Building the Future Health Workforce in California: Emerging Lessons from Experience to Date and Key Considerations

A Report
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The California Endowment
and
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Executive Summary

This report serves as a resource to inform the work of the California Future Health Workforce Commission (CFHWC) in the development of a statewide health workforce master plan. The impetus for the development of a master plan includes several key trends, including the growing knowledge that social, behavioral, and physical environmental factors play a significant role in determining our health. The knowledge that factors outside of health care service delivery play such an important role is given additional urgency by the movement towards “value-based” reimbursement. This emerging payment model is gradually shifting financial incentives for providers and payers away from filling beds and conducting procedures and will reward those who are more successful in keeping people healthy and out of acute care settings.

This emerging reality and future orientation is a key driver in the deliberations, priority setting, and actions to be taken by the Commission. In short, the CFHWC will focus on the workforce needed not just to treat, but also to prevent disease and improve the health of populations in the context of the communities where they live. While emphasis will be given to near term problem solving, equal attention will be given to the type of workforce, partnerships, and supporting structures needed in the coming decades. Other key issues include, but are not limited to addressing shortages and the geographic maldistribution in health professions disciplines that limit access to quality care, particularly in rural and inner-city communities, the rapid expansion of our aging population, and the need for a health workforce that better reflects the growing diversity of our communities, ensuring both optimal quality of care and career opportunities for youth who are under-represented in the workforce.

There is a need for a more comprehensive, coordinated approach to health workforce development that makes optimal use of expertise and assets among employers, educational institutions, and diverse community stakeholders. The report offers a set of summary observations and recommendations from three inquiries; a review of health workforce efforts in other states, a review of previous statewide health workforce development initiatives in California, and key informant interviews with 29 health employer, education and workforce development leaders. Each of the three inquiries are presented as distinct sections of the report, and summary findings and recommendations drawn from each are outlined in this executive summary. The inquiries are structured to address five core questions, including:

1. How do the processes, outcomes, and lessons from statewide health workforce planning efforts in other states inform the design of the process in California?
2. How do the processes, outcomes, and lessons from statewide health workforce efforts in California inform the upcoming effort?
3. What are priority issues to be addressed?
4. What are key design elements to ensure that a master plan will best add value to address current and future health workforce needs?
5. How do we define success, and what are key desired outcomes?

The review of health workforce planning and implementation efforts in other states covered 17 distinct processes in 13 states (two distinct processes in MA, and three in MI). Thirteen (13) of the 17 were planning processes, seven of which led to implementation processes, six which did not. The remaining four processes were implementation strategies which did not appear to have been preceded by planning processes. All 17 processes occurred within the last 15 years; 14 of which were initiated since the passage of the Affordable Care Act in 2010.

It should be noted that public reporting on prior efforts is limited to relatively superficial documentation of the processes, with limited analysis of what worked, what didn’t, and why. Nevertheless, there were a few key lessons that did emerge from the review of efforts in other states (addressing core questions 1 and 2):

- Most processes lacked explicit strategies to implement recommendations and a framework to monitor progress (with a few notable exceptions).
- Processes focused primarily on expanding pools of professionals while stakeholders retained legacy practices – little evidence of shared ownership for meaningful change.
- Limited attention to how recommendations may be implemented differently at the regional level (of particular concern, given the size and diversity in CA).

The review of previous statewide health workforce initiatives in California covered 22 initiatives, including processes initiated through state legislation, federal funding, and national and state foundation supported efforts. Key themes in shortcomings that were reinforced by key informants (inquiry three) include:

- Most recommendations not implemented
- Most efforts funded only the planning process
- Insufficient staffing/resources to ensure success
- Lack of institutional commitment to meaningful change
- Competitive dynamics among employers and academic institutions
- Competing priorities in policy arena
- Lack of engagement of key decisionmakers in private sector

Key themes in terms of positive outcomes associated with these initiatives that can serve as building blocks going forward include:

- Strong cohort of health workforce and diversity champions
- Increased shared knowledge of dynamics, trends, and needs
- Increased capacity and commitment to collaboration
- Enhanced continuity and quality of health career pathways programs
• *Increased capacity in regional coordination* in selected areas of the state
• *Increased educational capacity* in selected areas
• *Better data* for nursing (model for replication/scaling)
• *Selected* policy and regulatory actions

A summary of key elements of the 22 initiatives is provided in subsection III: Matrix of Initiatives on page 32, and additional information, including hyperlinks to associated program information is provided in subsection V: Table of Initiative Reports and Recommendations on page 49. The key informant interviews provided a wealth of insights that are reflected in the prior observations, and of even more importance, offer important guidance for moving forward. Core design elements identified by key informants include:

• Identify clear outcomes and definition of success
• Problem-focused approach with actionable solutions
• Plan for implementation
• Establish resource and organizational commitments for successful implementation
• Create infrastructure to ensure implementation
• Develop system to monitor progress towards measurable objectives

Cross cutting themes and identified needs detailed throughout the reported recommendations and findings include:

• Need for a *comprehensive* statewide planning approach.
• *Expand clinical training* opportunities.
• *Align education and training* programs with priority care and geographic needs *at the state and regional level*.
• *Invest in infrastructure* at the state and regional level to facilitate and monitor collaboration across health and education sectors.
• *Build pathway systems* from K-12 through graduate school with sufficient academic, career and psychosocial support.
• Identify and address *specific needs associated with core problems*, including: behavioral health, allied health professions, nursing, primary care and prevention.
• *Build capacity for data collection and sharing*, technology and resource development.
• *Ensure a focus on increasing diversity* and opportunities for those who are under-represented across all disciplines and relevant sectors.

While every effort was made to be inclusive and comprehensive, the authors acknowledge that there are gaps in information for initiatives documented in this report, as well as other efforts that may have been completely overlooked. This report should be viewed as a “living document” that will be supplemented through the ongoing input of colleagues and stakeholders across the state in the coming months. That having been said, considerable insights were gleaned from this review that have informed the design of the process.
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SECTION ONE

State and Regional Health Workforce Development: Review of Initiatives in Other States
I. Overview

The passage of the Affordable Care Act and movement towards value-based reimbursement have expanded coverage to low and moderate income populations and are creating financial incentives to reduce the demand for high cost clinical care for preventable conditions. These trends, while incremental in application and widely varying across regional markets, have heightened awareness of the limited capacity of the primary care and prevention workforce in California, a growing shortfall that is particularly acute in rural and inner-city communities. The expansion of coverage is also increasing awareness that the current health care delivery system is poorly positioned to address the drivers of poor health in communities; issues ranging from housing quality and affordable healthy food access to the toxic stress caused by low wages, job insecurity, unsafe neighborhoods, and a lack of social support systems.

In addressing this shortfall, there is also growing recognition of the importance of developing robust health career pathways that create opportunities for California residents to build a workforce and to align sectors that better position us to improve health in our increasingly diverse communities. Expanding our health workforce and related sectors is also a sound economic development strategy, providing livable wages that stimulate local economies and stable families that strengthen social fabric.

Both employers and higher education institutions are coming to grips with the reality that a more engaged, cooperative approach to workforce development offers significant potential to reduce costs and uncertainty, and produce the right number of graduates at the right time with the appropriate competencies to improve health and well-being in our communities. Moving in this direction will require substantial adjustments in historical patterns of organizational behavior to build common knowledge and trust, and to align strategies in a manner that both addresses proprietary and public interests.

With these challenges and opportunities in mind, a group of four California health foundations have come together to support the development and implementation of a state health master plan. The plan would serve as a guide for health professions employers, higher education, K-12, government agencies, policymakers, and community-based organizations to better align and focus strategies where needs are the greatest, and to proactively redesign education, training, and recruitment strategies to best meet emerging needs. Goals and objectives in the plan would reflect the shared interests and commitments made by these diverse stakeholders to optimally serve their communities.

The purpose of this inquiry is to provide insights into the experiences and outcomes of other statewide and regional health workforce planning efforts across the country. The examination of these other efforts is intended to inform the design of California’s health workforce master plan by highlighting key lessons learned that are applicable and relevant to our large and diverse state.
II. Methods

This inquiry began with an informal nominating process established through outreach to a variety of key informants. After the identification of candidate processes, an online search was conducted to identify reports, peer review & media articles in selected states and regions. The search was gradually narrowed to 17 processes where there was sufficient information and potential applicability. Analysis focused on various aspects of the planning processes, including, but not limited to the following:

- Content focus (e.g., primary care, behavioral health, diversity, nursing)
- Scope and form of stakeholder and public engagement
- Role and function of lead entity(ies)
- Goals and objectives established and outcomes achieved
- Lessons learned

Both comprehensive and more targeted statewide health workforce planning processes were examined, with an eye towards the applicability of those experiences to inform the development of a statewide health workforce master plan for the state of California.

The findings from this summary report are based upon an in-depth review of publicly available materials. In most cases, available reports focused on outcomes (e.g., recommendations, actions taken on recommendations). Most reports gave limited attention to key elements of the process and the factors that may have contributed to the relative effectiveness of the planning process and/or whether it was linked to a formal implementation process. As we move forward in the state of California, direct inquiries with selected stakeholders in other states may provide additional insights into lessons learned that would inform our own planning and implementation processes.
III. Results

A. Locations and Types of Health Workforce Development Processes

Seventeen health care workforce development processes were identified for inclusion in this inquiry. They included planning processes, implementation processes, and the establishment of formal entities for ongoing assessment. In some cases, planning processes did not result in the launch of an implementation process; in others, implementation processes were launched without evidence of a planning process. Finally, in some cases, an ongoing entity was established to support implementation and periodic reassessment. In general, the three distinct processes relevant to this inquiry might be defined as follows:

- Planning processes are time-limited distinct planning processes initiated to address health care workforce development at the state or regional level. They may vary from one day to several years, and multiple planning reports may be issued during that time to address different aspects of the health care workforce, or update recommendations.

- Implementation processes are activities or actions taken to address priority issues to advance health care workforce development. These processes may or may not have been the result of an identified planning process.

- Ongoing assessment activities are conducted by statewide health care workforce committees or councils that are authorized by the state legislature and tasked with conducting ongoing data collection and analysis, workforce assessment, and providing recommendations for workforce development and improvement at regular intervals.

Seven of the 13 planning processes reviewed for this inquiry led to documented implementation processes. The remaining six planning processes did not appear to result in the launch of an implementation process. A total of four implementation initiatives did not appear to have been the outcome of a documented planning process.

A brief overview of all planning processes, implementation initiatives, and ongoing assessment activities reviewed follows. Processes and relevant entities often include a hyperlink to online materials for convenient review. See Appendix A for a graphic representation of all health care workforce development elements and activities reviewed.

<table>
<thead>
<tr>
<th>Planning Processes Resulting in Implementation</th>
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<tbody>
<tr>
<td><strong>Alaska</strong></td>
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<tr>
<td>Alaska Health Workforce Planning Coalition – This coalition developed the Alaska Health Workforce Plan for the Alaska Workforce Investment Board in May 2010. The coalition also</td>
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created the Alaska Health Workforce Coalition Action Agenda 2012 – 2015 to implement the plan. The Coalition maintains a scorecard to track and measure progress toward Action Agenda priorities and objectives. The coalition is currently developing the 2017-2021 version of the Action Agenda in response to changing priorities due to Medicaid expansion and reform.

Massachusetts
Allied Health-Direct Care Workforce Plan – conducted by the Massachusetts Board of Higher Education’s Vision Project in 2014 to develop a workforce pipeline to meet health care workforce needs. The Allied Health Advisory Group was established in 2015 to create an implementation plan for the recommendations.

Minnesota
Minnesota Legislative Health Care Workforce Commission – Established in Legislature ML 2014, Ch 312, Art 30, Sec 3, Subd 3 in 2014. Committee is comprised of five members of the Senate and five members of the House of Representatives; reported annually to the Legislature from 2014 – 2016. Committee recommendations were implemented through legislation over the three years. Legislative authority for the commission sunset in 2016; final recommendations included continued workforce development activities.

New Jersey
New Jersey Health Care Workforce Council – Established in 2010 through a New Jersey State Health Workforce Development Planning Grant makes recommendations to the State Employment Training Commission. The New Jersey Health Care Talent Network, one of seven industry New Jersey Talent Networks that foster partnership with industry employers, was also established through the planning grant process; the Health Care Talent Network is an ongoing, active initiative.

Oregon
Oregon Health Workforce Committee – Established in 2010 by House Bill 2009, Section 7(3)(a) to develop health care work force recommendations and action plans for implementation by the Oregon Health Policy Board, the oversight and policy-making body of the Oregon Health Authority. The Committee has completed and continues to work on multiple recommendations and reports on the Oregon health care workforce. Committee recommendations have been implemented through multiple pieces of legislation; see Appendix B for detail. The work of the Oregon Health Workforce Committee is ongoing.

Vermont
Health Care Workforce Work Group – Created from the Vermont Health Care Workforce Strategic Plan (2013). The Director of Health Care Reform in Agency of Administration is charged with developing and maintaining the strategic plan. The Health Care Workforce Work Group is housed within the Health Care Innovation Project. The Green Mountain Care Board is tasked with annually reviewing and approving the strategic plan. This initiative is ongoing.
**Washington State**
Washington Health Workforce Council – The Governor tasked the Workforce Training and Education Coordinating Board with creating the Healthcare Personnel Shortage Task Force in 2002; the Task Force issued Healthcare Personnel Shortages: Crisis or Opportunity in 2002, a strategic plan to address health care workforce shortages. In 2003 the Legislature passed the Engrossed Senate House Bill 1852 that tasked the Workforce Board with convening the Health Workforce Council to track and update the state’s strategic plan, and report to the Legislature on an annual basis. This is an ongoing initiative.

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**Planning Processes with No Evidence of Implementation**

**Maryland**
Preparing Maryland’s Workforce for Health Reform: Health Care 2020 – was issued in 2010 through a US Health and Human Services Health Resources and Administration Health Care Workforce Development Planning Grant.

**Massachusetts**
State of the Healthcare Workforce in Massachusetts: Challenges, Opportunities, and Federal Funding – A planning process driven by four health care funders with a focus on leveraging federal funds for health care workforce development in Massachusetts. The report was released in January 2017.

**Michigan**

Proceeding from Re-Imagining Michigan’s Primary Care Workforce – The Michigan Health Council convened over 120 health care leaders in 2015 to prioritize recommendations to expand the primary care workforce.

**New Hampshire**

**New York**
Transforming the Health Workforce for a New New York – was issued in 2012 through a US Health and Human Services Health Resources and Administration Health Care Workforce Development Planning Grant. The state planned to subsequently apply for an Implementation Grant, but funding was not allocated in the federal budget.
Implementation with No Evidence of Prior Planning Processes

**Michigan**
Michigan Health Care Workforce Center – Housed in the Michigan Department of Community Health (MDCH), a collaboration with the Department of Labor and Economic Growth created in 2006 to address identified needs in the MDCH Survey of Physicians 2005.\(^1,2\)

**New Hampshire**
New Hampshire Profession Opportunity Project – A five-year initiative to train Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals for jobs in the health care workforce, and assisted those individuals with job placement from 2010 – 2015.

**New Mexico**
The New Mexico Health Care Workforce Committee was established in 2012 when the Legislature amended the Health Work Force Data Collection, Analysis and Policy Act to provide the University of New Mexico Health Sciences Center access to data from the Department of Health. UNM was charged with convening the Committee and reporting annually to the Legislature on health care workforce needs and priorities, and to make recommendations for workforce improvement. This effort is ongoing.

**Virginia**
Virginia Health Workforce Development Authority – The Virginia Department of Health received a Health Resources and Services Administration (HRSA) Affordable Care Act State Health Care Workforce Implementation Grant to launch the Virginia Health Workforce Development Authority implementation initiative.\(^3\) HRSA applicants were eligible to apply for implementation grants without having first received a planning grant if sufficient planning and partnerships to complete activities during the implementation period were demonstrated on the grant application.\(^4\) While there are active social media postings, a recent indication that a new intern was engaged, and the website copyright is current, it is unclear whether implementation activities are in play.

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1. Given the timeline and leadership role of the Department of Community Health and Department of Labor and Economic Growth in both the 2004 planning process and 2006 launch of the Michigan Health Care Workforce Center, it seems likely that the 2004 planning process played a role in informing the implementation initiative, however, the authors were unable to identify public documentation clearly connecting the two activities.

2. The current activity level of the Workforce Center is unclear; the website has a current copyright for 2017, with the most recent post being a 2016 survey published on the Michigan Public Health Institute website, and most recent publications posted from 2013. Email request for clarification did not receive a response.


Seventeen health care workforce development planning and implementation processes were analyzed from thirteen states: Alaska, Maryland, Massachusetts, Minneapolis, Michigan, New Hampshire, New Jersey, New Mexico, New York, Oregon, Vermont, Virginia and Washington State. Of the 17 processes, we identified 13 distinct health care workforce development planning processes: AK, MD, MA (two), MI (two), MN, NH, NJ, NY, OR, VT, WA. Seven of these 13 planning processes led to implementation (AK, MA 2014, MN, NJ, OR, VT, WA); 6 of the planning processes did not result in documented implementation activities (MA 2017, MD, two MI, NH, NY). Six of the seven planning processes that led to implementation have clear, transparent progress tracking mechanisms that range from a public scorecard (AK), to a summary progress report (MA 2014), to annual reports to the legislature (MN, VT, WA), to biennial reports to the legislature (OR). The remaining one of seven planning processes that led to implementation (NJ) included an external evaluation component to the planning process, conducted by the Rutgers State Health Policy Center.5

Distinct, ongoing implementation activities were identified from four of the 13 states (MI, NH, NM, and VA) that do not include clear documentation of any associated planning processes. One of the four ongoing implementation initiatives (NM) conducts reporting on the health care workforce annually to the legislature, including short- and long-term recommendations on health workforce improvement, incentives, and development. The other three of four ongoing implementation initiatives do not have clear mechanisms for accountability and reporting on progress toward objectives. None of the seven planning processes that did not lead to implementation included accountability or tracking measures; outcomes of these plans beyond documentation of the planning process are unclear.

Six of the seven planning process that were implemented are currently ongoing implementation initiatives that are supported by a formal entity established by the state (AK, MA 2014, NJ, OR, VT, WA; all but MN where the Commission sunset December 31, 2016, and called for establishment of such a body in its final recommendations). One of the four ongoing implementation processes that began without a clear planning processes (NM and VA) are currently active, ongoing initiatives; one of these four initiatives (NH) was an implementation project with a clearly defined project with a five-year implementation timeframe.

Fourteen of the 17 planning and implementation processes comprehensively addressed the full scope of the health care workforce; one (MI) focused on primary care; and two (MA 2014, NH implementation) focus on Allied Health (including, specifically in NH: Long-term Care, Child Care Health Advocacy, Health Information Technology and Nursing).


B. Impetus for Planning/Implementation Processes

Stated reasons for the launch of planning, implementation, or oversight activities in most states was to meet the demand for health care. In many states the stated imperative to meet that demand was further driven by anticipation of increased health care coverage associated with the implementation of the Affordable Care Act (AK, MD, MI 2015 – primary care specific plan, NY, OR). In Washington state, current shortages in the health care workforce were identified as an imperative. The importance of the health care industry to the state economy was also cited in several states as a driver in launching health care workforce development activities (AK, MI 2004 – comprehensive plan, NY).

Additional drivers for health care workforce development included: meeting the needs of an increasingly diverse population (MA 2014, NH, OR), increasing the diversity of the health care workforce and creating job opportunities for low-income individuals (NH), meeting the health care needs of an aging population and dealing with the challenges of an aging health care workforce (MA 2014, MI, WA), achieving the triple aim of care, health, and cost (NH, OR, VT), addressing health disparities and reducing health care costs (NH), and filling high vacancy rates for health care workers (AK).

The impetus for ongoing reporting/planning/implementation in NM was unclear. Part of the impetus for the implementation plan in VA was loss of federal funding for the state’s Area Health Education Centers, prompting the creation of the Virginia Health Workforce Development Authority to act as lead agency and State AHEC Program Office.7

C. Lead Planning Organizations

Ten of the 13 planning processes were initiated through the Executive Branch of state governments, with nonprofit organizations, or independent or academic public policy research institutes playing a secondary leading role in six out of those 10 planning processes.8 The Labor Department was the lead agency in six out of the 10 planning processes led by the Executive Branch (AK, MD, MI 2004, NJ, NY, WA) with the Workforce Investment Board specifically being the lead agency in four of those six processes (AK, MD, NJ, NY)9; the Department of

8 Primary lead agencies are defined here as agencies that received the funding to conduct the planning process, commissioned the plan or otherwise instigated the planning process, or whose endorsement or approval of the plan was critical to its implementation – they are the agencies that house or own the planning process. Many such plans relied on other organizations or coalitions to do the work of research and engaging in the planning process; these additional lead organizations and their roles are detailed below.
9 These four planning processes were funded through Affordable Care Act U.S. Department of Health and Human Services Health Resources and Services Administration State Healthcare Workforce Planning Grants. New Jersey State Employment and Training Commission (2011) states that WIB-led planning grants were the minority; the authors of this report were unable to find a comprehensive list of grantees awarded funds through this grant opportunity. We are reporting here details of planning processes that have publicly available information; data
Health/Human Services was the lead agency for one of the 10 planning processes (OR); the Education Department was the lead agency for one (MA 2014) of the 10 planning process; and the Agency of Administration was the lead agency for one of the 10 planning process (VT).

The Governor’s Office specifically played a role in three of the 13 planning and implementation processes (MI 2004, OR, MD). The Governor’s Office in the MD planning process played a particularly influential role, as the Workforce Investment Board is Governor-appointed. Three of the 13 planning processes were initiated outside of the state executive branch. MN was initiated and implemented through the State Legislature; MA 2017 was initiated by a collaborative of four health care foundations; NH was primarily led by an academic research center with the State Department of Health and Human Services acting as co-lead and co-author of research reports; MI 2015 was led by a nonprofit organization and consisted of a one-time large-scale convening of over 120 health care leaders. Only two of the 13 planning processes (MN, MI 2015) were initiated and led by groups outside of the state government. Of the 11 planning processes led by state government, non-profit or academic institutions or research centers played a secondary, complementary leading role in seven (AK, MI 2004, NH, NJ, NY, VT, WA) – two nonprofit (MI 2004, VT) and five academic.

A full breakdown of the lead agencies – including leading supportive or secondary organizations – engaged in planning processes follows in Table 1. (See Appendix A for a breakdown of all stakeholders involved in each planning process.)

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presented here does not reflect a comprehensive review of all health care workforce development planning processes conducted to date.
Table 1. Lead Planning Agencies/Organizations

*Italics indicates primary lead*

<table>
<thead>
<tr>
<th>State</th>
<th>Executive Branch</th>
<th>Legislative Branch</th>
<th>Nonprofit</th>
<th>Academic</th>
<th>Foundations</th>
<th>Coalition/Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>AK</td>
<td>Labor (Workforce Investment Board - WIB and Health)</td>
<td>State Executive Branch</td>
<td>University of Alaska Anchorage</td>
<td>Alaska Mental Health Trust Authority 10</td>
<td>AK Health Workforce Planning Coalition (public-private; AK Hospital &amp; Nursing Home Assoc. coalition lead on plg. grant)</td>
<td></td>
</tr>
<tr>
<td>MA (2014)</td>
<td>Education (Board of Higher Ed)</td>
<td>Legislative Council</td>
<td>Barr; Boston; BCBS of MA; Tufts Health Plan</td>
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<td></td>
<td></td>
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<tr>
<td>MD</td>
<td>Labor (WIB)</td>
<td></td>
<td></td>
<td></td>
<td>Steering Committee (Governor appointed)</td>
<td></td>
</tr>
<tr>
<td>MI (2015)</td>
<td>MI Health Council</td>
<td></td>
<td></td>
<td></td>
<td>Convened 120 health care leaders</td>
<td></td>
</tr>
<tr>
<td>MN</td>
<td>Legislative Health Workforce Commission</td>
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<tr>
<td>NH</td>
<td>Health (Office of Minority Health &amp; Refugee Affairs)</td>
<td>Legislative Council</td>
<td>Institute on Assets and Social Policy at Brandeis University</td>
<td></td>
<td>Health Workforce Council</td>
<td></td>
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<tr>
<td>NJ</td>
<td>Labor (WIB)</td>
<td></td>
<td>Rutgers Center for State Health Policy</td>
<td></td>
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<tr>
<td>NY</td>
<td>Labor (WIB)</td>
<td></td>
<td>Center for Health Workforce Studies, SPH, SUNY, Albany</td>
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<tr>
<td>OR</td>
<td>Health (Health Authority, Office of Health Policy)</td>
<td></td>
<td></td>
<td></td>
<td>Health Care Workforce Committee (Board appointed)</td>
<td></td>
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<tr>
<td>VT</td>
<td>Agency of Administration and Health</td>
<td>Legislative Council</td>
<td>JSI Research &amp; Training Institute</td>
<td>U. of Vermont AHEC Program</td>
<td>HC Workforce Work Group (multi-stakeholder)</td>
<td></td>
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<tr>
<td>WA</td>
<td>Labor (Workforce Training &amp; ED Coordinating Board)</td>
<td></td>
<td>Bates Technical College &amp; Washington State University</td>
<td></td>
<td>Health Care Personnel Shortage Task Force</td>
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10 According to the Mission Statement of the Alaska Mental Health Trust Authority, it is: “a state corporation that administers the Alaska Mental Health Trust, a perpetual trust, to improve the lives of the beneficiaries. The Trust operates much like a private foundation, using its resources to ensure that Alaska has a comprehensive integrated mental health program” ([http://mhtrust.org/about/mission/](http://mhtrust.org/about/mission/)). It should be noted that the Mental Health Trust Authority is categorized as a State of Alaska, Core Member of the AK Health Workforce Coalition in the Action Agenda. It is listed here as a foundation because of its role in funding the Director of the Coalition, and its stated function as a private foundation in the mission statement.
Of the five planning processes in which academic policy/research centers had a leading (primary or secondary) role, two (NH, NY) conducted data collection and analysis. The role of the academic partner in AK is to administratively house the Director of the coalition. Independent evaluation for the planning process was provided by the academic partner in NJ. The Chair of the 2002 planning task force in WA was the President of Bates Technical College. Two states engaged four lead planning entities. The Vermont Health Care Workforce Strategic Plan was created by the Health Care Workforce Work Group with consultative support from a nonprofit research institute, and financial support from the State Health Department and the University Area Health Education Center Program. The Alaska planning process included the executive branch (Departments of Labor and Health), foundation (see footnote 11), academic, and engagement of a public-private coalition.

Alaska appears to be the only state plan that produced an actionable agenda with a transparent mechanism to measure and track progress outside of the State Legislature. The scorecard tracking mechanism is used to monitor progress at four-to-six month intervals, and created an ongoing system for holding stakeholders accountable for the established goals. Alaska Health Workforce Coalition: Lessons Learned, explains that the three initial key lead agencies (Alaska Mental Health Trust Authority, the University of Alaska, and Department of Health and Social Services) were compelled to engage in this work by adherence to their respective missions, but were also successful due to the trust and collaborative attitude among the stakeholders. The Workforce Plan initially developed by the Coalition was endorsed by the Alaska Workforce Investment Board; and the Alaska Department of Labor and Workforce Development then secured funding to develop the Action Plan to implement the Workforce Plan. Of further note is the role of the Alaska Mental Health Trust Authority that functions as a private foundation and funds the Director position of the Healthcare Workforce Coalition; this represents the only example among the plans reviewed of local or regional foundation buy-in to implementation of the planning process.

Three of the four implementation initiatives that were not the outgrowth of distinct planning processes (NM Health Care Workforce Committee, OR Health Care Workforce Committee, and VA Health Work Force Development Authority) were established by their state legislatures for ongoing health care workforce assessment and implementation. The fourth, the New Hampshire Department of Health and Human Services Office of Minority Health and Refugee Affairs serves as the implementation agency for a specific project (Health Profession Opportunity Project). The University of New Mexico is charged with health care workforce data collection and analysis, and for convening the Health Workforce Committee (2012 legislation transferred this responsibility from the Department of Health to the Chancellor of Health Science at UNM).

12 Ibid (Pg. 3).
13 Funders did buy into the planning process of MA 2017, but that plan has not yet been implemented.
D. Staffing & Funding Support

The planning processes were staffed by lead organization or agency staff, and/or relied on staff from stakeholder agencies engaged. Staffing levels and capacity are directly tied to funding levels. All planning and implementation processes relied on a combination of project funded and/or agency assigned staff, and volunteer in-kind contributions from stakeholders. The specific breakdown of staffing patterns and funding levels for planning processes that led to implementation, planning process for which no implementation process was identified, and ongoing implementation processes is described in detail below.

The most common funding source for health care workforce development in the states were the Affordable Care Act State Healthcare Workforce Planning and Implementation grants administered by the US Department of Health and Human Services Health Resources and Services Administration (AK, MD, NY, VA). Only one state, VA, received an implementation grant. New York state anticipated a subsequent implementation grant to implement planning activities, and altered their scope and planning process when implementation funds were not appropriated. Other federal grant funding sources included: HRSA Rural Health Models and Innovations (AK), and HHS Office of Planning, Research and Evaluation, Administration for Children and Families – University Partnership Research Grants for the Health Profession Opportunity Grants Program of the Affordable Care Act (NH).

It appears that private philanthropy is only engaged in two initiatives – AK and MA 2017. Some implementation activities appear to be carried out without dedicated funds (e.g., NM and WA), despite the fact that recommendations call for additional support. In some cases, state agencies appear to have continued some level of activities without dedicated funding due to statutory responsibility. Only two processes (VA and MA 2014) included sub-grants for implementing activities.

Planning Processes Resulting in Implementation

Three of the seven planning processes that led to implementation created a coordinator or director position to lead the effort – with the Alaska Coordinator administratively housed by the University of Alaska, and Massachusetts and Vermont Directors housed within government departments. Two of the seven processes, are committee (OR) or commission (MN) led with support from government staff. All of the planning processes that resulted in implementation, detailed below, are supported by state government staff or funding.

Alaska

The Alaska Health Workforce Planning Coalition is staffed by a Director who is funded by the Alaska Mental Health Trust Authority. The initial Alaska Health Workforce Plan was developed by the Coalition members. The Alaska Department of Labor and Workforce Development then received a $150,000 Affordable Care Act U.S. Department of Health and Human Services Health Resources and Services Administration State Healthcare Workforce Planning Grants (HRSA Planning Grant), with the Alaska State Hospital and Nursing Home Association as the coalition lead on the grant. The HRSA Planning Grant and members provided the funding to hire
dedicated staff to develop the Action Agenda and Implementation Plan.14 Staff included a fulltime Coalition Coordinator employed by the ASHNHA and a consultant. Coalition members also contributed in kind staff time.15

Massachusetts
The MA Department of Higher Education created the Director of Healthcare Workforce Development position in 2015 to implement the Allied Health-Direct Care Workforce Plan that was approved by the MA Board of Higher Education in 2014.16 The Director regularly convenes stakeholders through the Allied Health Advisory Group Council to develop implementation recommendations. The Allied Health Advisory Group Council is comprised of 82 stakeholders representing academia (community and four-year colleges), employers, industry, regional employment boards, and state agencies; the group meets quarterly with an average of 32 members attending each of the four meetings in 2015-2016.17 The Allied Health Advisory Group issued two rounds of grant funding (making a total of $200,000 available in each round) focusing on development of career pathways and core competencies in public institutions of higher education; the funding opportunities particularly encouraged strategies for regional and/or statewide systems change.18

Minnesota
The Minnesota Legislative Health Care Workforce Commission includes five members of the Senate and five members of the House of Representatives,19 and is supported by legislative staff and staff from the Minnesota Department of Health.20 The legislature made a one-time appropriation of $75,000 in fiscal year 2015, expiring June 30, 2017, for the Health Care Workforce Commission.21

New Jersey
The Department of Labor and Workforce, New Jersey State Employment and Training Commission, received a HRSA Planning Grant to convene the New Jersey Health Care Workforce Council. Matching funds additionally support staff (in addition to other resources);

15 Alaska Health Workforce Coalition: Implementation Plan. (2011). Retrieved from https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVMYXVsdsGRvbWFpbnxhGfza2FoZWFsdGh3b3JrZm9yY2Vjb2FsaXRpbs258Z3g6NzYwYTUxZWFhM2M5YzI5NA.
16 Unable to determine funding allocated for staffing.
council members contributed time in-kind. The New Jersey State Employment and Training Commission staff supported the council in implementation.  

The new Jersey Department of Labor and Workforce Development maintains the Health Care Talent Network which is staffed by a Director and Co-Director.

**Oregon**
The Oregon Health Workforce Committee is support by senior-level staff from the Health Policy and Analytics Division of the Oregon Health Authority. Members are appointed to the Committee by the Oregon Health Policy Board for three year terms; members of the committee are not compensated, but are reimbursed for travel expenses.

**Vermont**
State of Vermont Act 48 (H.202) created the Director of Health Care Reform Position in the Agency of Administration (Section 1b), and tasked the Director “to oversee development and maintenance of a current health care workforce development strategic plan” (Section 12a). The Vermont Health Care Workforce Strategic Plan was funded by the Vermont Department of Health, Office of Rural Health and Primary, and the University of Vermont Area Health Education Center Program, and received consultation services from the JSI Research and Training Institute.

**Washington State**
The Washington Health Workforce Council staff includes a Coordinator and Administrator, both who are employed through the Workforce Training and Education Coordinating Board. The Health Workforce Council 2016 Annual Report included a recommendation for dedicated staff support at 1.5 FTE for the Council, noting that the recommendation has been made in prior years, and that Workforce Board is statutorily charged with staffing the council without funding since 2012 when previously received grant funds were terminated.

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Planning Processes with No Evidence of Implementation

Three of the six planning processes that did not result in identified implementation activities were funded through HHS grants – two (MD and NY) through HRSA Planning Grants, and one (NH) through a Office of Planning, Research and Evaluation, Administration for Children and Families - University Partnership Research Grants for the Health Profession Opportunity Grant. These HHS grant opportunities were available to support increase in health care utilization as a result of the ACA. Among the other two planning processes, one (MI) was funded through a government department, and one (MA) through a consortium of regional funders.

Maryland
The Governor’s Workforce Investment Board received a one-year $150,000 HRSA Planning Grant to develop Preparing Maryland’s Workforce for Health Reform: Health Care 2020. The plan was developed by the GWIB with input from the Health Care Workforce Planning Grant Steering Committee with the Health Care Reform Coordinating Council and Governor’s Office of Health Care Reform listed as core planning and implementation agencies. Staffing levels of the planning process were not specified in the planning document.

Massachusetts
State of the Healthcare Workforce in Massachusetts: Challenges, Opportunities, and Federal Funding is one of a series of three reports conducted by Jobs for the Future, commissioned by a consortium of four regional funders: the Barr Foundation, the Boston Foundation, the Blue Cross Blue Shield of Massachusetts Foundation, and the Tufts Health Plan Foundation. Staffing and funding levels are unclear from the report document.

Michigan
The Michigan Department of Labor & Economic Growth commissioned a private organization, Public Policy Associates, Inc. to prepare the Final Report on Health Care Workforce Development in Michigan (2004). Public Policy Associates staff were supported by staff from the Michigan Department of Labor and Economic Growth and Michigan Department of Community Health. Specific funding and staffing levels for this planning process are unclear. The Michigan Health Council convened over 120 health care leaders and issued a report entitled Proceedings from Re-Imagining Michigan’s Primary Care Workforce. The staffing and funding level for this planning process are unclear.

New Hampshire
The Health Care Employer Research Initiative was conducted by staff from the Institute on Assets and Social Policy at the Heller School for Social Policy and Management at Brandeis University in collaboration with New Hampshire Health Profession Opportunity Project staff from the New Hampshire Office of Minority Health and Refugee Affairs, Office of Minority Health and Refugee Affairs. Funding for this initiative came from the US HHS Office of Planning, Research and Evaluation, Administration for Children and Families - University Partnership Research Grants for the Health Profession Opportunity Grants (HPOG) Program of the Affordable Care Act (ACA).
New York
Transforming the Health Workforce for a New New York was conducted through a $150,000 US Health and Human Services Health Resources and Administration Health Care Workforce Development Planning Grant. The state had planned to subsequently apply for an Implementation Grant, but funding was not allocated in the federal budget. The planning process was staffed by the New York State Department of Labor which assigned a staff member to each of five workgroups that were led by a nominated or volunteer from participating stakeholder agencies. The Center for Health Workforce Studies at the School of Public Health, State University of New York, Albany was commissioned to support the data collection and analysis needs of the project.

Implementation with No Evidence of Prior Planning Processes

Michigan
Michigan Health Care Workforce Center is staffed by the Michigan Department of Health and Human Services. Staffing and funding levels are unclear.

New Hampshire
The New Hampshire Profession Opportunity Project was a five-year initiative funded through US HHS Administration of Children and Families, a funding opportunity authorized by the ACA. The funding award was for close to $12 million over 5 years, with $2.38 million awarded in the first year. The majority of funds were directly for program participants, for tuition assistance and other supportive services. The project was staffed by the NH Department of Health and Human Services, Office of Minority Health and Refugee Affairs; a contract was awarded to Ascentria Care Alliance of New England for delivery of the Case Management & Training component of HPOP.

New Mexico
The New Mexico Health Care Workforce Committee is not funded, though the committee has made funding one of their recommendations to the legislature in their last three annual reports (2014, 2015, and 2016). The University of New Mexico is responsible for convening the Committee and providing annual reports to the Legislature.

Virginia
Virginia Health Workforce Development Authority received $1.93 million in funding through a Health Resources and Services Administration (HRSA) Affordable Care Act State Health Care Workforce Implementation Grant to launch the Virginia Health Workforce Development Authority implementation initiative.29 This is the only HRSA implementation grant that was awarded. $1,000,000 of the funds were allocated as pass-through grants for community-based projects. The Health Workforce Development Authority is staffed by an Executive Director, with support from additional staff and Board. Current funding levels and sources are unclear.

E. Stakeholder Engagement

All planning processes relied on engagement of diverse stakeholders. Stakeholder groups engaged include government agencies, academic institutions, health care industry groups, health care professional associations, organized labor and workforce development associations, non-profit organizations, civil rights organizations, and philanthropic foundations. Stakeholder groups engaged in the workforce development planning processes are detailed in Appendix A.

All planning processes included the state Department of Health and Human Services/State Health Department. None included local health departments, but New York did include the State Association of County Health Officials. The implemented New Hampshire Office of Minority Health and Refugee Affairs within the Department of Health and Human Services led the implemented Profession Opportunity Project and played a leading role in the subsequent 4-year research initiative conducted with the Institute on Assets and Social Policy at Brandeis University. Notably, equivalent offices of minority health, health disparities, or health equity and inclusion from other states did not appear to be involved in planning or implementation processes. The Department of Education appears to have been an under-engaged relevant public sector agency, included in only three planning processes (AK, MD, NY) and three implementation processes (AK, MI, NH) as compared to Department of Labor.

The specific forms of engagement of employers is difficult to ascertain from public documents, though both the MA 2014 Department of Education process and the New Jersey Healthcare Workforce Council appear to have secured ongoing engagement. An external evaluation of the New Jersey process indicates that stakeholders felt their needs were addressed. In general, it is notable that there was generally little detail provided about the methodology and process for stakeholder engagement. The lack of detail extends to the decision-making process, as well as the expectations of stakeholders. More information is needed regarding how stakeholder input was ultimately incorporated into plan recommendations and implementation activities, as well as changes they made to enhance workforce development efforts. Methods for engagement documented included: conducting stakeholder interviews, regional listening sessions, convening work groups, and convening a public summit.

The types of meetings ranged considerably from the MD “Health Care 2020 Summit” that sought to validate the plan with stakeholders (after having conducted regional listening tours and directly soliciting recommendations and guidance from stakeholders), to the MI convening that engaged 120 stakeholders in the primary care workforce planning process that solicited their input on six recommendations for consideration. The New Hampshire planning process included a literature review, qualitative interviews with over 100 stakeholders, ongoing meetings, and a public presentation of findings (that had been vetted by key partners at various stages of the research process). The NY planning process convened five work groups. The WA Health Workforce Council holds meetings open to the public at least two times a year. The Michigan stakeholder engagement included interviews with health care leaders, focus groups,
and surveys of hospital, nursing home and human resources officials to provide insight into the health care workforce and health care workforce development.

IV. Discussion

There are limited lessons to be drawn from experiences to date in the development and implementation of state and regional health workforce planning processes, in part because most public reporting focuses primarily on the description of the process, and almost not at all on what worked, what didn’t, and why. There is also limited information on what kinds of changes may be needed in the way that stakeholders do business in order to enhance workforce development efforts. Examples include, but are not limited to ways in which employers may coordinate efforts at the regional level, coordinated strategies to expand health career pathways, and better alignment of academic programs and clinical placements. For the most part, most processes appear to focus primarily upon strategies to expand pools of desired health professionals while retaining legacy practices.

In addition to limited detailed documentation of the stakeholder engagement process, integration of input into recommendations, and associated expectations, there is little information regarding mechanisms to hold agencies and other stakeholders accountable for implementing stated objectives. A few notable exceptions with clear mechanisms for accountability that are transparent to the public include Alaska, New Mexico, Oregon, Virginia, and Washington. In the cases of NM and VA (implementation processes without clearly documented planning processes), and MN, OR, VT, and WA (planning processes that led to implementation), the implementation processes are codified through the state legislature, which creates a system for tracking and accountability. The New Mexico legislature tasks the Health Care Workforce Committee with conducting an annual assessment of the health care workforce that is reported to the state legislature with committee recommendations to improve the workforce. Annual reports are available to the public. The Committee holds the legislature accountable by reporting on progress annually, and assessing the state of the workforce in light of the recommendations made in previous years – noting whether or not those recommendations have been adopted. Similarly, the OR Health Care Workforce Committee reports to the state legislature. In VA, the Public Auditor reports to the Governor and Legislature on the VA Health Work Force Development Authority, thereby holding the Authority accountable.

AK represents an alternative model to the formal legislative accountability mechanism.30 The Alaska Health Workforce Coalition online scorecard lists all priorities and objectives from the action agenda with specified timeline, who is accountable, and the status (new initiative, completed, on track, need to address, or goal missed). This is a clear, simple, transparent

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tracking mechanism that builds in accountability among stakeholders. Let’s Get Healthy CA’s online progress tracking of featured indicators is another clear, simple, model to consider of a clear progress tracking mechanism readily available to all, that serves as an accountability mechanism.31

Whether through a formal legislative process, or a simplified public document, establishing a system of accountability for acting on plan recommendations and achieving plan goals is critical to implementing health care workforce development plans, making progress on goals, communicating progress to key stakeholders and the general public, and for future workforce assessment. Many of the plans reviewed appeared to either sit on the shelf, or likely led to developments that were made in the state – but those initiatives could not be easily or clearly credited back to the planning process.

With the exception of the Health Care Workforce Development in Michigan Final Report issued in 2004, all other planning or implementation initiatives began in 2010 or more recently. This timeline aligns with the impetus of increased health care demand created through the Affordable Care Act, and was cited as the core basis for engaging in health care workforce development by many of the states. It is not clear, however, the degree and manner in which stakeholders were engaged in a process of projecting future workforce needs in the context of changes in financing and associated incentives. Among other issues beginning to come in play are the ways in which health care providers begin to engage more deeply with diverse stakeholders in communities to address the drivers of poor health, most of which lie well outside of the delivery clinical services.

What kinds of workforce needs will emerge as employers begin to grapple with acute care facilities shifting from revenue centers to cost centers, with an increasing imperative to engage and coordinate services, data collection, and actions across sectors? In most cases, planning and implementation processes appear to assume that core functions and associated demands remain relatively constant, with only a gradual trend towards increased engagement of physician extenders and allied health workers such as medical assistants and community health workers to support management of patient panels.

Going forward, state and regional health workforce development planning and implementation processes will be well advised to establish more clear objectives that are informed by a robust examination of emerging trends and their implications. There is also a need for a more holistic, ecological analysis of workforce supply and demand; not just at the state level, but in different regions, particularly in a state as large and diverse in demographic terms as California. This analysis should lead dialogue among the educational institutions and employers towards a much deeper consideration of how to both meet their organization needs and move beyond proprietary interests. Such an approach offers significant potential to yield significant cost savings through increased efficiency and reduced disruption that has resulted from the differential expression of economic power and fragmented interests.

There is a clear role for state public sector agencies, as well as the legislative and executive branches in supporting the design, the collection of data, the monitoring of processes, and the allocation of resources and associated incentives to encourage optimal organizational behavior. At the same time, there is a clear *need for a more thoughtful and active engagement of key private sector stakeholders and the public at large to design, support, and implement strategies* that make optimal use of available resources.

There is no question that prior health workforce planning and development efforts documented in this report represent serious efforts to serve the public interest. Moving forward, it has become increasingly clear that a *more balanced approach – one in which there is shared ownership and commitment among public and private sector stakeholders for meaningful change*, offers the most promising path towards building the health workforce needed to improve health in our increasingly diverse communities.
**Appendix A: Matrix of Stakeholder Engagement**

**Key**

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<td><em>O</em> = ownership for implementation initiative</td>
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<td>^Stakeholders engaged in planning process not identified in plan documentation</td>
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*a*Planning processes that led to distinct implementation process both processes documented; stakeholders varied slightly

x = participating stakeholder

Stakeholders from ongoing initiatives taken from most recent documentation

O = ownership, lead agency housing or administering initiative

O* = ownership for implementation initiative
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Appendix B: Legislation

The following is a list of legislative actions that authorized health care workforce councils/committees, charged those councils/committees with specific responsibilities, and implemented the workforce planning recommendations of those councils/committees.

Authorizing and/or Charging Statewide Health Care Workforce Bodies

- Minnesota Health Care Workforce Commission: Minnesota Laws 2014, Ch 312, Art 30, Sec 3, Subd 3
- Oregon Health Workforce Committee:
  - HB 3396, Provider Incentive Recommendations
  - House Bill 2009, Section 7(3)(a)
- Virginia Health Workforce Development Authority: Code of Virginia 32.1-122.7
- Vermont Health Care Workforce; Strategic Plan: Act 48, Section, 12a
- Washington Health Workforce Council: 2003 Engrossed Senate House Bill 1852

Implementation of Health Workforce Planning Recommendations

- 2016 Final Report on Strengthening Minnesota’s Health Care Workforce outlines legislation successfully introduced in the 2015 Legislature directly related to recommendations made by the Legislative Health Care Workforce Commission:
  - Loan forgiveness program expanded
  - Primary care residency expansion grant program created
  - International Medical Graduates Assistance program created
  - Mental Health Workforce Summit recommendations partially enacted
  - Telemedicine expanded and interstate physician licensure compact passed
  - Medicaid long term care reform enacted, with significant workforce implications
  - PIPELINE project for health care apprenticeship programs enacted
• $15 million appropriated for University of Minnesota Medical School, in part dedicated to physician workforce programs\textsuperscript{32}

• Oregon Health Workforce Committee\textsuperscript{33}
  o SB 879 (2011) standardizing administrative requirements for student clinical placement through Oregon Administrative Rule 409-030
  o HB 3650 (2011) establishing the Traditional Health Worker Commission
  o HB 3341 (2012) adverse impact law repeal


Appendix C: Additional Documents of Interest

Plan Evaluation

• Rutgers Center for State Health: Evaluation of the New Jersey Health Care Workforce Development Project – Interviews with members of Health Care Workforce Council of New Jersey\(^34\) – The New Jersey State Health Workforce Development Planning Grant process included an independent evaluation by the Rutgers Center for State Health Policy that was completed in August 2011. The Council intended to use the report to inform establishing next steps coming out of the planning process.\(^35\)

Documentation of Lessons Learned

• Alaska Health Workforce Coalition: Lessons Learned – Issued in 2012, lessons learned provides a review of the first three years of the Alaska Health Workforce Coalition.\(^36\)

Implementation Plans

• Alaska Health Workforce Coalition Implementation Plan – Released in Sept. 2011, the Implementation Plan complemented the Action Agenda and included a series of issue papers on: Background Check Program; Health Workforce and Registered Apprenticeships; Health Workforce Data; Professional Licensing.\(^37\)

• Massachusetts Allied Health Advisory Committee Proposed Goals and Themes – The Allied Health Advisory Group was convened to create an implementation plan based on the recommendations of the Allied Health-Direct Care Workforce Plan. The proposed goals and themes document outlines short-term (six to 18 month) and long term (18 to 24 month) goals based on the stated goals in the workforce plan report.\(^38\)

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\(^37\) Alaska Health Workforce Coalition: Implementation Plan. (2011). Retrieved from https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxhbGFza2FoZWFsdGh3b3JrZm9yY2Vjb2lsaXRpb28bZ3g6Nz4wYTuxZWFhM2M5YzI5NA

SECTION TWO

The California Experience: Review of Statewide Health Workforce Planning and Development Initiatives
I. Overview

Over the past 15 years there have been numerous statewide health workforce and diversity initiatives in California. Key factors providing the impetus for action and a sample of examples include:

- **Growing health workforce shortages in key professions and regions.**
- **Under-representation** of major population groups in the health professions and health professions training programs.
- **Expansion** of the health care sector and increased demand for workers.

The University of California launched a system-wide study and issued a report in 2005 that outlined challenges and opportunities for its Health Sciences Education programs and offered a set of recommendations for enrollment planning and growth. In 2012, concerns about the large scale retirement of leaders in the public health arena created the impetus for the development of a coordinated workforce development strategy across CA Schools of Public Health, the CA Department of Public Health and local public health departments. The effort informed the California Department of Public Health’s health workforce strategic plan in 2013.

In 2016, growing concern among the membership of the California Primary Care Association (CPCA) about shortages in primary care physicians, nurse practitioners, physician’s assistants, and medical assistants provided the impetus for the commissioning of a report with recommendations entitled Horizon 2030 in 2016. CPCA is continuing to convene stakeholders in 2017 to explore strategies including state policy initiatives.

The California Hospital Association (CHA) is currently convening members and related experts in the field to address shortages of allied health professionals and nurses. While recent investments eased the nursing shortage of the last 10 years, there is continued concern among hospitals about the ability to meet demand for services in the context of expanded coverage associated with the ACA.\(^\text{39}\) The convenings include an Academic Medical Center Steering Committee on graduate medical education funding.\(^\text{40}\)

- **New federal funding or loss of funding** to support statewide health workforce planning and health workforce initiatives.

The California Health Professions Consortium (CHPC) was formed in 2005 in response to federal termination of funding for Health Careers Opportunity Programs and Centers for Excellence. Both federal programs had provided funding to expand health career opportunities for those who are under-represented in health professions. CHPC’s membership began with a focus on

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shared policy advocacy and quickly expanded to share learning and coordinate efforts to build the capacity of health career pathways programs.

In 2010, impetus for statewide health workforce planning and development was provided by the federal Health Resources and Services Administration (HRSA) with the release of funding for planning and implementation grants as part of the implementation of the Affordable Care Act (ACA). The California Labor Agency, in partnership with OSHPD, secured a $150,000 planning grant to support the formation of the California Health Workforce Development Council (HWDC). California did not secure implementation funding from the federal government.

- **State legislation and funding for programs in health workforce, diversity, education and health career pathways.**

In 2004, growing shortages in services and associated professions galvanized action by the California executive branch to develop Proposition 63, which proposed a tax increase that generates over $800 million per year as part of the Mental Health Services Act (MHSA), to support expanded mental health services. MHSA includes an Workforce Education and Training (WET) component led by OSHPD to build mental health workforce capacity.

In 2005, growing shortages in the nursing workforce led Governor Schwarzenegger to launch of the California Nurse Education Initiative, a statewide initiative providing $90 million over five years. In 2009, another $60 million for nursing programs was approved, and as well as $32 million to launch an Allied Health Initiative. The nursing initiative focused on launching building capacity and launching new nursing programs at California Community Colleges, California State University campuses, and the University of California system. The Allied Health Initiative supported the expansion of programs in respiratory therapy, radiology technicians, health information technology, dental hygiene, pharmacy, and clinical lab scientists.

- **Support from California and national foundations for health workforce, diversity and health pathway initiatives.**

Impetus for investments by California foundations emerged from concerns in the wake of the passage of Proposition 209 in 1996, and the observation of substantial drops in the number of racial and ethnic minority students accepted into health professions education programs. Building on a national program funded by the Robert Wood Johnson Foundation, The California Endowment (TCE) launched a dental pipeline program in 2002 to increase the enrollment, retention, and graduation of under-represented dental students. There were a number of other related investments focusing on expanding health career pathways programs in K-12 and undergraduate school settings.

In 2005, TCE funded the Connecting the Dots (CTD) initiative, which focused on building momentum for a comprehensive strategy to increase health workforce diversity. Impetus for CTD were reports by the Institute of Medicine, the Sullivan Commission, and the UCSF Center for Health Professions documentation of the under-representation of racial and ethnic groups,
and evidence that increased diversity would improve health quality and access. The initiative team conducted a series of inquiries and engaged diverse stakeholders to develop a comprehensive, evidence-based strategy to increase diversity and address shortages.

In 2009, The California Wellness Foundation (TCWF) provided funding to OSHPD to develop a strategy to increase health workforce diversity. A report published included a set of recommendations for action by the executive and legislative branches to strengthen existing efforts.

Additional impetus for investment in nursing programs was made possible by the publication of a report through the Institute of Medicine entitled the Future of Nursing, and the parallel funding of a national Initiative by the Robert Wood Johnson Foundation in partnership with the American Association of Retired Persons. Funding included the development of a parallel report by the California Action Coalition in 2016. Work continues to date to refine and update strategies through the development of a California Nursing Education Plan, which focuses on positioning the nursing profession for success in future delivery models.

- Development of new programs and coalitions by health workforce and education champions to advance more coordinated, systematic efforts.

The California Health Workforce Alliance (CHWA) was formed in 2009 to support increased collaboration of diverse stakeholders at the regional and statewide level. With support from stakeholders, TCWF, and TCE, CHWA convenes quarterly meetings in Los Angeles and Oakland that bring together employers, advocates, government agencies, educational institutions to build a common platform for advocacy and support increased collaboration. In 2012, CHWA and CHPC began to hold joint quarterly convenings.

In summary, statewide health workforce planning initiatives in California have been led by state agencies, health associations, academic institutions and consortiums made up of key stakeholder group leaders. In almost all efforts, a priority focus has been bringing diverse stakeholders representing the continuum of health professions and levels of education. However, with the exception of selected nursing, community college and UC statewide initiatives, recommendations were not fully and in many cases even partially implemented. Most that were implemented did not produce their intended results.

There have also been many regional and local health workforce initiatives and collaborative partnerships. Regional efforts are critical since workforce needs, barriers and opportunities vary by region and mobilization of key stakeholders can be more targeted and have quicker impact. However, regional collaboration and program implementation can take many years and faces turf, control and resource competition challenges. It is too early to measure the impact and lessons learned from these regional initiatives.

For purposes of this report, we focus on identifying and reviewing statewide health workforce and diversity planning and development efforts. In reviewing these efforts we examined their
impetus, structure, stakeholders, funding source, end product and outcomes. We also assessed the lessons learned relative to planning successful future statewide health workforce and diversity planning efforts.

II. Methods

Our assessment included a review of available reports that was supplemented by input from selected leaders among the 29 who participated in key informant interviews and had direct experience with the initiatives. Information and insights were also drawn from team members who had participated in these processes. Initiatives documented begin in 2002 (CA Dental Pipeline Initiative) to present.

A total of 22 initiatives were reviewed, including:

1. Connecting the Dots Initiative
2. Governor Schwarzenegger’s Nurse Education Initiative
3. Governor Schwarzenegger’s Allied Health Initiative
4. Health Workforce Tracking Collaborative
5. California Health Workforce Diversity Advisory Board (OSHPD)
6. California State University Diversity Initiative
7. California Health Workforce Development Council
8. California Nursing Education Plan
9. California Campaign for the Future of Nursing
10. California Health Professions Consortium
11. California Health Workforce Alliance
12. California Public Health Alliance for Workforce Excellence
13. CCCs/CA Inst. for Nursing in Healthcare: Nursing Education Capacity Building
14. CA Workforce Development Board/Slingshot Initiative
15. OSHPD Mental Health Workforce Education and Training
16. California Health Workforce Policy Commission – Song Brown Program
17. California Community Colleges Strong Workforce Initiative
18. CPCA: Horizon 2030 Report
19. California Hospital Association Workforce Committee
20. UC Office of the President, Enrollment Plan
21. California Dental Pipeline Initiative
22. TCE 21st Century Health Career Pathways

This is intended to be a representative, rather than an exhaustive list of all statewide initiatives in California relevant to health workforce development. Additional relevant initiatives will be identified and added to this list as part of the statewide health workforce master plan development process. It should also be noted that there are a broad spectrum of health career pathway and pipeline programs that are documented separately as part of this inquiry.
### III. Matrix of Initiatives

The table below lists the relevant statewide health workforce planning initiatives reviewed and relevant findings. The table includes relevant formal outcomes, participating stakeholders, and current status.

<p>| Initiative | Year (s) | Funder | Lead | Participating Stakeholders | Outcomes                                                                 | Current Status |
|------------|----------|--------|------|----------------------------|---------------------------------------------------------------------------|               |
| 1. Connecting the Dots Initiative | 2005-2009 | The California Endowment (TCE) | Kevin Barnett and Jeff Oxendine | Employers, Health Professions Education, Higher Education, Government Agencies, Foundations | Connected and fueled network to advance health workforce diversity, initiated more systematic, coordinated approach including employers, frameworks and recommendations used for subsequent initiatives, established CA Health Workforce Alliance, links of state and regional initiatives. Seven reports informed further action and investment. | Inactive Work assumed by the CA Health Workforce Alliance in partnership with the CA Health Professions Consortium. |
| 2. Nurse Education Initiative | 2005-2015 | State of California Labor and Workforce Development Agency | CA Community Colleges (CCC), nursing schools and universities, high schools, hospitals, health systems, medical | Increased number of students enrolled in pre-licensure nursing programs; number of nursing education programs; nursing faculty for pre-licensure nursing | Inactive |</p>
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<th>Participating Stakeholders</th>
<th>Outcomes</th>
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<td>3. Allied Health Initiative</td>
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<td>State of California Labor and Workforce Development Agency</td>
<td>State agencies, CCCs, University of CA, CSU system, and CA Hospital Assn. (CHA).</td>
<td>Increased number of CLS, pharmacy, radiology tech students enrolled in programs</td>
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<td>TCE</td>
<td>Center for Health Professions at UCSF (Healthforce Center)</td>
<td>Researchers</td>
<td>Issued reports and recommendations.</td>
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<td>Office of Statewide Health Planning and Development (OSHPD)</td>
<td>Assns, Advocacy Groups, Academics, diversity champions, State govt.</td>
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<td>CWIB interest in state master plan. Potential partner.</td>
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<td>Regional plans/budgets could be directed, &amp; WIA &amp; Gov. discretionary funds for commission recs.</td>
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<td>CA WIB working closely with CA Community Colleges on key initiatives.</td>
</tr>
<tr>
<td>8. California Nursing Education Plan</td>
<td>2015-2016</td>
<td>Gordon and Betty Moore Foundation</td>
<td>Health Impact</td>
<td>Am. Nurses Assn., CA Assn. of Nurse Leaders, CA Student Nursing Assn., Board of Registered Nursing, CA Assn. of Colleges of Nursing and CA Org. of Associate Degree Programs (North and South)</td>
<td>White paper and recommendations endorsed by participating organizations and expert panel being used for nursing ed &amp; practice.</td>
<td>Active</td>
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<td>Health Impact and partners implementing as guide for decisions for nursing education.</td>
</tr>
</tbody>
</table>

41 The most recent meeting materials posted in the website archive ([https://cwdb.ca.gov/special_committees/sc_hwdc/](https://cwdb.ca.gov/special_committees/sc_hwdc/)) are dated March 9, 2016.
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Year(s)</th>
<th>Funder</th>
<th>Lead</th>
<th>Participating Stakeholders</th>
<th>Outcomes</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Action Coalition: Campaign for the Future of Nursing</td>
<td>2010-Present</td>
<td>AARP Foundation, Robert Wood Johnson Foundation</td>
<td>Health Impact, Mary Dickow and Linda Zorn</td>
<td>Nursing Leaders throughout CA, non-nursing partners and champions, health employers, state government, Board of Registered Nursing</td>
<td>Action plans implemented for many key recommendations with structure for coordination, action and accountability. Ongoing workgroup structure. Health Impact serves as nurse data center/CA has best nursing workforce data in country.</td>
<td>Active Ongoing implementation under Health Impact. Progress made on recommendations and many programs are offered.</td>
</tr>
<tr>
<td>California Health Professions Consortium</td>
<td>2005 - Present</td>
<td>The California Wellness Foundation and The California Endowment</td>
<td>Katherine Flores, UCSF Fresno and Jeff Oxendine, UC Berkeley</td>
<td>Health pathway program leaders, Health professions schools, diversity champions, health employers, associations, Advocacy Groups, K-12 educators, higher education, state govt.</td>
<td>Established network of health pathway leaders from across the state. New and sustained partnerships, grants and programs, expanded opportunities for students, pathway program expansion, &amp; shared learning.</td>
<td>Active Ongoing quarterly meetings in partnership with CHWA. Continued leadership of major CA workforce diversity initiatives. Insufficient funding</td>
</tr>
<tr>
<td>California Health Workforce Alliance</td>
<td>June 2009 to present</td>
<td>TCE, TCWF, Kaiser Permanente, Cedars Sinai, Cal Optima</td>
<td>Kevin Barnett, Public Health Institute, Jeff Oxendine, UC Berkeley</td>
<td>Health employers, HPEIs, K-12, govt, advocates, pathway programs, foundations, Recs, networking &amp; TA through CHWA and CHPC have informed investments, policies and actions to advance workforce and diversity</td>
<td>Active, with ongoing quarterly meetings in partnership with CHPC.</td>
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<tr>
<td>12. California Public Health Alliance for Workforce Excellence</td>
<td>2008-2014</td>
<td>CA Pacific PH Training Center (previously funded by HRSA)</td>
<td>Reps from all CA SPHs, CA Dept. of PH &amp; major health departments.</td>
<td>WIBs, &amp; non-profits.</td>
<td>in primary care, health pathways, /CHWs and other key professions.</td>
<td>Continued leadership of major CA workforce initiatives. Insufficient funding</td>
</tr>
<tr>
<td>13. CCCs and CA Institute for Nursing in Healthcare: Nursing Education Capacity Building</td>
<td>2004 – current (Nursing Resource Center)</td>
<td>FDN for CCCs/ Nursing Ed Investment Fund; Gordon and Betty Moore Foundation.</td>
<td>Kathy DeGuerre, Manager of Health Care Programs, Foundation for CCCs</td>
<td>Health Departments, Health Professions Schools, Non-profits, CDPH</td>
<td>Recommendations informed CDPH Health Workforce Development. PH conferences (funded by OSHPD). Training for state/local workers.</td>
<td>Inactive Loss of HRSA funding</td>
</tr>
<tr>
<td>14. SlingShot</td>
<td>2014 – Present</td>
<td>Federal Workforce Investment Act</td>
<td>The California Workforce Development Board Health one of multiple industry sectors</td>
<td>K-12 school districts, local workforce boards, community colleges and programs, community organizations, &amp; employers.</td>
<td>Investments made in regions throughout the state. Outcomes TBD</td>
<td>Active</td>
</tr>
<tr>
<td>15. OSHPD Mental Health WET</td>
<td>2004 – Present</td>
<td>Prop 63 funding; required statewide</td>
<td>OSHPD</td>
<td>WET 5-yr Plan Advisory Subcommittee, industry</td>
<td>$445 million invested over 10 years: $210 million to local county WET programs, and</td>
<td>Active</td>
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<td>Initiative</td>
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<td>Current Plan 2014 - 2019</td>
<td>2014 - 2019</td>
<td>OSHPD, and regional plan informs budget allocation.</td>
<td>$234.5 million to support 2 state WET 5-year plans. OSHPD administered programs to date: 15,000 students exposed to mental health careers; 90 student internships in public mental health system; $10k in loan repayment provided to 6,700 mental health professionals who worked 12 months in public mental health system; $21k provided in stipends to 620 mental health professions who worked 12 months in public mental health system; increased residency and training positions in the public mental health system; trained (at least) an additional 64 Clinical Psychiatrists and 68 Psychiatric Nurse Practitioners; training and job placement in the public mental health system provided to &gt;800</td>
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<tr>
<td>16. <a href="#">California Health Workforce Policy Commission</a></td>
<td>1973- Present</td>
<td>Grants for primary care specialties, NPs, PAs, &amp; RN training/residencies.</td>
<td>OSHPD</td>
<td>Health professionals, health professions schools, government &amp; consumers.</td>
<td>Allocation of millions in funding to residency programs throughout the state in alignment with policy, priorities and criteria. Greater connection of residency programs to health pathway programs. Outcomes from FY 2012-13 through 2015-16 (FM = Family Medicine; NP/PA = Nurse Practitioner/Physician Assistant): Programs funded: <strong>FM</strong>: 29 (2012-13); 51 (2013-14); 63 (2014-15); 37 (2015-16); 38 (2016-17); TOTAL 218 <strong>NP/PA</strong>: 12 (2012-13); 24 (2013-14); 24 (2014-15);</td>
<td>Active Ongoing, quarterly meetings: provide guidance and recommendations to OSHPD.</td>
</tr>
<tr>
<td>Initiative</td>
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<td>16 (2015-16); 17 (2016-17); TOTAL 93</td>
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<td>Residents/Students Supported:</td>
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<td><strong>FM:</strong> 56 (2012-13); 452 (2013-14); 438 (2014-15); 116 (2015-16); 98 (2016-17); TOTAL 1,160</td>
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<td><strong>NP/PA:</strong> 954 (2012-13); 2,006 (2013-14); 1,967 (2014-15); 1,282 (2015-16); 1,625 (2016-17); TOTAL 7,834</td>
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<td>% Under-Represented Minority (URM):</td>
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<td></td>
<td><strong>FM:</strong> 33% (2012-13); 26% (2013-14); 33% (2014-15); 29% (2015-16); 30% (2016-17)</td>
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<td><strong>NP/PA:</strong> 34% (2012-13); 24% (2013-14); 23% (2014-15); 30% (2015-16); 31% (2016-17)</td>
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<td>% Training Sites in Areas of Unmet Need (AUN):</td>
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<td></td>
<td><strong>FM:</strong> 98% (2012-13); 96% (2013-14); 93% (2014-</td>
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<td>15); 78% (2015-16); 78% (2016-17)</td>
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<td></td>
<td><strong>NP/PA:</strong> 87% (2012-13); 83% (2013-14); 57% (2014-15); 60% (2015-16); 59% (2016-17)</td>
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<td>% Graduates Practicing in Areas of UMN <strong>FM:</strong> 73% (2012-13); 73% (2013-14); 49% (2014-15); 51% (2015-16); 51% (2016-17)</td>
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<td></td>
<td><strong>NP/PA:</strong> 76% (2012-13); 51% (2013-14); 42% (2014-15); 51% (2015-16); 44% (2016-17)</td>
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<tr>
<td>California Community Colleges Strong Workforce Initiative</td>
<td>2016 – present</td>
<td>State Budget</td>
<td>California Community Colleges, Chancellor’s Office</td>
<td>CCC leaders, student reps and faculty, CWIB, labor, industry, industry assn, chamber of commerce, CBOs, government.</td>
<td>TBD</td>
<td>Active</td>
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<td>Strong Workforce Program District and Region Allocations for Round 2: 2017-18</td>
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<td>Round 1 funding allocated; round 2 funding pending approval.</td>
</tr>
<tr>
<td>CPCA: Horizon 2030 Report and Broad Based Coalition</td>
<td>2015 – Present</td>
<td>California Primary Care Association</td>
<td>CPCA, Jeff Oxendine, Kevin Barnett</td>
<td>Employers, health professions schools, professional and trade assns, foundations, state government</td>
<td>CPCA, CAFP, CMA and other coalition partners utilized the report in their advocacy and legislative efforts which helped lead to $100 million in the state</td>
<td>Active. CPCA and coalition partners successfully stopped the 2018 portion of the residency expansion budget from being cut from the state budget.</td>
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<td>Initiative</td>
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<td>19. CHA Health Workforce Committee</td>
<td>2007 – Present</td>
<td>CHA</td>
<td>CHA</td>
<td>CHA member hospital and health system representatives</td>
<td>budget to fund primary care residencies for the safety net. CPCA is committed to developing actionable primary care policy recommendations is convening a statewide group to develop and advance solutions. Assisted in securing policy support for $100M in additional funding for primary care GME.</td>
<td>CPCA developing actionable recommendations and advocacy campaign to accelerate advancement of primary care workforce supply and diversity in CA.</td>
</tr>
<tr>
<td>20. UC Health Sciences Enrollment Planning</td>
<td>2005</td>
<td>UC</td>
<td>Michael</td>
<td>UC and key external partners statewide</td>
<td>Plan completed and approved just prior to major state budget challenges and recession. Not formally implemented and funded as an overall plan. However, many of the priority recommendations, including PRIME Program expansion and new UCR</td>
<td>Inactive</td>
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<tr>
<td>Initiative</td>
<td>Year(s)</td>
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<td>21. California Dental Pipeline Initiative</td>
<td>2002 - 2010</td>
<td>TCE (Phase I in cooperation with RWJF)</td>
<td>CA Dental Schools</td>
<td>CA Dental Assn., CPCA, FQHCs</td>
<td>Phase 1: CA dental schools collaborated on URM/LI student recruitment, policy, and community-based dental education and cultural competency training information and resource sharing. 70 community health centers received student and residency rotations serving thousands of medically-compromised, rural, and low-income patients. Cultural competency training provided to faculty and staff and integrated into curriculum. Increased percentage of freshman URM students[^42]. Phase 2: established partnerships between dental schools and...</td>
<td>Inactive</td>
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<th>Initiative</th>
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<tr>
<td>22. 21st Century Health Career Pathways(78,2-million-in-grants-to-increase-california-s-health-care-workforce)</td>
<td>2013 - Present</td>
<td>TCE</td>
<td>Program Managers of Building Healthy Communities sites.</td>
<td>Diverse stakeholders at Building Healthy Communities sites.</td>
<td>Goal to strengthen and accelerate student-centered, grade 7-16 pathway programs, expand frontline health workforce jobs, and expand cultural competency. Significant investment in regional health pathway program and system development around TCE Building Healthy Community Sites Initiatives still in progress so outcomes TBD</td>
<td>Active. Grant funded programs, regional initiatives and systems change efforts being implemented. Statewide learning community being coordinated by Jobs for the Future.</td>
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</table>

IV. Key Themes

Our analysis of the 22 statewide initiatives revealed the following themes, many of which were cited by key informants interviewed as part of this process. Themes are organized in three sections; strengths, weaknesses and lessons learned:

Strengths

- **Engaged champions** with health workforce, diversity, education and government expertise.
- **Strengthened relationships and the network** among key stakeholders.
- Identified **priority** health workforce **challenges**, corresponding **barriers** and recommended **solutions**.
- Advanced knowledge and **understanding of future trends** and corresponding innovative workforce practices and solutions.
- Developed and **applied practical models and tool kits** to address solutions to key barriers in priority professions.
- Secured **buy-in by selected stakeholders** regarding emerging roles and needs for health professionals (nursing) and strategies for building the future.
- Designed and implemented **innovative strategies and programs** to advance diversity in the health workforce and in health professions education.
- **Increases in educational capacity** in selected areas to address priority health supply needs (e.g., Nursing Education Initiative, PRIME, UC Riverside).
- **Quantitative supply and demand data** for some licensed professions. Nursing data is best in the country.
- Broad-based **coalition mobilization** to advance education, advocacy and policy change.
- **Policy and regulatory changes** that advanced scope of practice innovations and funded important solutions (CPCA $100 million in GME for Primary Care).

Weaknesses

- Many recommendations were **not implemented**.
- Recommendations were often **high level, general and not prioritized**. “All things to all people, not strategic.”
- Most initiatives did not fully or even partially meet identified goals and objectives due to **lack of clarity of action plans and resource commitments**.
- In some cases, initiatives included **funds for planning only**; limited or no funding and commitments for implementation.
- **Over-dependence on private and public sector philanthropy**; insufficient institutional investment and commitment to change behavior.
- **Insufficient staffing capacity** and expertise to successfully implement recommendations and programs to meet intended results.
• **Competing priorities**; lower priority than coverage expansion, cost, quality, etc.
• **Insufficient quantitative data** on supply and demand for health professions other than nursing; particularly for unlicensed workers.
• Difficulty making the **business case** for long term investment and sustainability.
• **Constraints of State-led processes** combined with insufficient staff expertise, capacity and significant turnover.
• **Private sector-led processes under-resourced** to meet expectations for progress.
• **Federal funding cuts** and lack for dollars for planning, programs and implementation.
• **Conflicting political priorities** among governor, legislature and state agencies.
• **Lack of agency or entity “ownership”** of health workforce.
• **Competitive dynamics among providers**; some meet their workforce needs at the expense of others.
• Insufficient focus on **public and institutional policy change**.
• **No system to track outcomes** and tell stories with data and examples.
• **Lack of participation of key decision-makers** with the ability to make commitments.

**Lessons Learned**

• Important to have **clear agreement among leadership and participants** on the end-product and definition of success.
• Ensure inclusion of a **plan for implementation** with explicit roles and expectations.
• **Up front agreement** on how recommendations will be selected.
• Secure **funding to complete the process and support implementation**. “Putting money on the table makes it real and leads to action.”
• State led processes may fall short of expectations without:
  o **commitment to sufficient staff** with expertise, capacity and relationships;
  o resources **investment to complete the work** and achieve intended results;
  o necessary **political support** from administration and legislators;
• **Invest in technical assistance** and shared learning for successful implementation.
• Ensure **broad and inclusive engagement** of stakeholders to ensure buy-in and accuracy.
• Engage **technical advisors and key influencers** to “endorse” the process and recommendations.
• **Define the problems to be solved** and develop corresponding actionable priorities.
• **Include decision-makers** who can make commitments and difficult priority choices.
• Design process with a **bias towards actionable solutions** that produce intended results.
• Ensure engagement of key stakeholders and consultants with **necessary policy and political expertise and relationships** to develop and advance recommendations.
• **Align regional investment** of governments, education, foundations and employers with the priorities of statewide recommendations.
• **Monitor and evaluate outcomes**. Establish effective feedback and accountability mechanisms to decision makers and funders.
IV. Building Blocks for Master Plan Development

Many valuable outcomes from previous statewide initiatives have laid the groundwork for and will enhance the potential of success of the 2017-2018 development of a CA Health Workforce Master Plan including:

1. **Relationships and networks among key stakeholders**
   Statewide initiatives over the past 10 years have brought together and facilitated solid relationships among leaders from a broad and diverse set of health workforce and diversity stakeholders from throughout the state. In 2005-9, the Connecting the Dots Initiative found that there were many promising health workforce programs and practices throughout California led by passionate champions with a depth of health workforce expertise but that there was very few connections and little shared learning and action among them. Stronger relationships are particularly important since California is such a large, complex and diverse state with hundreds of health workforce, health pathway and education related programs led by a wide range of stakeholders from different sectors and regions. Insufficient knowledge and connections can lead to costly duplication, parallel efforts, and re-inventing the wheel. Lack of awareness and relationships can also lead to inefficiency, longer times to ramp up and achieve the intended results for initiatives.

   The greater degree of relationship and trust built through previous initiatives will enhance the commission, Technical Advisory Committee (TAC) and workgroup’s ability to deal with difficult issues, gain commitments, make decisions and implement recommendations. Greater awareness of and relationships among programs can also lead to better investments and more resources being allocated to promising programs with higher probability of being able to meet intended results in less time.

2. **Individual program benefits**
   Health workforce, pathway and education programs have benefitted tremendously from participation in previous and current statewide initiatives. Categories of benefits include:
   - Increased access to funders and funding opportunities to sustain and grow programs;
   - opportunities to expand programs and develop new partnerships;
   - knowledge and tools to improve, evaluate and grow programs;
   - technical assistance from sponsoring entities, connections made with consultants and from each other
   - progress and shared leanings from cross sector collaboration;
   - connections for students to advance in their education and careers;
   - formal and informal learning communities;
   - state level visibility and recognition leading to key relationships and opportunities

3. **Development of promising new programs and policies**
   Previous health workforce initiatives have initiated or facilitated development of promising new programs and policies that have advanced health workforce solutions and provided
lessons learned to inform future strategies. A recent example is the broad based coalition that was mobilized to advance policy recommendations from the 2016 CPCA Horizon 2030 report successfully securing $100 million in funding for primary care.

4. Experience and lessons learned regarding collaboration
Successes and shortfalls over the past 15 years have provided insights about the strengths, weaknesses and key success factors for effective collaboration among health workforce stakeholders.

5. Greater support and opportunities provided to students throughout the continuum
Previous initiatives have built relationships and networks among health pathway and education programs at all levels and health employers that have resulted in students gaining valuable education, experiential, job and employment opportunities as they advance in their pursuit of education and health careers.

6. Employer and education system benefits
While cumulative totals reflect that more focused effort is needed going forward, health employers have increased access to talented, diverse candidates through new sources and programs that have enhanced their ability to meet priority workforce and quality needs. K-12 and higher education have secured increased health career exposure and pathway opportunities, partnerships and tool kits (CHA tool kit). Health professions education institutions have achieved expanded enrollment, successful new programs, and increases in diversity and excellence.

7. Reports, frameworks and recommendations
The documented results of previous efforts can form the basis for the commission deliberations.

8. Progress on advocacy and policy change
Individual advocacy organizations and broad based coalitions have increased education and the profile of health workforce among public and private stakeholders. This is important as health workforce issues had previously not been on the radar screen of many key stakeholders or had not been given sufficient priority. In addition, legislation passed through individual and collaborative efforts have advanced solutions, infrastructure, data and funding. They have also advanced key programs.

9. Programs and funder investments that can be leveraged
Public and private investments have led to the growth and expansion of health workforce and diversity efforts and their impact. Many of these efforts continue to have programs, systems or policies in place that can be leveraged as part of future solutions. Many lessons have been learned from the successes, progress and shortfalls of these efforts that can inform the work of the commission and additional investment. There are also promising opportunities for program expansion and replication and policy change that can be
10. Regional program and pathway development

Statewide initiatives and funding have led to development and expansion of health pathways and programs at the regional level. This has included new programs and partnerships among education and employers. Statewide entities like the WIB, CA Dept of Education and OSHPD and educational systems like the community colleges have provided substantial guidance and funding for regional development. The California Endowment has also supported significant investments and technical assistance for regional health workforce and health pathway development.
V. Table of Initiative Reports and Recommendations

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<tr>
<th>Initiative</th>
<th>Reports and Recommendations</th>
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| 1. Connecting the Dots Initiative | The seven reports linked to below each include recommendations for increasing health professions workforce diversity:  
  - [Diversity in California’s Health Professions Current Status and Emerging Trends](#)  
  - [The Benefits of Diversity: An Exploratory Study](#)  
  - [Profiles in Leadership: A Review of Exemplary Practices to Increase Health Professions Workforce Diversity in California](#)  
  - [Increasing the Diversity of the Health Professions: K-12 Networks of Support](#)  
  - [If It’s a Pipeline, Why Isn’t There More Diversity at the Other End?](#)  
  - [From the Mouths of Leaders: Challenges and Opportunities to Increase Health Professions Workforce Diversity in CA](#)  
  - [Health Professions Accreditation and Diversity: A Collaborative Approach to Enhance Current Standards](#) |
| 2. Nurse Education Initiative | The following four annual reports detail the accomplishments of Governor Schwarzenegger's Nurse Education Initiative:  
  - [Annual Report 2006](#)  
  - [Annual Report 2007](#)  
  - [Annual Report 2008](#)  
  - [Annual Report 2009](#) |
| 3. Allied Health Initiative | The following links to the initiative announcement and news article provide details about Governor Schwarzenegger’s Allied Health Initiative:  
  - [Announcement](#)  
  - [BusinessWire Article August 27, 2009](#) |
| 4. Health Workforce Tracking Collaborative (HWTC) | The following five reports resulted from the HWTC:  
  - [Staffing Patterns in California's Licensed Community Clinics: Registered Nurses, Licensed Vocational Nurses, and Medical Assistants](#)  
  - [Comparative Snapshot of Four Allied Health Occupations in California: Community Health Workers, Medical Assistants, Certified Nurse Assistants and Home Health Aides](#)  
  - [The Utilization of Medical Assistants in California's Licensed Community Clinics](#)  
  - [Registered Dental Hygienists in California: Regional Labor Market Chart Book, 2005–2006](#)  
  - [Considering Language Access Services for California Hospitals; Improving Language Access in California Hospitals](#) |
| 5. CA Health Workforce Diversity Advisory Board | The following report includes overarching, high education, and workforce recommendations:  
  - [Diversifying California's Healthcare Workforce, an Opportunity to address California's Health Workforce Shortages](#) |
| 6. CSU, Improving Health Professions | The following report includes final recommendations:  
  - [A Call to Action for Increasing the Enrollment of Underrepresented Groups into the Health Workforce in California](#) |
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| **Pathways and Best Practices** | The following two reports include recommendations:  
- Report on Health Workforce Development Needs - Findings and Recommendations  
- Career Pathways Sub-Committee Final Report |
| **California Health Workforce Development Council (CWDC)/California Workforce Investment Board (CWIB)** | The following white paper includes recommendations:  
- Nursing Education Plan White Paper and Recommendations for California |
| **California Action Coalition: Campaign for the Future of Nursing** | The following report includes eight recommendations:  
- Nursing and the Future of Health Care: California Action Coalition Report |
| **California Health Professions Consortium (CHPC)** | The CHPC website provides detailed information about the initiative:  
- California Health Professions Consortium |
| **California Health Workforce Alliance** | The following two reports include recommendations:  
- Taking Innovation To Scale: Community Health Workers, Promotores, and the Triple Aim  
- Community Health Workers in California: Sharpening Our Focus on Strategies to Expand Engagement |
| **California Public Health Alliance for Workforce Excellence** | The following action plan details objectives, activities, anticipated outcomes, timeline, lead and resources, and evaluation method:  
- Public Health Action Plan |
| **CCCs and CA Institute for Nursing in Healthcare: Nursing Education Capacity Building** | The link below provides more information about the Nursing Resource Center and Nursing Education Investment Fund:  
- Foundation for California Community Colleges: Health Care Education |
| **SlingShot** | The following link provides a compilation of workforce innovation publications, slides, and webinars:  
- Big Ideas in Workforce Innovation |
| **OSHPD Mental Health WET** | The following reports include needs assessment, recommendations, and five-year plan, including recommendations specific to career pathways, and Summit presentation with summary of state administered programs:  
- MHSA WET Five-Year Plan  
- MHSA WET Summit Presentation March 9, 2017 |
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<td>MHSA WET Five-Year Plan 2014-2019 Needs Assessment: Master Executive Summary to the Final Reports</td>
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<td>Report 5—Educational Training of Mental Health Professionals</td>
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<td>Report 6—Public Mental Health Services Demand/Users</td>
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<td>OSHPD CWIB Health Workforce Development Council Career Pathway Sub-Committee Report</td>
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<td>Mental Health Workforce Needs Assessment 2014</td>
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<td>County-Reported Mental Health Workforce Needs – December 2013</td>
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<tr>
<td>California Social Work Education Center (CALSWEC) Report, Mental Health Program Student Characteristics and Employment 2005-2010</td>
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<td>Historical documents are archived</td>
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<td>16. California Health Workforce Policy Commission Song Brown Commission</td>
<td>The following link provides information on the commission, funding opportunities and awards:</td>
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<td>• OSHPD Song-Brown Healthcare Workforce Training Programs</td>
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<td>17. California Community Colleges Strong Workforce Initiative</td>
<td>The following are reports and recommendations from the Strong Workforce Initiative Task Force:</td>
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<td>• Task Force on Workforce, Job Creation and a Strong Economy: Report and Recommendations</td>
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<td>• Strong Workforce Task Force Recommendations</td>
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<td>18. CPCA: Horizon 2030 Report and Broad Based Coalition</td>
<td>The following links include more information on the CPCA Broad Based Coalition and Horizon 2030 Report with Recommendations</td>
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<td></td>
<td>• CPCA Workforce</td>
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<td>• Horizon 2030: Meeting California’s Primary Care Workforce Needs</td>
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<td>19. CHA Health Workforce Committee</td>
<td>The following links are for a guide, report, and recommendations from the California Hospital Association Health Workforce Committee:</td>
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<td>• Health Facility Work-Based Learning Program Guide (Health Employer/K-12 Partnerships)</td>
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<td>• Critical Roles: California’s Allied Health Workforce Follow-Up Report</td>
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<td>20. UC Health Sciences</td>
<td>The following report includes profession-specific fact sheets, findings, and recommendations:</td>
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<td>Enrollment Planning</td>
<td>• [The Imperative for Strategic Workforce Planning and Development: Challenges and Opportunities][1]</td>
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<td>University of California Health Sciences Education Workforce Needs and Enrollment Planning</td>
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<td>21. CA Dental Pipeline Initiative</td>
<td>The following links include detailed information about the dental pipeline initiative, and evaluation and identified best practices from Phase II.</td>
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<td>• [California Pipeline Program][2]</td>
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<td>• [California Pipeline Program Phase II: Evaluation][3]</td>
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<tr>
<td>22. 21st Century Health Career Pathways</td>
<td>The following links include press release and reports that helped inform the</td>
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<td>Pathways ()</td>
<td>grantmaking strategy behind the initiative.</td>
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<td>• [Press Release][4]</td>
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<td>• [Health Care Pathways for Opportunity Youth][5]</td>
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<td>• [In And Beyond Schools][6]</td>
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SECTION THREE

Developing a Statewide Health Workforce Master Plan in California: Priorities and Insights from Key Leaders
I. Overview

In the design of a health workforce master plan for the state of California, it was determined that it would be important to seek early input from leaders who could share insights from prior efforts and who have a major stake in ensuring the success of efforts going forward. A survey instrument was developed in consultation with foundation representatives to set interview objectives, recommend key informants and review interview guide questions.

A structured interview guide was developed (see Appendix A) and a total of 29 key informants (Appendix B) were engaged in 30 to 90 minute interviews. The interview guide was divided into two sections; one focusing on previous health workforce initiatives in California, and a second on the value and design of a new statewide health workforce master plan process. Key informants who participated in previous efforts were asked questions in both sections. Others were asked only questions about the new process.

Findings and recommendations are structured to align with the five core questions outlined in the executive summary of this report.

In general, the interviewees were unanimous in their enthusiasm and support for development of a statewide health workforce master plan in 2017-2018. They expressed this enthusiasm despite concerns and uncertainty related to Federal health policy changes that could significantly undermine the progress California and providers have made under the Affordable Care Act and the potential billions of dollars of budget reductions. In fact, many expressed that these factors create a stronger case for development of the plan now. Many believe it is not only important now but necessary and critical. All agreed that developing the plan for completion by the upcoming 2018 gubernatorial election was also an important strategy and window of opportunity.

The following sections include a summary of themes from stakeholders regarding key outcomes identified by key informants; priority health professions, challenges, and timing concerns; process design and execution issues; and proposed structure and roles of stakeholders.
II. Key Outcomes of a Statewide Health Workforce Master Plan

Key informants indicated that the following would be key elements of a successful master plan process as part of a “blueprint” for California’s future health workforce (2030 and beyond):

Agreement on targeted solutions to make California healthier, more productive and create greater economic opportunity

- **Actionable solutions to priority health and education challenges** based on projected changes in population demographics, growth and health needs and assumptions regarding future health models and population health improvement strategies. “It’s about health impact, not just the professions.”
- **Targeted recommendations** to address priority health workforce problems linked to collective Triple Aim and Let’s Get Healthy CA strategies.
- **Commitment to action plans** for a portfolio of near-, medium- and long-term solutions for priority professions and regions. **Fund with public and private dollars.** Strong business case for proactive long-term investments.
- **Systematic, coordinated strategies** among employers, all levels of education and government to ensure Californians are trained with the right skills for the right jobs.
- **Financial incentives** to promote successful graduation of priority professionals, practice in key regions, quality services to all populations and provider retention and satisfaction.
- **Commitment and plans to increase the diversity** of health professions schools and the health workforce and to strengthen educational and economic opportunity and equity.

Additional investment, reallocation and alignment of public, university, employer and foundation funding

- “**Not all new money,**” “Need to terminate some programs and start new ones.”
- “Need to target funds at **training for a workforce that is needed** and employable based on knowledge of what is coming.”
- **Link enrollment plans and funding** for higher education and health professions schools at community colleges, CSU, UC to **future workforce production** and training needs.
- Recommend innovations to **enhance the structure, scope and effectiveness** of current federal, state and private funding streams for workforce development. Establish targeted outcomes and standards.
- **Propose standards** for public- and foundation-funded workforce program best practices, proven tools and success criteria.
More strategic and aligned public policy

- Provide a “blueprint” for next administration to prepare the future health workforce.
- Develop a policy agenda and actionable policy recommendations for 2019 and beyond with buy-in and support from influential commissioners and key stakeholder groups.
- Strengthen education and engagement of legislators and staff on the importance of health workforce development and the commission’s plan.
- Engage health committees of the legislature. Build momentum and will.
- Make actionable policy recommendations for systems changes that increase K-12 education preparation and attainment and college access and completion.
- Make systemic policy changes with defined performance measures regarding financing.
- Influence state educational master plan.

Plan and resources to ensure successful plan implementation

- Sufficient staffing to implement recommendations and plans.
- Foundation funding to jump-start recommendation implementation and to support required infrastructure.
- Commitment to roles that key employers, educational institutions and government agencies on the commission will take to advance the recommendations.
- Agreement and action plans regarding the leadership role that key stakeholders will play to ensure successful implementation and relevant initiatives outside the scope of the commission’s recommendations.

Shared metrics and plans to monitor and communicate progress

- Develop 10-year supply and distribution benchmarks in priority professions and regions with agreed-upon plans to meet them.
- Provide an annual report card and outcomes update with state and regional metrics.

Regulatory, licensing and accreditation innovations aligned with future workforce models and solutions

- Proposed regulatory changes and processes for securing these changes.
- OSHPD pilot projects to assess the efficacy and impact of new workforce solutions.
- Proposed scope of practice changes.

Strategies, guidelines and investments to support regional health workforce and pathway development

- Shared investments in regional infrastructure by employers and other key stakeholders.
- State policy creating incentives for investment (e.g., matching funds).

Increased supply of key targeted providers

- Establish a financially sustainable, stable system to sustain supply increase overtime.
III. Priority Health Professions, Challenges, and Timing

Key informants strongly supported the focus of the master plan being on building the future health workforce. However, they emphasized the importance of also developing actionable strategies to address priority immediate and emerging health workforce needs. They also emphasized that the plan would be most effective if there is a focus is on specific priority challenges and opportunities and corresponding practical solutions. Towards that end, the following are the most important health professions key informants thought should be addressed and high priority challenges:

**Priority Professions**

- Primary care providers and all members of the primary care team
- Mental and behavioral health providers, including substance use counselors
- Community Health Workers and Health Navigators
- Advanced Practice Nurses
- Physician Assistants
- Experienced Registered Nurses
- Health IT Professionals
- Medical Assistants
- Home and long-term care workers
- Health Administrators

**Priority Challenges**

- Standardize, train, and pay for community health workers.
- Increase diversity in all health professions in California; particularly the under-representation of Latinos.
- Increase rural health access – recruitment and retention of primary care, mental health and specialty care. Providers.
- Scope of practice innovations; including at top of legal scope and scope expansion.
- Living wage and pay equity for front line workforce.
- New delivery model and team development aligned with the Triple Aim and emerging payment models.
- Payment and other financial incentives to increase access to quality, affordable care for all populations.
- Targeted investment and expansion in Graduate Medical Education to address priority workforce gaps; particularly in underserved communities and safety net settings.
- Meet primary care capacity and network adequacy requirements.
- Increase access to quality, culturally and linguistically appropriate mental and behavioral health services integrated with primary care.
- Support innovative, cost effective wellness and treatment of our growing, aging population within and outside of institutions and at the end of life.
Solutions to promote health and health equity for all Californians, particularly the residents of economically disadvantaged communities.

Support upstream innovations in health, addressing social determinants and meeting social needs integrated with health services.

Increase opportunities for youth and residents from California communities to be the next generation of diverse health leaders and professionals and have greater education and economic opportunity.

Reduce the cost of college and medical education.

Strengthen the alignment of educational capacity and the training of workers with priority employer needs.

Increase timely access to high quality and affordable specialty care services.

Timing: Why and Why Now?

Growing workforce shortages in key professions and regions.

Increasing focus on and competition for talent acquisition and retention.

Aging workforce with a “tidal wave” of retirements expected in the next 5-10 years.

Growing, aging, increasingly diverse population with access and health challenges.

Workforce shortages have major access, cost, quality implications.

Focus on team-based care and leveraging to technological advances with transition to value based payments necessitates a different type and training of health workers

Previous efforts to address health workforce and diversity needs have fallen short. Some current efforts are parallel, uncoordinated, costly and duplicative. Opportunity for proactive, coordinated solutions with larger collective impact

Foundations, employers and public entities have invested hundreds of millions without meaningful progress.

Policy window and sense of urgency with the next gubernatorial election.

Sufficiently trained and equitably distributed workforce in priority professions is necessary to meet Triple Aim and other statewide and regional health goals. Greater recognition of this than in past.

Health careers offer tremendous employment, economic and career opportunities and the ability to have place committed individuals make a difference in their communities.

SWOT Analysis for a Statewide Health Workforce Master Plan

Strengths:
- CA Leadership in ACA implementation and innovation. Leverage that for health workforce leadership
- Nursing workforce data: Best in the country, institutionalized through legislation
- Commissions and master plan development
- Tele-health experience and infrastructure
- Technology leadership and innovation
Weaknesses:

- Poor data on many fronts.
- Clearing house not doing job and not adequately staffed and funded to do it. Nor supported.
- OSHPD not staffed and funded to carry out state health workforce planning and development functions. Tremendous turnover.
- No entity or individuals “own” health workforce.
- Legislative reactivity rather than long term strategic investment in health workforce.
- CA capacity in health professions training and graduate medical education far short of emerging production needs and among lowest in the nation.
- Payment levels for CA health providers lower relative to the rest of the nation; particularly for MediCal.
- High and growing cost of living, particularly housing for low income populations.

Opportunities:

- Greater felt need among health professions employers.
- Leverage major recent public and private investments (see chart- CCPT, Foundation).
- Foundation leadership to support master plan.
- Individual organization and association advances and increased commitments, initiatives (e.g., CPCA, CHA)

Threats:

- Changes at the Federal level resulting in loss of coverage, safety net services totaling billions of $, need to devote attention.
- Labor opposition.
- Turf wars will continue, more of the same “Organized medicine constantly opposes, more compelling- real data is more important, could fall on deaf ears, very politicized process, certain amount of credibility from the process, a larger coalition of real thinkers can add credibility but still be difficult.”
- Dept of Finance may be against issues that go against the long term good.
- WET going away.
Key informants provided insights into key lessons learned from the successes and weaknesses of previous initiatives. The following themes were suggested as factors to ensure success for the new workforce commission and master plan process:

**Design a process and structure to achieve intended results**

- Clear agreement on objectives, outcomes and definitions of success.
- Develop practical and actionable solutions to specific problems.
- Use evidence to define problems, assess solutions and develop recommendations.
- Agree on the time frame for impact and ROI expectations.
- Ensure the “right people are at the table”. Combination of higher level leaders with power, influence and ability to commit resources and champions with workforce expertise and the ability to ensure effective implementation of recommendations.
- Manage inherent differences in terminology, perspective, incentives and priorities.
- Achieve a balance between organization self-interest and common good.
- Organize structured discussions toward actionable end results.
- Implement processes to secure broad stakeholder input in efficient ways.
- Plan for engagement and securing support from Labor and professional associations.
- Use proven frameworks and models to structure the discussions.
- Be clear who makes decisions and how decisions are made.
- Choose a set of realistic priorities. “Can’t be all things to all people.”

**Maintain a bias for action**

- Build in opportunities for action and impact that can be attributed to the work of the commission. “Have to have action- feel like they are doing something” “Previous initiatives have been more of a discussion group rather than a strategic body.”
- Plan for and celebrate “quick wins” that result from the commission’s work.
- Establish commitments, “put a stick in the sand” and say where we are going.

**Align, leverage and build on other relevant efforts**

- Essential to align work with and build on previous and current efforts in health workforce, pathways, and education at statewide and regional levels.
- Ensure that key stakeholders are in a position to lead efforts and collaborations in their “lanes” of expertise and passion.
- Have people on and partnering with the commission who have policy expertise and political experience and relationships.
Include a commitment of resources for successful implementation

- When things like this effort are grant funded. Need to be clear about how what is produced will be implemented and funded. If not, “there is a potential to flounder.”
- “If you put money on the table, much more likely to do it”
- Foundations and other stakeholders should include a commitment of resources to support some level of implementation. Lack of resources for implementation was a major factor that led to the false starts in previous efforts.
- Successful implementation will require a sufficient infrastructure, staff and data which will need to be funded and/or provided through in kind commitment. Staff need to have the expertise, capacity, relationships and incentive to implement the solutions in the plan at the scale and within the desired time frame. Stable staffing is also important.
- Most innovations in health workforce and diversity have been grant funded, “need to institutionalize what is produced.”
- Plan for change management that can guide the design of the process and implementation of the recommendations.
- Need to manage expectations that change takes a long time and that ROI with that expectation, a portfolio of approaches, need to have longer term perspective.

Accountability for results and adjustment as dynamics and needs change

- Make decisions and priority plans with knowledge that conditions will change so important to have mechanisms to adjust
- Will need data and mechanisms to track progress and inform adjustments. Plan for results evaluation and feedback loop
- Need to monitor changing health landscape and proactively adjust as dynamics and needs change
- Important to have quantifiable goals and metrics and system for tracking

Working together differently is key

- Gain agreement that future delivery model and payment trends will necessitate different ways health organizations and government will work together. Leverage that for different ways employers work together to advance health workforce and diversity.
- Move beyond proprietary interests for collective impact

 Include parallel campaign for education and influence

- Need framing assistance; workforce is difficult to explain, get people enthusiastic about, not sexy, education needed, “not an easy sell for many.”
- Identify levers for change and incentives, making the business case where possible.
- Find a way to link workforce to higher competing priorities.
- Gain the support of the next governor and key legislators. Need Gubernatorial candidate willing to look at long term good re annual financial consequences.
V. Structure and Roles

Key informants unanimously expressed belief and relief that the master plan process would not be a State led process. They liked the approach of having a private commission and process with active State government participation. Key informants emphasized the importance of structuring the process and targeted outcomes according to the critical success factors summarized in the previous section. There was also agreement that there needs to be a focus on the end product and that it should be driven by practical and actionable solutions to priority workforce problems and challenges. Key informants emphasized the need for resource commitments and staffing support to ensure effective implementation. Other key factors relate to stakeholders to be represented, their roles, and how it should be different from previous efforts:

Key stakeholders to be represented

- Health employers
- Educational institutions at all levels
- Labor
- Elected officials
- Technology companies and experts
- Health professions diversity champions and programs
- Professional and trade associations
- Regional health pathway initiatives
- Community stakeholders
- State agency leaders
- Foundation representatives
- Health workforce experts

Key informants indicated that a key question is how they will work together toward collective solutions rather than solely represent their individual areas of interest and expertise. They indicated that there is a need to focus on different ways that stakeholders will work together during and after the process to ensure successful plan implementation and success of new partnerships and initiatives.

Roles of key stakeholders

- Input into priority needs and barriers
- Share data and promising solutions and practice
- Represent stakeholder interests and contribute to collective solutions
- Mobilize support for recommendations
- Advocate for policy change
- Make commitments and investments to ensure effective implementation
• Government should provide data, resource allocation, experience from previous initiatives, partner in solutions, advise on viability or proposed changes.
• Participation and support from organized labor is critical to the success of the master plan process and implementation. Most informants found it challenging to answer the best way that labor should be engaged.

Role of philanthropy

Key informants expressed the following themes regarding the role of philanthropy. All were appreciative that foundation leaders were considering funding the master plan process and hopefully support for implementation and recommendations.

• Convey the importance and rationale for master plan development at this time and how it is linked to overall health improvement and health systems transformation in California.
• Emphasize and promote key principles and outcomes for the planning process.
• Fund the master plan development process including expert staff and necessary research and data.
• Provide the results and lessons learned from previous health workforce, diversity and health pathway initiatives they have funded or sponsored.
• Provide seed funding and assist in mobilizing support for implementation and recommendations.
• Assist in bringing key stakeholders to the table and encouraging collective action for greater common good.
• Support education and raising the visibility of the process and outcomes to key target audiences.

How this will be different (from previous statewide health planning initiatives)

• More compelling need and case for change.
• Recognition of need to move beyond proprietary interests
• Stronger engagement of the private sector
• Recent investments, initiatives to serve as building blocks- including CCPT, Com Colleges, TCE Health Pathways, Irvine, Atlantic, College Futures and lessons learned.
• Not State led nor response to govt funding
• Clear accountability, objectives and outcomes
• Sufficiently resourced & expert led planning process
• Commitment of front end funding for implementation
• Commission membership of senior, influential decision makers
• Product to include draft legislative initiatives
• Potential support from new governor, promising policy window
• Foundations investing more in communications and advocacy strategies
Appendix A: 
Interview Guide

Developing a Health Workforce Masterplan for California: Issues, Options, and Experience to Date

Key Informant Interview Guide
January 2017

Introduction 
Health care organizations in California are faced with unprecedented challenges in the redesign of care delivery and financing towards a system that shift incentives from filling beds and conducting procedures to keeping people healthy and out of inpatient facilities. As they assume increasing financial risk for enrolled populations, both providers and payers will need to enhance the management of existing conditions and address the drivers of poor health in local communities. As part of these efforts, payers and providers are building new alliances with public health, mental health and community organizations to advance improvements in population health, cost and quality.

Taking these steps will require substantial efforts to build workforce capacity in areas such as primary care and preventive services, as well as in non-clinical areas such as data analysis and management, technology, and cross-sector collaboration. California is already faced with substantial shortages, maldistribution and insufficient diversity in key health professions including primary care providers, medical assistants, mental health professionals and clinical lab scientists, and we are once again faced with a shortage of nurses. These challenges are felt most acutely by safety net institutions and facilities in rural areas, and there is an imperative for definitive action at the regional and state level. Continued increases in California's population growth, aging and diversity will exacerbate these challenges.

While California has made tremendous progress and is the national leader in providing health coverage for all and implementation of ACA related health reforms, looming changes in Federal policies and funding threaten to undermine all that has been accomplished and adversely impact health organizations and the populations they serve. As all in the health sector try to push back on and navigate potential changes and funding shortfalls, there will still be a need to address current and future health workforce challenges. The question is how much attention and resource can be devoted to health workforce and diversity issues in the next span of time.

With these issues in mind, and with the support of multiple California foundations, we are conducting a series of key informant interviews with leaders among health care employers, health professions education institutions, and government agencies. The purpose is to a) identify lessons from prior experiences to address related issues at the state level, b) determine the potential need for and viability of a statewide master plan for health workforce at this time, and c) solicit input on potential options, opportunities, and issues to consider in the design
and implementation of a statewide health workforce masterplan. The following questions are intended to serve as opening inquiries for a broader examination of issues, options, and opportunities in the development of a state health workforce masterplan in California.

A. **Experience to Date**

1. Have you participated in prior state level health workforce initiatives or commissions?

2. For those you were involved with:
   a. Who led and organized the initiatives?
   b. How long were you involved?
   c. What was your role?
   d. What were some of the outcomes?
   e. What were some of the impacts?

3. Which aspects of the process, the approach, the composition, or the roles of stakeholders contributed most to the effectiveness of those initiatives?
   a. Which aspects of those initiatives were barriers to full success?
   b. What might you have done differently, and how might that have changed the outcome?

4. What are some key lessons learned that should be considered in the design of future statewide health workforce initiatives?

5. Are there aspects of any other collaborative health or non-health initiatives that you would identify as worthy of replication?

B. **Need for a statewide health workforce master plan**

1. Is health workforce development a priority for your organization? Why or why not?

2. What are some of your most significant emerging health workforce needs? How do you see health workforce needs changing with new delivery and payment models and use of technology?

3. Do you believe there is need in your for more coordinated efforts to address these challenges or will requirements be met through marketplace or other mechanisms?

4. What is your understanding of what a health workforce plan for California would involve and attempt to accomplish?

5. What do you see as the rationale and value of developing such a workforce master plan?

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44 For interviewees with knowledge and experience with prior efforts.
45 These key informants will have reviewed the concept paper prior to our interview.
6. Given your organization’s current priorities, do you think there is an imperative to develop a health workforce master plan sometime in the next 2-3 years? If so, why?

7. Given current policy dynamics at the federal and state level, what would you view as the most significant challenges to the development of a state master plan?

8. What current dynamics in the CA marketplace would you identify as most problematic in building workforce your organization needs?

C. Options, Opportunities, and Issues

1. What would you identify as the factors that contribute and/or serve as obstacles to a more cooperative approach to health workforce development among competing providers and payers?

2. Based upon your experience to date, what would be the optimal roles of the following State agencies in the development of a state health workforce masterplan?

   a. The Office of the Governor?
   b. State Health Agencies (CADHS, OSHPD, CDPH)?
   c. The Labor Agency?
   d. The Legislative Branch?

3. What kind of role(s) do you think may be optimally played by private philanthropy to help address the emerging workforce needs of the health sector?

4. What kind of entity would you envision as an optimal convener, facilitator, and/or manager of a health workforce masterplan development process, and what qualities would be most important?

5. What steps would you like to be taken by which of the following stakeholder entities in the next two to five years to support a more cooperative approach to health workforce development?

   a. Tax-exempt hospitals and health systems
   b. Investor-owned hospitals and health systems
   c. Teaching hospitals
   d. Public hospitals
   e. Other government hospitals (e.g., veterans)
   f. Community health clinics
   g. Physicians groups
   h. Trade associations
   i. Allopathic and osteopathic medical schools
   j. Nursing schools and programs
k. Allied health educational institutions
l. County organized health systems
m. Tax-exempt payers
n. Investor-owned payers

6. Are there any issues we may have overlooked that will be important considerations in determining whether it is prudent at this juncture to pursue the development and implementation of a state health workforce masterplan in the state of California?
Appendix B:
Key Informant Interviewees

Providers
1. Charlie Francis, Senior Vice President, Dignity Health
2. Jill Ragsdale, Sr. VP, Chief People and Program Officer, Sutter Health,
3. Dean Germano, CEO, Shasta Community Health Center
4. Jane Garcia, CEO, La Clinica
5. Mitch Katz, Director, LA Department of Healthcare Services
6. Tim Joselin, CEO, Community Medical Centers, Central Valley

Health Plans
7. Liz Gibboney, CEO, Partnership Health Plan
8. Brad Gilbert, CEO, Inland Empire Health Plan

Legislative
9. Senator Ed Hernandez, Chairman, Senate Health Committee
10. Assembly Member, Jim Wood, Chairman, Assembly Health Committee

Health Associations
11. Carmela Castellano-Garcia, Jane Garcia and Beth Malinowski, CPCA
12. Yvonne Choong, Policy Director, California Medical Association
13. Susan Hogeland, ED California Association of Family Physicians
14. Cathy Martin, VP of Workforce, California Hospital Association
15. Judee Berg, ED, Health Impact

Union Leaders
16. Rebecca Miller, SEUI California

Higher Education and Health Professions Schools
17. Cathryn Nation, UC Office of the President
18. Linda Zorn, Statewide Director, Health Workforce Initiative, California Community Colleges Chancellor’s Office
19. David Carlisle, President and CEO, Charles R. Drew University
21. Joanne Spetz, Health Force Center, UCSF
22. Chris Cassel, Planning Dean, KP Med School
**State Agencies**

23. Bob Redlo, Chair, California Health Workforce Development Council, CA Workforce Investment Board

**Community Health and Public Health Leaders**

24. Kim Belshe, Executive Director, First 5 LA
25. Maria Lemus, Vision y Compromiso

**Behavioral Health**

26. Kimberly Mayor, Vice President, California Institute for Mental Health
27. Darryl Steinberg, Mayor of Sacramento, Former Senator and Author of Mental Health Services Act

**Pipeline Program Leaders**

28. Katherine Flores, MD, UCSF Fresno, Latino Center for Medical Education and Research, Fresno
29. Henrietta Williams, The Convergence, Inland Empire