[50] Researchers project that people of color will continue to account for only one-third of workers in the health-care industry,[51] despite their population majority. Individuals facing substantial barriers to employment, including formerly incarcerated people and workers with transitional legal statuses, face additional challenges securing stable housing, income, food access, transportation, and other basic needs to succeed in training programs and the workplace. Many of these individuals also experience chronic and past exposure to trauma and community violence, which also impacts their ability to succeed and requires a comprehensive set of restorative justice, community mental health, and other direct support services that can help build stability and capacity in their lives.

These challenges are exacerbated within California's rural communities. Geographic provider rural distribution remains a major barrier to accessing culturally competent care for some of the state's most vulnerable residents. While certain regions of the state experience an overconcentration of health-care providers, the state's rural areas—including the Central Valley and rural North region—face limited health-care infrastructure and training opportunities and, in turn, insufficient numbers of providers, especially in primary care.

In the section following, we highlight six specific structural challenges that impede the existing health workforce system from reaching and preparing the Californians who are most left behind. We also point to examples of promising practices in the field that can help address these obstacles to building an inclusive health workforce.

Career Pathways Trust Program

Recognizing the value of experiential and work-based learning, the state passed AB 86 in 2013 and made a critical investment to launch the California Career Pathways Trust program at the Department of Education. The $500 million program offers one-time competitive grants to school districts, community colleges, and other eligible education entities to build robust career pathway programs from ninth grade to community college that can prepare students through work-based learning for jobs in growing industries, including health care.

Challenge 1: Limited capacity of public education and training institutions

California's K-12 public education system serves as a central institutional vehicle to expose, engage, and prepare students to pursue training and employment opportunities within the health sector. While policymakers, leaders, and advocates have long worked to improve public education infrastructure and policies, the system still falls short in preparing large numbers of students of color and students from low-income families with the skills needed to succeed in school and in the workplace. The interplay of structural, environmental, and cultural factors has resulted in significant racial achievement gaps across the state between Latinx, African American, and Native American students and their White counterparts.[52] Factors shaping student success in schools include but are not limited to: inequitable distribution of public education resources by race, place, and class; racial residential and school segregation; criminalization and over-policing of students of color; and limited economic, social, and health-promoting resources faced by many families living in low-income neighborhoods.[53]

The impact of these compounded inequalities is felt from early childhood and persists beyond high school: many students who do graduate from high school are left unprepared and without adequate basic math and language skills to successfully complete training and postsecondary education programs.[54] This sets up the state's vast majority of students of color to fail when entering advanced training or education programs to pursue health careers. Although students of color comprise the majority of enrollment in the state's community college system, with Latinx students making up over 40 percent of enrolled

students,[55] six years after enrolling, only 26 percent of Black and 22 percent of Latinx students achieve the major educational completion milestone of completing their degree.[56]

Higher education institutions, particularly community colleges, face distinct challenges in adequately training students to take on emerging jobs in the health sector. Community colleges face major capacity challenges to meet rising student demand in health-care fields and accommodate all interested students, especially low-income students of color who rely on the community college system as an affordable pathway to access health careers.[57] Due to the resource- and cost-intensive nature of health career training, community colleges can offer only a limited number of spots in programs and course offerings. Many students are unable to enroll in required courses, extending their graduation timeline and financial obligations. Community colleges also face challenges in recruiting effective field-based instructors with up-to-date knowledge of medical practice, which contributes further to misalignment between training entities and industry partners. Additionally, limited pathways exist to transition from an entry-level, low-skilled position to a middle-skill position (i.e., jobs that require more than a high school education, but not necessarily a bachelor's degree), including occupations that require licensure, credentials, or an associate's degree, such as a medical or physician's assistant, which contributes further to the state's overall skills gap. Community colleges face two other critical challenges: training misalignment and the proliferation of for-profit institutions, described on page 21.

To ensure that students from marginalized backgrounds have the best chance of success in health education programs, community college and higher education institutions are increasingly recognizing the need for and investing resources in effective strategies—such as remedial, contextualized, cohort-based, and co-requisite education models—to build basic math and literary skills required for course and training completion. Expanding community colleges' capacity to partner with the K-12 system and employers can improve course offerings and scheduling, promote smoother administrative processes, and help all interested students successfully enroll in and complete these programs. Furthermore, exposure to a broad range of occupations in the sector, starting in K-12, is needed to engage and recruit diverse students into promising heath careers. To reach and support low-income students, students of color, and others facing employment challenges, education institutions are continuing to work with a diverse set of partners to implement culturally relevant outreach, recruitment, and retention strategies—including community-based and faith-based organizations. Culturally relevant programming, such as those modeled by historically Black colleges and universities and other minority-focused education institutions, career advancement academies, and other non-traditional social media campaigns can also help increase the visibility of health-care career pathways.

Challenge 2: Lack of alignment and coordination between education/training entities and employers

Along the pathway, the persistence of training curricula and instruction that neither reflect students' experiences nor are responsive to changing health employer demands and real patient needs remains a challenge. Without relevant education and training programs, trainees emerge from community colleges and other training programs inadequately prepared to take on new jobs and succeed in a demanding work environment. As the health-care landscape is evolving, employers are requiring new and different sets of skills from workers, and the education and workforce training system has not kept up with the appropriate changes in training and education. Factors that drive this misalignment include limited access to data and up-to-date analysis on regional workforce trends and needs—information about available jobs and the skills that employers are seeking—as well as a lack of infrastructure and coordination between the education and training institutions that are tasked with preparing workers and employers who are actively hiring. There is often insufficient infrastructure to place graduates of targeted training programs—with a focus on individuals with barriers to employment—into meaningful employment. This creates a mismatch between the supply and demand of workers: trained workers do not have the opportunity to practice and improve their skills, and the system produces more providers in specialty areas that do not face a workforce shortage.

Shifting toward competency-based, contextualized education centered on real-time patient, community, and employer needs is essential—under this framework, training and education curricula focus on helping workers build a set of core skills that are adaptable to a range of employment opportunities. A focus on population health and the whole-person care model can also be integrated into the curriculum to help trainees develop capacity for coordination across health, behavioral health, and social services that will be needed in a team-based care

Merritt College's Bridge to Health Careers and Dual Enrollment Medical Assisting Program

In Oakland, California, Merritt College has launched a number of efforts, in partnership with local high schools and other community-based organizations, to provide accessible opportunities for students of color to train in a health career. Over the course of six weeks, participants in the Bridges to Health Careers Summer Program learn about the college's health and science programs through interactive, hands-on sessions led by instructors from the field. Through the Dual Enrollment Program, Oakland Unified School District high school students can take college-level classes and receive college credit at local high school sites, helping them successfully transition into corresponding college programs. Together, these programs have helped to strengthen recruitment and enrollment of local high school seniors into Merritt's Medical Assisting Program.

Source: Career Ladders Project

model.[58] Experiential and work-based learning—through internships, apprenticeships, vocational training, and other on-the-job models—offers a promising approach to integrate knowledge, skills development, leadership, and capacity building into real work experience that can include paid opportunities. This approach also fosters relationships between education, training, and workforce intermediaries to help align training curricula with the current needs of the health field. Workforce intermediaries, such as a workforce development board, task force, or community-based organization, in particular, play an important role in fostering coordination between education and training entities. For example, intermediaries can help negotiate with employers to secure commitments to hiring diverse graduates who complete a training program.

Challenge 3: Proliferation of for-profit institutions

More recently, the increase in associate degrees and postsecondary certificates awarded for entry-level health occupations has largely been driven by the growth of for-profit institutions.[59] With students facing barriers to enrolling in community college health training programs—due to limited slots in required courses and a longer period of time dedicated to earning a degree—many are turning to for-profit institutions for easy access to training programs that can jump start their career and job prospects. Students of color in the college-age group comprise a larger proportion (nearly 75 percent) of students in these institutions—the majority of Black and Latinx students who pursue a short-term certificate program have done so at for-profit institutions.[60] However, compared to community college institutions, for-profit entities charge higher fees, offer subpar curricula, and produce inadequate labor market returns. The mismatch between the training that these institutions provide and health employer workforce needs is of particular concern because students completing these programs often find themselves unable to secure employment, which some have characterized as a form of predatory practice toward low-income students of color. Under the Obama Administration, federal legislative and executive action sought to strengthen regulation of this sector and protect vulnerable students. However, as of this publication, the Trump Administration is projected to undo these regulatory reforms.[61]

Challenge 4: Limited wraparound supports and infrastructure to support stability across the pathway

Participation in a health education or job training program is a time- and resource-intensive undertaking, with rigid requirements related to unpaid training hours and licensure or certification processes. While low-income individuals, students of color, and those facing barriers to employment remain priority targets of many workforce development efforts, the current system is not fully equipped to address their unique needs. Trainees who do not receive or have access to stable income through a program's duration, or are navigating external hardships or chronic exposure to past or current trauma, face tremendous challenges in successfully participating and completing a training program. The state's affordable housing crisis is pushing students and workers further away from training and employment opportunities, resulting in high turnover rates for positions within metropolitan areas or longer commutes and increased financial burden of training. Lack of accessible transportation, childcare support resources, income supports, and other financial resources, as well as predatory traffic and court fines and fees, can also impede their ability to successfully complete a training program, or hold regular hours for an internship or future employment. Many health training programs are not equipped to navigate, nor have sufficient financial resources, to address the full array of social services and programs that may be needed. Additionally, existing workers in lower wage positions who seek career advancement face major challenges in completing traditional training or education programs—many already work multiple jobs with inflexible hours and the prospect of completing training hours for licensure or certification without a steady wage is economically infeasible to support themselves or their families. While education and training institutions have explored online and technology-based curricula to improve access to these programs, the skills and competencies demanded in the health-care setting require in-person and in-the-field training.

These challenges involving stable and affordable housing, transportation, childcare, and other needs may persist even as trainees successfully gain employment. For example, new workers may still need flexible hours and sufficient leave benefits if they have children, or if they have multiple forms of employment. These dimensions of job stability—factors that exist outside the workplace but shape an employee's capacity to focus and be successful at his or her job—are not always apparent to employers seeking to fill an urgent employment need. They also have important implications on employee turnover and seamless service delivery, as workers who face competing life challenges without appropriate supports experience poorer retention rates.[62] Further down the pathway, these challenges also continue as workers holding entry-level positions seek additional credentials or training to advance into higher wage jobs. Job stability supports serve as a foundation for economic mobility, enabling an individual to pursue certification, on-the-job training, and other career advancement opportunities in the future.[63]

Fostering Regional Collaboration through the Slingshot Program

A program developed by the California Workforce Development Board, the Slingshot Program provides flexible funds to foster regional collaborations in innovative workforce development. Funded regional coalitions bring together employers, industry leaders, government, workforce, and education stakeholders to address employment challenges and increase income mobility across the state through region and/or industry specific strategies. Key characteristics of these efforts include strong industry engagement, integrated strategies, and alignment around a shared outcome.

Challenge 5: Discriminatory hiring practices

People who are low-income and people of color, particularly young men and women of color, formerly incarcerated people, and undocumented or newly arrived immigrants, continue to face substantial hurdles in accessing low- and middle-skill positions in the sector. Negative implicit bias and harmful stereotypes have resulted in discriminatory training, credentialing, licensing, hiring, human resources, and other policies that create additional educational and employment barriers for vulnerable communities that can result in hostile workplace cultures. Accrediting bodies and licensing boards often include restrictive and outdated criteria that make training requirements difficult to meet. Additionally, licensure or certificate applications for many entry-level and allied health professions require criminal background checks or other forms of screening that negatively affect communities of color which are overrepresented in the criminal justice system. Civil rights and consumer laws are in place at the state and federal level to remove employment barriers for qualified, formerly incarcerated applicants for some health-care occupations;

however, many of the fastest-growing health-care positions—including home health aides and emergency medical technicians—do not have the same worker protections. The California Department of Consumer Affairs and the California Business and Professions Code at times place lifetime bans on applicants with a criminal history, even for nonviolent offenses and dismissed convictions misdemeanors that are not relevant to the occupation.

Even after individuals complete training and receive the appropriate license, certificate, or degree, many face the next challenge of navigating the hiring process. In fact, a recent meta-analysis found no change in racial discrimination in hiring, particularly among Black candidates.[64] Cultivating commitment to inclusive hiring, opportunities for workplace learning, and workforce development is needed in order for top organizational leaders to shift institutional practice. Narrative shifts and framing strategies can help counter negative perceptions about hiring low-income individuals and workers of color. Employers can also implement training for hiring managers, human resources employees, and other staff to better understand and reduce the obstacles faced by prospective applicants who are already facing education and employment barriers. For instance, employers can adopt recruiting guidelines that enlarge the local talent pool and better access an untapped workforce of people who have been formerly incarcerated. In fact, the 2012 Equal Employment Opportunity Commission offered guidelines that state employers must take into account regarding an applicant's background, as well as key factors related to a previous record (such as age and nature of offense, evidence of rehabilitation, and relevance to job). Policy strategies like restricting the screening of applicants with prior criminal history ("banning the box") until after a conditional offer has been made, eliminating automatic disqualification policies, and adopting more inclusive language have been implemented by institutions across 24 states and 130 localities.[65] While some federal and state laws can require background checks for certain health-care occupations, the laws do not prevent employers from hiring individuals with a criminal history. Other legal tools and incentives to hire formerly incarcerated persons include the Work Opportunity Tax Credit, Federal Bonding Program, and wage subsidies linked to the federal workforce development program.[66] Stronger employer partnerships with community-based, public interest, and legal service organizations can further support employers as they navigate these pathways.

Challenge 6: Limited worker protections, career ladder opportunities, and job quality issues among low-wage occupations

Critical to an inclusive health workforce is access to a high-quality job that provides workers with long-term economic security, improved health, and that promotes a healthy work-life balance. This includes multiple dimensions, such as family sustaining wages; comprehensive medical, leave, and retirement benefits; career ladder opportunities for skills development and advancement; flexible and predictable schedules; and a fair and engaging workplace environment that promotes worker voice, respect, and dignity.[67]

Although poised to experience the greatest job growth, support and technician positions in allied health, especially those providing long-term care, face considerable job quality challenges.[68] Access to a quality job is heavily stratified by race, gender, geography, and level of education attainment and training. Black, Latinx, and Native American health workers, including workers from specific Asian Pacific Islander ethnic groups and immigrant backgrounds, tend to be concentrated in entry-level positions with lower barriers to entry, but with lower wages and stressful working conditions.[69] These positions, such as community health workers, medical assistants, and home health aides, are also often part-time hourly or temporary positions with limited benefits and limited career advancement opportunities.[70] Overall, positions that involve "feeding, moving, cleaning, and caring for patients" are generally part-time and offer fewer benefits.[71] Workers in this sector, who are predominately women of color, on average earn a little over $20,000 a year and often work two or three jobs to make ends meet.[72] Given these unattractive conditions, employers face an uphill battle in recruiting and retaining workers for the fastest-growing positions. Although demand and job availability are high, these occupations experience notoriously high turnover rates, which can lead to poorer quality and fragmented patient care and increasing costs to the employer. The rate in which long-term care workers, such as personal care or home health aides, medical assistants, or licensed vocational nurses, leave the profession for other employment far outpaces the rate of entry into these jobs—and those who do leave are more likely to be unemployed, report higher rates of disability, and experience higher rates of poverty.[73]

As the health-care sector increasingly relies on entry-level roles, employers can play an active role to address these challenges and invest in their workers. Whether employers choose to hire more workers to alleviate added demand, or re-train current workers to take on more roles, workers are directly impacted. When workers are asked to take on expanded roles, will appropriate changes in compensation and working conditions be made or will these workers be overlooked? What on-the-job training opportunities exist for workers to build skills and advance into middle-skill and higher wage positions, and what can employers do to facilitate this skill building among their workers?

Employers who develop robust organizational retention, career ladder, and professional development strategies have been shown to reduce turnover and increase staff effectiveness, career mobility, and overall workforce morale. Surveying staff regarding their interests, and career goals, and temporary rehiring of retirees to address current worker shortages are steps that employers can take to fill open positions. Other effective strategies include mentorship programs, offering wages, stipends, or release time toward work-based learning, and flexible scheduling, and "cross-training," which allows staff to develop diverse skills in different departments and promotes general career ladder mobility.[74] Data systems are helpful to assess both the health-care job landscape in a particular region as well as metrics for recruitment and retention.

Building Career Ladders for Frontline Workers

With the passage of the Affordable Care Act, Jersey City Medical Center (JCMC)/Barnabas Health recognized that investing in their workforce was a central strategy to improve patient experience, lower the costs of care, and improve population health. JCMC began to invest internally, launching a career ladder program focusing on skills and leadership development specifically for frontline workers—those who work at bedsides, transporting patients, receptionists, housekeeping, and food service. To date, key success factors for the program include organizational buy-in and budget commitment, investments in human resources activities to assess employee interests and skills, as well as integrating an intentional strategy to connect employee growth with patient satisfaction. To date, 40 frontline workers have successfully completed the career ladder program and almost all secured positions with improved salaries at the facility.

Strengthening California's Health Workforce Pathway:
Policy Opportunities and Recommendations

The ACA signals major shifts in the American health-care system that have already been underway for years. The State of California, and its regulatory and fiduciary government agencies, must take a leadership role to ensure that all Californians have equitable access to the emerging health jobs of the future. California's economy depends on a strong health workforce that is prepared to address the pressing and complex health needs of the state's increasingly diverse communities. State policies, coupled with institutional commitment and equitable industry practices, are central to creating an inclusive health workforce development system, one marked by strong alignment between employers, educational institutions, service providers, and intermediaries, and the elimination of barriers for those facing the most significant challenges to economic stability and mobility. The following recommendations offer four types of policy actions that state agencies should take to achieve these outcomes. Enacting these policies points the state toward a sustainable future where all will have the opportunity to participate and prosper, through education and training, meaningful jobs, and career ladders that enable thriving, healthy lives for workers, their families, and their communities. Appendix B provides information about key California state agencies engaged in health workforce development. Appendix C provides examples of workforce legislation in California, including health sector-related bills.

Policy Opportunities for an Inclusive Health Workforce in California			
Remove barriers and target investments in training & hiring	**Increase funding for community-based training and career ladder opportunities**	**Enact stronger worker protections**	**Improve state/regional infrastructure and data systems**
• Establish targeted hiring criteria for public workforce dollars • Provide adequate preparation and support services for vulnerable populations	• Support a wider array of community-based training strategies • Increase incentives and resources for advanced career ladder training	• Ensure quality jobs for entry-level health workers • Raise the wage floor for entry-level and care coordination workers	• Invest in a regional training pathway infrastructure and alignment of support systems • Strengthen data collection quality and coordination

Remove Barriers and Target Investments in Training/Hiring

Establish targeted training and hiring criteria for public workforce dollars. State agencies that provide funding for health workforce development should develop clear and consistent language within grant program eligibility criteria and application/review processes to prioritize training and targeted hiring of individuals from disadvantaged communities, those facing barriers to employment, and other vulnerable populations identified by California WIOA.[e] Such funding mechanisms should prioritize regions with the highest health workforce development need and applicants proposing workforce strategies that can address health-care services for high-need, patient populations requiring complex care management. Local workforce development boards, K-16 education institutions, community-based training entities, nonprofits, education institutions, workforce intermediaries, and other eligible applicants seeking public funding for health workforce training funds should be required to:

- Describe specific patient populations and regions with the greatest need for services, and describe efforts to recruit and hire a culturally relevant workforce;
- Identify a target population and set benchmarks to ensure that the majority of training program participants or new hires are made up of residents reflecting the patient population and those facing barriers to employment;
- Promote local and regional coordination by partnering with a community-based organization and/or training entity with extensive expertise in offering workforce development and social supports for individuals facing barriers; and
- Outline a detailed plan for targeted outreach and engagement to achieve this goal, including how and with whom they plan to partner within a diverse group of workforce development partners, as well as metrics to monitor progress.

Provide adequate preparation and wraparound support services for vulnerable populations. Although some state funding has been allocated toward on-the-job training opportunities in the K-16 system, such as the Career Pathways Trust, significant funding is still needed toward these and other programs' capacity to address basic skills gaps and other barriers that impact vulnerable populations and regions, such as rural areas, facing the greatest need. Additional investments and the alignment of existing funding sources toward pre-training needs (e.g., basic skills training, remedial education, adult education programs) and contextualized, work-based learning models can ensure that trainees have the best chance to succeed in workforce training programs that lead to credential attainment and employment. State education and workforce development agencies should:

- Increase funding for culturally competent instructors and training strategies that effectively and efficiently build basic employment, literacy, and financial skills among trainees and students;
- Increase funding for contextualized, work-based learning models, such as apprenticeship and vocational programs, that enable stipends or some form of compensation for work;
- Increase funding to facilitate cross-sector and cross-agency alignment, such as between community-based organizations and community colleges, with critical supports needed for successful participation in career pathway programs, such as affordable housing, childcare, counseling, trauma-informed healing, case management, transportation, and income supports; and
- Remove legal and human resource barriers to training and employment for vulnerable populations, such as formerly incarcerated people and juvenile justice-involved youth. This includes strengthening implementation of "ban the box" legislation and other policies that remove automatic disqualification for applications with previous criminal history, expanding licensing/certification eligibility, fostering partnerships between public safety, legal experts, and employers to establish clear and just protocols for screening job applicants with prior histories, and providing technical assistance or human resources training on mitigating implicit bias in hiring processes.

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e This includes long-term unemployed, low-income workers, CalWORKS participants, immigrants, formerly incarcerated individuals, and juvenile justice-involved youth.

Increase Funding for Community-Based Training and Career Ladder Opportunities

Support a wider array of community-based training strategies. The state should create stronger infrastructure to align education/training institution curricula and employer workforce needs, specifically in expanding training opportunities in community-based, nontraditional settings that serve diverse patient populations. This includes expanding public funding to finance on-the-ground health training opportunities in community-based settings such as federally qualified health centers, community health centers, school-based health centers, rural and tribal clinics, and other safety net institutions. Funding to facilitate partnerships between community-based organizations and workforce entities is needed, as well as more flexible reimbursement mechanisms that can fund roles and services critical to a team-based care model. Specific actions include:

- The California Department of Health Care Services, which jointly administers with Centers for Medicare and Medicaid Services the state's Medi-Cal, Children's Health Insurance Program, and Medicare programs, should expand the scope of reimbursable services to include crucial functions and roles such as care coordination, service management and follow-up, and community health education and outreach, which can be completed by entry-level and community-based employees. For example, the Medi-Cal Schedule of Maximum Allowances should increase service compensation rates and the range of providers eligible for reimbursement for serving Medi-Cal populations, including community health workers, nonlicensed care providers, peer support specialists, care navigator specialists, medical assistants, home care providers, and other allied health occupations.
- The Health Professions Education Foundation division of the Office of Statewide Health Planning and Development should expand available county/state scholarship, loan forgiveness, and loan repayment programs for additional positions, including care coordinators, community health outreach workers, and other critical entry-level technical and support positions, particularly for geographic regions and occupations facing the greatest need for diverse, culturally competent workers.
- The Office of Statewide Health Planning and Development and other relevant agencies should increase grant funding toward health-care training and education in community-based settings and medically underserved rural, tribal, and urban regions. Priority should be given to community-based, nonprofit, and other organizations with strong history and experience in recruiting, training, and preparing diverse frontline workers that reflect high-need patient populations. These grants should require grantees to present a detailed plan for targeted outreach, recruitment, and retention efforts of priority communities and plans for facilitating employer/industry partnerships. This includes information such as:
  - Outline of efforts to engage priority populations such as boys and men of color, individuals with barriers to employment and education, formerly incarcerated individuals, and those seeking mid-career advancement opportunities;
  - Evidence that education/training curricula are culturally relevant and contextualized to the experiences of these priority populations;
  - Evidence of components that provide remedial education to equip trainees with basic skills to succeed in training programs and the workplace; and
  - Outline of efforts to engage health-care employers and other industry stakeholders to ensure that education/training curricula align with on-the-ground employer and patient needs.
- The state legislature and governor's office should allocate funding for innovative workforce programs that prioritize vulnerable individuals with multiple barriers to employment and facilitate workforce-community partnerships, such as the Breaking Barriers to Employment Initiative established by AB 1111 (Eduardo Garcia). The BBEI program would fund partnerships between local workforce development boards and community-based organizations to provide pre-training supports and services, such as remedial education and work readiness skill building, for individuals facing barriers to employment. Funding this initiative would enable the state to remove barriers for vulnerable workers and better prepare them for training, education, or employment opportunities, including those in the health-care sector.

- The California Department of Education should establish an Office of School-Based Health Programs, as proposed by AB 834 (O'Donnell), to not only support school districts to establish or strengthen school health programs, but also coordinate with training and education institutions to expand school-based health centers as potential training sites. Resources through this office should be prioritized for low-income schools that would most benefit from integration of school-based health services.

Increase incentives and resources for advanced career ladder training. The state should offer incentives and additional resources for employers to invest in career ladder and advanced training programs that build skills for entry-level allied health workers to transition into higher-paying, middle and advanced skilled jobs. Priority should be given to support pathways toward occupations facing the greatest demand in the field. Policy actions should include the following:

- Expand the types of employers who can access funding through California's Employment Training Panel (ETP) program to include health care, long-term care, community clinic, and other employers in high-demand sectors. The ETP program offers funds for employers to implement new and incumbent worker training programs, but is largely limited to employers who contribute into the State Unemployment Insurance program. The ETP program should also establish criteria prioritizing funding toward individuals with multiple barriers to employment and/or advancement, and require employers to partner with local and regional intermediaries and organizations.
- Agencies such as the California Employment Development Department and the Workforce Development Board should increase resources for technical assistance and human resources training for employers to assess baseline hiring and workforce development practices, and in turn, develop professional development pathways for incumbent workers.
- Building on SB 697, a 1994 bill introduced by Senator Torres that represents the state's community benefit requirement for private, nonprofit hospitals to maintain tax-exempt status, hospital community benefit plans should be required to include information on the amount and percentage of community benefit funds that are utilized for local hiring and health workforce development activities.

Enact Stronger Worker Protections

Ensure quality jobs for entry-level health workers. The state should enact robust and comprehensive workforce protections for vulnerable workers and ensure that employers are held accountable for violations of labor laws. This includes protections for allied health and entry-level professions that often lack such protections, such as home health/personal care aides, domestic workers, community-based outreach workers, enrollment workers, peer navigators, care navigators, and other frontline, support jobs. These critical but vulnerable occupations serve as bridges between community residents and access to services. Given increasing reliance on these positions as part of team-centered, community-based care models, the state should take strong action to substantially improve and expand protections for these positions, including the right to:

- Overtime compensation;
- Comprehensive health and medical benefits;
- Paid sick leave and meal/rest breaks;
- Flexible work hours without punishment or retaliation;
- Safe working conditions; and
- Protection from harassment and discrimination due to race/ethnicity, language, gender, immigration status, ability, age, or prior incarceration.

Raise the wage floor for entry-level and care-coordination workers. The state should adopt labor policies that ensure family sustaining wages and salaries for all positions, particularly entry-level, traditionally low-wage jobs, that focus on improving care coordination and integration of primary, preventive, and community-based services. Savings due to reduced emergency care, hospital services, and other improved care quality and health outcomes can be leveraged as incentives for employers to raise baseline wages for workers.

- The California Labor Code, as implemented by the Department of Industrial Relations, should be expanded so that the definition of employers who are subject to minimum-wage laws include those overseeing the work of individuals involved in supervised long-term work or training experiences. These work-based learning experiences often involve hundreds or thousands of unpaid hours but are required to obtain a professional degree or allied health profession licensure, registration, or certification.

- The California Labor Code, as implemented by the Department of Industrial Relations, should also be amended to require employers to prioritize part-time employees for new work opportunities and hours. For example, AB 5 (Gonzalez-Fletcher), Employers: Opportunity to Work Act (2017), modeled after San Jose's Opportunity to Work Ordinances, would require employers to offer additional hours to existing part-time employees before hiring a new employee. The bill would also authorize an employee to file a complaint for violation with the state or bring a civil action for remedies under the Act.
- As described above, financial incentives, funding streams, and reimbursement models should be expanded to fund services and roles that advance team-based, primary care, prevention, and care coordination work in medically underserved regions. Reimbursement and other payment models should also foster seamless integration across multiple care systems, including social service, mental health, and behavioral health, and utilize allied health workers such as community health workers. Other existing workforce education and training funds, such as those through the Mental Health Services Act (Proposition 63), can also be leveraged to identify funding mechanisms that encourage further systems alignment and improved care coordination between medical, behavioral health, and mental health systems.

Improve State/Regional Infrastructure and Data Systems

Invest in a regional training pathway infrastructure and alignment of support systems. Alignment and coordination across entities along the full health workforce pathway—from identifying target populations and regions, education and training requirements, funding and provider reimbursement, administrative processes, rules and procedures, and accountability mechanisms—are needed more than ever. Accompanied by legislative support and direction, state agencies such as the California Workforce Development Board, in strong partnership with other relevant agencies, and education, labor, and industry, should align infrastructure and guidelines that can foster coordination of training and education activities across regions. This infrastructure should be robust and align with state workforce goals, yet remain responsive to regional needs. The state legislature should direct and support state agencies, including the Board, to increase coordination and alignment to foster the following:

- Prioritize investments toward target communities with limited infrastructure to connect education/training entities and employers for workforce training, such as those living in rural, tribal, and low-income regions.
- Remove financial barriers faced by low-income students and trainees of color to successfully complete health training/education programs.
- Sustain investments in, and align, critical wraparound supportive services—such as access to affordable housing, food assistance benefits, health and mental health benefits, transportation subsidies or stipends that prepare trainees to successfully complete training programs and transition into steady employment.
- Strengthen guidelines and increase capacity-building resources for programs, such as the Slingshot Program, to facilitate long-term partnerships between local and regional workforce development boards, nonprofits, education and training entities, community-based organizations, and support-service agencies. Such partnerships are needed to align training curriculum with industry needs and remove barriers to employment faced by individuals from disadvantaged communities within allied health and entry-level positions.

- Develop robust stakeholder engagement processes to accurately learn about barriers, needs, and opportunities within the health workforce pathway and ensure that Board policies, programs, and practices appropriately respond to these challenges.

Strengthen data collection quality, coordination, and transparency. Given the rapidly evolving nature of the health-care sector, high-quality workforce data collection and analysis that can support regional and state planning, coordination, and alignment is needed. This includes timely, accessible, longitudinal information, including data on student, trainee, and employee demographics (by race/ethnicity, gender, language capacity, age, immigration status, etc.) compared to statewide population demographics, occupation, education, training, or career ladder program participation and success rates (completion, time dedicated to employment or advancement), retention rates, median wage, job quality indicators, and geographic distribution.[75] Actions include:

- Increase funding to strengthen the Office of Statewide Health Planning and Development's capacity to implement quality health workforce data collection and analysis activities through its Healthcare Workforce Clearinghouse. This includes alignment with other state workforce programs that collect training and education data that could inform health workforce development, including the Employment Development Department's Labor Market Information Division, Department of Consumer Affairs, California Department of Public Health, and California Community Colleges Chancellor's Office. A robust public engagement process is critical to engage relevant stakeholders and ensure transparent access to health workforce data.
- Invest in a centralized, easy to use, longitudinal K-16 education data system that can inform health-training gaps, identify needs, and prioritize populations or regions. Data from this system can be leveraged to shape priorities for health workforce policy and budget decisions. This includes data on training participation, education outcomes, and other indicators.

Conclusion

Health-care employers, workers, patients, educators, advocates, and policymakers have a collective stake in ensuring that current and future workers have equitable access to meaningful education, training, and employment opportunities. While the current demographic, policy, and system shifts in the sector present challenges, they are not insurmountable. Building on past efforts and current momentum, the State of California should bring about the policy and systems change strategies that will create a skilled and diverse health workforce, well-organized career pathway systems, and ultimately, a more inclusive economy. The recommendations offered here serve as a path to strengthen the state's capacity and translate these aspirations into reality—improving the health and economic outcomes for those most often left behind and, in doing so, paving the way for all Californians to thrive.

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Appendix A: Health Workforce Occupational Taxonomy

There are various systems of classifying, categorizing, and organizing what we refer to as the "health workforce." These include taxonomies offered by the Bureau of Labor Statistics, the Standard Occupational Classification system, and the US Census American Community Survey. In general, they are grouped by factors such as function, scope of role, and setting which are associated with particular types and levels of training, education, and licenses/certification/degree requirements. Each sector or occupational category is informed by another body of in-depth research and literature around training, education, practice, and policy. For an example of this, please see the work of David Demo and others in the *Journal of Allied Health* (2015) on primary care and allied health professions and John E. Snyder's work on community health workers (2016) at the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Health Workforce Occupational Taxonomy

Broad Occupational Category	Examples of Titles and Roles
Primary Care Family and general practice, internal medicine, general pediatrics, and urgent care (Demo 2015)	Physicians Physician Assistants (PA) Medical Assistants (MA)
Nursing	Nurse Practitioners (NP) Registered Nurses Licenses vocational nurse (LVN) Home health aides
Public Health	State and local health department Health educators Lab science Epidemiologist Data / informatics
Allied and Other Support "deliver services involving the identification, evaluation, and prevention of diseases and disorders; dietary and nutrition services; and rehabilitation and health systems management" (Demo 2015)	EMT Imaging Therapists Technicians Diagnostic support
Community-Based Health Workers (Snyder 2016)	Community health workers (CHW) Lay health worker / *promotoras* Outreach and enrollment agent Care navigator and coordinator Community organizer Capacity builder Health educators
"New" (or repositioning existing) roles focusing on coordination and care management	Care coordinators Patient navigators Expanded roles for existing professions: MA, PA, RN, NP, CHW
Pharmacy	Pharmacists Pharm technicians
Mental Health, Behavioral Health, Social Work	Mental health clinicians Counselors Psychologists Social workers
Dental and Oral Health	Dentists Dental hygienists Dental assistants (DA)

Appendix B: Key California State Agencies Engaged in Health Workforce Development

State Agency	Description
California Labor and Workforce Development	The California Labor and Workforce Development is an executive branch agency that oversees several major departments on workforce development and economic development, labor law enforcement, benefit administration, and other functions. These departments include the California Workforce Development Board (CWDB), Employment Development Department, Employment Training Panel, as well as the Department on Industrial Relations.
California Workforce Development Board (CWDB)	The California Workforce Development Board (CWDB) is charged with setting the strategic direction of state workforce development policy, as required by the federal Workforce Innovation and Opportunity Act (WIOA of 2014). Members of this board, appointed by the governor, represent a range of relevant sectors and also administer key workforce development and training funds. This includes workforce development programs in partnership with agencies such as: Labor and Workforce Development Agency, California Community Colleges, Employment Development Department, Department of Education, and California Department of Rehabilitation, among others. Areas of program focus, as reflected in the CWDB Strategic Plan, include regional partnerships and coordination, workforce/education alignment with industry needs to advance "demand-driven skills attainment," pre-apprenticeship and training/placement, and improving access for individuals with barriers to employment. California WIOA also requires the establishment of a local workforce development board in each local workforce development area of the state to carry out analyses of the economic conditions in the local region.
Health Workforce Development Council (HWDC)	A subcommittee of the California Workforce Development Board, HWDC was established by the California Workforce Development Board and Office of Statewide Health Planning and Development in 2010 in response to the passage of ACA and is focused on preparing and expanding the state's health workforce in order to ensure access to quality health care for all Californians. The council is tasked with engaging diverse public and private stakeholders to achieve the council's goal to increase the state's primary care workforce by 10-25 percent over the next 10 years. The Health Workforce Development Council (HWDC) issued a March 2013 report on the state's health workforce development needs. The report identified key next steps, which included establishing regional coordination and data infrastructure. The Council also established the Career Pathways Sub-Committee tasked with developing strong career pathways for priority health professions, such as primary care physicians and nurses, medical assistants, community health workers, public health professionals, and social workers.

State Agency	Description
Office of Statewide Health Planning and Development (OSHPD)	OSHPD oversees research, data collection, and dissemination of information regarding the state's health care infrastructure, including the health workforce. Within OSHPD, the Healthcare Workforce Development Division offers funding and training opportunities for health professions focused on health-care shortage areas, including the Health Careers Training Program and Health Workforce Pilot Projects. The Health Professions Education Foundation offers scholarships and loan repayments for health trainees, students, and professionals. The division also oversees the Healthcare Workforce Clearinghouse, which houses data, and analysis of the health workforce employment and educational trends in the state. The Clearinghouse utilizes data from the Department of Consumer Affairs, California Department of Public Health, Employment Development Department's Labor Market Information Division, and California Community Colleges Chancellor's Office. The 1973 Song-Brown Health Care Workforce Training Act established a set of programs, housed within the OSHPD office, with the goal of increasing the number of students and residents receiving quality primary care education and training in medically underserved areas throughout California with unmet need. This includes funding for training and education programs for family medicine practitioners, nurse practitioners, physician assistants, and registered nurses. The Act also requires the Director of Statewide Health Planning and Development to contract with accredited medical schools, teaching health centers, training programs, hospitals, and other health-care delivery systems to advance these efforts.
California Healthcare Workforce Policy Commission	The California Healthcare Workforce Policy Commission, appointed by the governor and housed within OSHPD, is tasked with ongoing review of the program's alignment to established Song-Brown Act goals.
California Department of Health Care Services (CDHCS)	CDHCS oversees the state's health-care safety net, administering key health care, dental, mental health, and behavioral health programs, including the state's Medicaid program, Medi-Cal. The agency also sets the Medi-Cal Schedule of Maximum Allowances (SMA) reimbursement and service compensation rates and oversees the state's Section 1115(a) Medicaid Waiver Renewal, entitled Medi-Cal 2020, which includes $62 billion in federal funding over five years (2016 to 2020) to implement innovative programs focused on improving the quality of care, access, and efficiency of Medi-Cal services. Currently there are five state waiver programs through which counties can apply to receive funds to implement local models focused on payment reform within safety net hospitals; incentives for primary and prevention care; behavioral health, social service, and health-care coordination; dental health incentives; and substance use disorder treatment services.
Employment Training Panel (ETP)	ETP is a statewide program, focused on strengthening strategic partnerships between business, labor, and government. Currently, the program offers funding to employers to implement worker-training programs that lead to good wages and opportunities for advancement.
Department of Industrial Relations (DIR)	DIR is tasked with protecting and improving the "health, safety, and economic well-being" of California workers and helps their employers comply with state labor laws." The agency administers and enforces laws governing wages, hours, breaks, overtime, workplace safety, benefits for injured employees, and more.

State Agency	Description
Employment Development Department (EDD)	EDD is tasked with administering state programs that involve unemployment insurance, state disability insurance, payroll tax, as well as job training and workforce services. EDD's Workforce Services Branch houses two offices, the Central Office Workforce Services Division (COWSD) and the Labor Market Information Division (LMID), which offers program guidance to Workforce Innovation and Opportunity Act (WIOA) partners in California. COWSD coordinates delivery of training programs, provides technical assistance, and oversees CalJOBS, an online resource for job seekers and employers.

Appendix C: Examples of Workforce Legislation in California, including Health Sector-Related Bills

Legislation	Description	Category of Policy Recommendation
AB 1111 (Eduardo Garcia): Breaking Barriers to Employment Initiative (2017)	This bill would establish a new program that would fund partnerships between local workforce development boards and community-based organizations to serve vulnerable populations and prepare them to connect to, enter, and succeed in workforce development and postsecondary credential attainment programs. **Status: Passed.**	Remove barriers and target investments in training/ hiring; Increase funding for community-based training opportunities
AB 1639 (Eduardo Garcia): Victims Compensation Fund Expansion (2017)	This bill would prohibit the board from denying an application for a claim solely because the victim or derivative victim is a person who is listed in the CalGang system. **Status: Still current as of the release of this report.**	Remove barriers and target investments in training/ hiring
AB 1629 (Bonta): Victims Compensation Fund (2014)	This bill supports physical and emotional recovery for Californians injured by gun or other violence by extending peer counseling services and reimbursement through the Victims Compensation Fund. **Status: Passed.**	Remove barriers and target investments in training/ hiring
AB 1056 (Atkins): Second Chance Program (2014)	This bill directs Prop 47 savings toward community-based programs that address the root causes of recidivism among formally incarcerated people, including the need for stable and affordable housing, mental health services, and substance abuse disorder treatment. **Status: Passed.**	Remove barriers and target investments in training/ hiring
SB 1384 (Mitchell): Certified Nursing Assistants (2014)	This bill expands opportunities for qualified, rehabilitated individuals with a prior conviction to become a certified nurse assistant, by removing a requirement that the State Department of Public Health deny, suspend, or revoke a training/examination application or certificate given a prior conviction. **Status: Passed.**	Remove barriers and target investments in training/ hiring
AB 2396 (Bonta): Convictions; Expungement; Licenses (2014)	This bill prohibits the Department of Consumer Affairs to deny a professional license to individuals with a court-ordered dismissal of a prior conviction. **Status: Passed.**	Remove barriers and target investments in training/ hiring

Legislation	Description	Category of Policy Recommendation
AB2560 (Ridley-Thomas, 2006) /SB 564 (Ridley-Thomas, 2008): The Public School Health Center Support Program. AB 834 (O'Donnell): School Based Health Programs (2017)	This set of bills established a state office and grant program for School Based Health Centers, which to this date, has not yet been funded. **Status: AB 2560 and SB 564-passed; AB 834- still current as of the release of this report.**	Increase funding for community-based training opportunities
AB 316 (Waldron): Workforce Development (2017)	This bill amends the Employment Training Panel (ETP) to create a competitive performance contracts program to fund projects by an employer, a training agency, or a nonprofit organization to expedite and increase the number of persons employed in an industry that employs individuals in middle-skill jobs, including allied health care. This bill also establishes the Employment Revitalization Initiative, directing the California Workforce Board to develop a grant program to support individuals with multiple barriers to employment to receive remedial education and work readiness skills training to prepare to participate in training and apprenticeship opportunities. **Status: Failed to pass.**	Increase funding for career ladder opportunities
SB 1015 (Leyva): Domestic Work Employees; Labor Standards (2016)	Currently, the Industrial Welfare Commission regulates wages, hours, and working conditions for household occupations, according to existing labor law. The 2013 Domestic Worker Bill of Rights (AB241) regulates the hours of work of domestic work employees who are personal attendants and requires overtime compensation rate for those employees. The 2016 Domestic Worker Bill of Rights removed the sunset provision of the original legislation, which would have repealed the law in January 2017. **Status: Passed.**	Enact stronger worker protections
AB 387 (Thurmond): Minimum Wage: Health Professionals; Interns (2017)	This bill would expand the definition of employers subject to minimum-wage law to include employers that oversee the working conditions and wages of persons engaged in supervised work experience (e.g., internships) that satisfies requirements for licensure, registration, or certification as an allied health professional; and thus, they would be subject to minimum-wage requirements. **Status: Failed to pass.**	Enact stronger worker protections
AB 957 (Levine): Higher Education Regional Workforce Coordination; California Workforce Development Board (2017)	This bill aims to strengthen coordination between education and workforce development entities, by requiring the California State University system, and requesting the University of California and California Community College system, to participate in regional efforts to implement federal WIOA. **Status: Passed.**	Improve state/regional infrastructure and data systems

Legislation	Description	Category of Policy Recommendation
AB 2105 (Rodriguez): Workforce Development: Allied Health Professions (2016)	Currently, the California Workforce Development Board is required to submit a report to the legislature regarding findings and recommendations for expanding allied health job training and employment. This bill requires the Department of Consumer Affairs to "engage in a stakeholder process to update policies and remove barriers to facilitate the development of earn and learn training programs in the allied health professions" by January 2020. **Status: Passed.**	Improve state/regional infrastructure and data systems
AB 2102 (Ting): Health Workforce (2014)	This bill aims to capture more complete and consistent demographic data on the state's health workforce. The bill builds upon existing law that requires the collection of demographic data (including ethnicity, gender, and language capacity) for physicians and dentists, and expands this requirement to professional boards within the Department of Consumer Affairs to submit demographic information to OSHPD for allied health and other health workers, including nurses, nurse practitioners, physician assistants, technicians, and more. **Status: Passed.**	Improve state/regional infrastructure and data systems
AB 1336 (Mullin): California Workforce Development Board (2017)	Existing law requires the California Workforce Development Board to develop a workforce metrics dashboard, updated annually, to provide a status report on credential attainment, training completion, degree attainment, and participant earnings from workforce education and training programs. This bill would require the board to 1) utilize available data collected and accessible by state agencies to the extent feasible, and also 2) expands the authorized recipients of confidential information (e.g., Social Security numbers of adults participating in adult education programs collected by the State Department of Education) to be used by the board or the board's designee. The bill would also expand the use of the confidential information to include tracking of program participation, credential attainment, training completion, degree attainment, and participant earnings from workforce education and training programs. **Status: Passed.**	Improve state/regional infrastructure and data systems

Appendix D: Research and Evaluation on Financial Incentives and Payment Models

The Affordable Care Act has stimulated the growth of new delivery models that promote integration and coordination of care. To adapt to these shifting forms of delivery, emerging payment models are moving away from fee-for-service (FFS), volume-based payment to values-based payment models that are linked to patient outcomes and provider performance. ACA is also aiming to better compensate for primary care—Medicaid and Medicare—more appropriately by increasing reimbursement, while attracting providers to serve these patients. The Center for Medicare and Medicaid Innovation (CMMI), created under ACA, has been tasked with advancing new innovative models.

Payment Models/Reform	Description	Evidence in Literature
Medicare Payment Incentives	Financial penalties for hospitals with higher (than expected) rates of readmission of Medicare patients within 30 days and avoidable threats to safety (such as hospital-acquired conditions).	• Led to national decline in readmissions rates, with disproportionate impact on safety net and teaching hospitals with patients who have more complex social and medical issues (Blumenthal 2015).[f]
Medicare Payment Incentives	Enhanced Medicaid reimbursement; under ACA, state Medicaid programs required programs to reimburse primary care providers (PCP) at the full 100 percent rate of Medicare reimbursement for first 2 years and 80 percent for outpatient care, and also receive a federal match.	• Study of 10 participating states found that availability of PCP docs for Medicaid patients rose 8 percent among providers accepting Medicaid. A total of 15 states extended this reimbursement enhancement beyond 2 years (Blumenthal 2015). • Research has found differential impact in rural and urban hospitals, and states with and without Medicaid expansion. In California, this has been found to be insufficient to incentivize primary care providers (Kaufman et al 2016).[g]
CA State Pilots: Alternative Payment Methodology (APM)	Legislated by SB 147 in 2015, APM is a major mechanism for community centered health homes (CCHH) to advance primary care payment and delivery transformation. Involves a capitated payment preparedness program (CP3).	

f David Blumenthal, Melinda Abrams, and Rachel Nuzum, "The Affordable Care Act at 5 Years," New England Journal of Medicine 372 (2015): 2451-2458.

g Brystana Kaufman et al., "Medicaid Expansion Affects Rural And Urban Hospitals Differently," *Health Affairs* 35 (2016): 1665-1672.

Payment Models/Reform	Description	Evidence in Literature
Pioneer and Advance Accountable Care Organizations (ACO)	Aligns incentives to promote higher quality care, greater accountability. ACOs are "groups of providers, with or without an affiliated hospital, who accept joint responsibility for the costs and quality of care for an assigned group of patients." ACOs still rely on fee for service (FFS), but are eligible for "shared savings." This model is accountable to a continuum of care but retains the limits of FFS.	• Evidence suggests this model has been shifting clinical practice toward population health (Gofin 2015).[h] • Early reports suggest financial savings of $700M through Medicare Shared Savings Program ACOs, and $385M through Pioneer ACOs (Blumenthal 2015). • Challenges to implementing in rural health workforce setting have been noted (Allen 2013).[i] ACOs require at least 5,000 beneficiaries, which is a challenge for rural communities and where newer patients likely to be enrolled in Medicaid (Kaufman 2016).
Bundled Payment	Provides upfront support to transform primary care practice while focusing on incentives that reward care coordination, quality, and service efficiency. Involves a single set of payments for a set of services (for a defined condition/ episode and period of time). Like ACOs, seen as "bridge" from fragmented FFS toward integrated, coordinated care.	• 7,000 hospitals, organizations, and providers signed up for bundled payment incentives (Blumenthal 2015).
Pay for Value / Pay for Performance	Combination of payment models. Incentives to improve performance on quality and cost metrics. Providers receive payment for meeting pre-established targets.	• Modest financial impact on physicians. • Evidence has been mixed due to concern about risk selection of patients of color with more complex chronic conditions (Gofin 2015, Peterson 2017).[j] • Peterson 2017 found no risk selection in Veterans Affairs (VA) pay for performance model on care for Black patients with hypertension.

h Jaime Gofin, Rosa Gofin and Jim P. Stimpson, "Community-Oriented Primary Care (COPC) and the Affordable Care Act: An Opportunity to Meet the Demands of an Evolving Health Care System," *Journal of Primary Care & Community Health* 6 (2015): 128–133.

i Suzanne M. Allen et al., "Challenges and Opportunities in Building a Sustainable Rural Primary Care Workforce in Alignment With the Affordable Care Act: The WWAMI Program as a Case Study," *Academic Medicine* 88 (2013):1862–1869.

j Laura Peterson et al., "Impact of a Pay-for-Performance Program on Care for Black Patients with Hypertension: Important Answers in the Era of the Affordable Care Act," *Health Service Research* 52 (2017): 895-1248.

Payment Models/Reform	Description	Evidence in Literature
Patient Centered Medical Home or Health Home (PCMH/PCHH), Community Oriented Primary Care (COPC)	Models have been around for a while, but found synergy with ACA provisions. Model characterized by approach whereby "primary care physicians and other health professionals are the nexus of health care for patients and focus on providing care that is patient-centered, comprehensive, team based, coordinated, accessible, safe, and of high quality" (Allen 2013).	• Evidence suggests improved patient outcomes including decreased emergency room visits and hospital visits and improved quality of care (Edwards 2014).[k] • Challenges and barriers to receive National Committee for Quality Assurance recognition as a PCMH/HH have been noted.

k S.T. Edwards, M.K. Abrams, R.J. Baron et al., "Structuring Payment to Medical Homes After the Affordable Care Act," *Journal of General Internal Medicine* 29 (2014): 1410.

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