Assembly
California Legislature

ASSEMBLY COMMITTEE ON HEALTH
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Informational Hearing

Diversity in California's Health Care Workforce
Tuesday, February 20, 2024 - Upon Adjournment of Session
1021 O Street, Room 1100

BACKGROUND

Introduction. California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity.

According to the 2022 American Community Survey, no race or ethnic group constitutes a majority of California's population: 40% of Californians are Latino, 35% are white, 15% are Asian American or Pacific Islander, 5% are Black, 4% are multiracial, and less than 1% are Native American or Alaska Natives. More than half of young Californians (52% of those 24 and under) are Latino. Conversely, more than half of those 65 and older are white (53%). The survey also notes that 27% of Californians are foreign born, more than twice the share in the rest of the nation (12%). Several other states have relatively high shares: New Jersey (24%), New York (23%), and Florida (22%). More than half (54%) of foreign-born Californians are naturalized U.S. citizens, compared to 39% in 2000, and most other immigrants are legal permanent residents.

This informational hearing will focus on the need for increased diversity in California's health care workforce, work to identify the scope of the problem, discuss current efforts and investments to improve the diversity of the workforce, and explore what more needs to be done to achieve the goal of an adequate and diverse health care workforce.

Importance of Diversity. According to a December 2022 Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University report, "The Race and Ethnicity of the California Health Workforce," a health workforce that reflects the racial and ethnic diversity of the population can improve access to, quality of, and outcomes of care. Studies have also documented that having a diverse student body in the health professions increases the cultural awareness and competence of all students. Historically, Black, Hispanic and Native American

populations have been underrepresented in health professions requiring higher education. This underrepresentation contributes to health disparities. It also limits access to high-paying, meaningful professions for underrepresented minorities.

The report found that Hispanic and Black workers are very underrepresented in the existing health workforce in California. The report notes that new graduates are more diverse than the current workforce for many professions, but even with these improvements, Hispanic and Black graduates are still underrepresented in most health professions requiring post-secondary education, indicating that disparities in the workforce will continue into the future. Asian and Native Hawaiian/Pacific Islanders, on the other hand are well-represented in most health professions but are underrepresented in behavioral health professions.

Health Quality. Let's Get Healthy California, a state-sponsored effort to improve the health of Californians, describes quality health care as consistent, affordable, patient-centered, timely, and delivered in a linguistically and culturally competent manner.

Although health insurance provides access to care, it does not ensure that everyone receives appropriate or high-quality care at the right time; nor does it fully address the remaining financial barriers to access for low-income people with insurance. Factors such as distance to care, transportation, time off work, child care, and other out-of-pocket costs impact access to care for Californians.

According to the Office of Health Equity in the California Department of Public Health, racial and ethnic minorities and individuals with low household incomes are more likely than their non-Hispanic white and higher-income counterparts to experience culturally insensitive health care and dissatisfaction with health care – health care experiences that have been linked to poorer health outcomes.

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment. Many populations experience health disparities, including people from some racial and ethnic minority groups, people with disabilities, women, people who are LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex, or other), people with limited English proficiency, and other groups.

Across the country, people in some racial and ethnic minority groups experience higher rates of poor health and disease for a range of health conditions, including diabetes, hypertension, obesity, asthma, heart disease, cancer, and preterm birth, when compared to their white counterparts. For example, according to Centers for Disease Control and Prevention data, the average life expectancy among Black or African American people in the United States is four years lower than that of white people. These disparities often persist even when accounting for other demographic and socioeconomic factors, such as age or income.

Disparities in utilization of health services are also found among all races, ethnicities, sexual orientations, and gender identities and expressions.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to:

- Address historical and contemporary injustices;
- Overcome economic, social, and other obstacles to health and health care; and,
- Eliminate preventable health disparities.

To achieve health equity, we must change the systems and policies that have resulted in the generational injustices that give rise to racial and ethnic health disparities.

Implicit Bias. According to the University of San Francisco's Office of Outreach and Diversity, bias is a prejudice in favor of or against one thing, person, or group compared with another usually in a way that is considered to be unfair. Biases may be held by an individual, group, or institution and can have negative or positive consequences. There are types of biases: conscious bias (also known as explicit bias) and unconscious bias (also known as implicit bias). Biases, conscious or unconscious, are not limited to ethnicity and race. Though racial bias and discrimination are well documented, biases may exist toward any social group. Age, gender, gender identity, physical abilities, religion, sexual orientation, weight, and many other characteristics are subject to bias. Unconscious, or implicit, biases are social stereotypes about certain groups of people that individuals form outside their own conscious awareness. Unconscious bias is far more prevalent than conscious prejudice and often incompatible with one's conscious values.

It is well-documented that implicit bias among health care professionals is prevalent and impacts patient care. A July 2022 article, "Tackling Implicit Bias in Health Care," published in the *New England Journal of Medicine,* notes that our individual biases operate within larger social, cultural, and economic structures whose biased policies and practices perpetuate systemic racism, sexism, and other forms of discrimination. The article notes that in medicine, bias-driven discriminatory practices and policies not only negatively affect patient care and the medical training environment, but also limit the diversity of the health care workforce, lead to inequitable distribution of research funding, and can hinder career advancement.

The article also discusses a review of studies involving physicians, nurses, and other medical professionals which found that health care providers' implicit racial bias is associated with diagnostic uncertainty and, for Black patients, negative ratings of their clinical interactions, less patient-centeredness, poor provider communication, under-treatment of pain, and views of Black patients as less medically adherent than white patients. In one study, 48.7% of U.S. medical students surveyed reported having been exposed to negative comments about Black patients by attending or resident physicians, and those students demonstrated significantly greater implicit racial bias in year four than they had in year one.

The article also notes that a review of literature on reducing implicit bias, which examined evidence on many approaches and strategies, revealed that methods such as exposure to counter-

stereotypical exemplars, recognizing and understanding others' perspectives, and appeals to egalitarian values have not resulted in reduction of implicit biases. In fact, no interventions for reducing implicit biases have been shown to have enduring effects. The article concludes that instead, it makes sense for health care organizations to forgo bias-reduction interventions and focus instead on eliminating discriminatory behavior and other harms caused by implicit bias.

Department of Health Care Access and Information (HCAI). HCAI houses the California Health Workforce Research Data Center (Research Data Center), the state's central hub for health workforce data. All health professional licensing boards in California are required to collect core data about the health workforce they oversee and provide this data to HCAI for analysis. The Research Data Center provides this data and analysis regarding issues of workforce shortage, equity, and distribution in order to inform state policy.

The Research Data Center collects, from most licensed professionals, the following information:

- Basic license details such as type, number, address of record, issue date and expiration date
- Date of birth
- Retirement estimates
- Area of practice/specialty
- Primary and secondary practice address
- Educational background
- Average hours spent in direct patient care, training, research, and administration including percent of time spent on telehealth
- Languages spoken
- National Provider Identifier
- Race and ethnicity
- Sexual orientation
- Sex at birth and gender identity
- Disability status
- Employment status

This work is guided by the California Workforce Education and Training Council. The Council provides strategic direction for the state's health workforce education and training priorities; ensures the health workforce meets the needs of the state; and, focuses on increasing health workforce diversity and improving access, quality, and equity to populations and communities in need. The Council focuses on primary care, behavioral health, oral health, and allied health.

California Future Health Workforce Commission (the Commission). The Commission was created in 2017 by a group of the state's leading health philanthropies to create a comprehensive action plan for building the health workforce California will need by 2030. The Commission's final report included a set of 27 detailed recommendations within three key strategies that will be necessary for: i) increasing opportunities for all Californians to advance in the health professions; ii) aligning and expanding education and training; and, iii) strengthening the

capacity, retention, and effectiveness of health workers. Throughout its deliberations, the Commission focused on the need to increase the diversity of the state's health workforce, enable the workforce to better address health disparities, and incorporate new and emerging technologies.

The Commission's 10 priorities for immediate action and implementation were:

1) Expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers;

2) Recruit and support college students, including community college students, from underrepresented regions and backgrounds to pursue health careers;

3) Support scholarships for qualified students who pursue priority health professions and serve in underserved communities;

4) Sustain and expand the Programs in Medical Education program across University of California campuses;

5) Expand the number of primary care physician and psychiatry residency positions;

6) Recruit and train students from rural areas and other under-resourced communities to practice in community health centers in their home regions;

7) Maximize the role of nurse practitioners as part of the care team to help fill gaps in primary care;

8) Establish and scale a universal home care worker family of jobs with career ladders and associated training;

9) Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved rural and urban communities; and,

10) Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement.

California's Health Workforce Pipeline. An April 2021, California Health Care Foundation report (CHCF report), "Health Workforce Strategies for California: A Review of the Evidence," intended to complement the work done by the California Future Health Workforce Commission. The CHCF report reviewed evidence of the impact of health workforce policy interventions (pipeline programs, scholarship programs, loan repayment programs, funding of graduate-level health profession training programs, residency funding) on the following: Increasing the availability of primary care, behavioral health, and dental providers in medically underserved areas ("access"); Increasing the diversity of primary care, behavioral health, and dental providers to better reflect California's population, particularly Latinx Californians ("diversity"); and, Improving health care access for patients with limited English proficiency by increasing the number of primary care, behavioral health, and dental

providers able to provide services in a language other than English ("language concordance"). The CHCF reports' major findings include:

Pipeline programs: Positive program outcomes include changes in the attitudes and intentions of participants regarding careers in health care, their academic performance, and the likelihood they will enroll in health professional schools. Some studies also showed improvements in graduation rates from health professions schools, and studies of post-baccalaureate programs have shown that these programs increase the numbers of students underrepresented in the health professions who graduate from medical school, choose primary care careers, and work in health professional shortage and medically underserved areas.

Scholarship programs: Scholarships are particularly advantageous for health professional students who are certain upon their entry to training that they are committed to working in a particular specialty or geographic area upon graduation. This level of certainty may be easier to achieve for students of health professions with a shorter pathway to practice, such as advance practice nursing and social work, compared with physicians, whose training takes a minimum of seven years. The primary benefit of a scholarship is that it removes the financial burden from recipients during their training so they can focus on academic success and personal well-being. Scholarships also allow students to graduate without the burden of high educational debt, which can affect choice of specialty and geographic area. Studies have shown that the amount of debt incurred by medical and dental students has grown by 172% in the last few decades. Economically disadvantaged students, in particular, may lose confidence and their ability to visualize a successful career path in the health professions when faced with major financial stressors and accumulating educational debt.

Loan repayment programs: Loan repayment provides the most immediate impact on access because the health professional is ready to work, or already working, in the area of need to receive the benefit. Though results have been mixed, studies indicate that there may be higher workforce retention rates with loan repayment programs, compared to scholarship programs.

Graduate-Level Health Professional Training Programs: Expanding and diversifying the workforce in California could be accomplished by expanding capacity at these training programs. A related health workforce policy intervention with the most evidence is the creation of specialized training tracks or programs within medical schools. These training tracks are supportive programs designed to increase access to care for underserved rural or urban populations in the state. Successful training tracks recruit students from the regions that they are aiming to serve, train them within those settings, and provide academic support and career planning throughout their training with the hope that graduates will choose to work in those regions after graduation, positively impacting access in those regions and overall diversity of the health workforce.

HCAI does not currently collect longitudinal data that could demonstrate which of these programs are more effective.

Ongoing State Efforts. HCAI administers a number of programs intended to improve healthcare access through scholarships, loan repayments, and grants to students, graduates, and institutions providing direct patient care in areas of unmet need. Loan repayment programs generally require physicians, nurses, or other health care professionals to serve within areas that lack sufficient access to health care providers. Other programs provide grants to organizations that train health care professionals or programs that help build a diverse "pipeline" of health professionals. For instance, the Health Professions Pathways Program is designed to recruit and support students from underrepresented regions and backgrounds to pursue health careers. It supports pipeline programs, summer internships, and post undergraduate fellowships. In addition to addressing direct patient access in medically underserved areas, HCAI's workforce programs address various stages of a health such career pathway, and can thereby increase the accessibility of health professions careers for individuals who are traditionally underrepresented in health professions.

Recent State Investments in Health Workforce. In addition to longstanding and ongoing state health care workforce programs, the 2022-23 Budget Act enacted a multiyear package of one-time health workforce initiatives across several departments, with a majority of the initiatives and associated spending from the General Fund and housed at HCAI. In addition to initiatives in higher education and training programs, the original health workforce package included the following:

- $486.6 million over four years for public health, behavioral health, primary care, and clinical workforce investments.
- $281.4 million over three years to recruit, train, and certify Community Health Workers.
- $220 million over three years for the Nursing Initiative.
- $126 million over three years for the Social Worker Initiative.
- $60 million one-time for the Emergency Medical Services Corps.
- $26 million one-time for substance use disorder workforce training.
- $25 million for the Healthcare Workforce Advancement Fund.
- $24 million over two years for the Indian Health Program Grant Restoration program.
- $20 million one-time for Reproductive Health scholarships and loan repayments.

In the 2023-24 Budget Act, to alleviate General Fund pressure, portions of these initiatives were delayed to future years, and the state reduced General Fund spending by shifting funding for behavioral health workforce initiatives to the Mental Health Services Fund. The 2024-25 Governor's Budget largely maintains the workforce package, but proposes to delay a portion of the funding for the Nursing Initiative and the Social Work Initiative to the 2025-26 Budget Year. In addition to these direct workforce investments, the State has in recent

years allowed Medi-Cal reimbursement for services of several nonclinical personnel, including birth doulas; community health workers (CHWs), promotoras, and community health representatives; and, peer support specialists in the county behavioral health system. Medi-Cal reimbursement is intended to expand and sustain the services of these nonclinical health care workers as part of a health care team. Compared to the workforce of licensed health care professionals, this nonclinical workforce better reflects the population served by Medi-Cal. The Medi-Cal CHW provider manual, for instance, explicitly requires that a CHW must have lived experience that aligns with and provides a connection between the CHW and the community or population being served. It indicates lived experience may include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

Although diversity in nonclinical health professionals is not a substitute for and does not diminish the importance of increasing diversity of physicians, nurses, and other licensed health care professionals, the relatability and cultural competence of professionals like CHWs can improve the ability of many health care providers' to deliver effective, patient-centered, and culturally competent care.

Conclusion. According to the Commission's final report, greater diversity among health professionals is associated with improved access to care for people who are racial and ethnic minorities, enhanced provider choice and patient satisfaction, better patient-provider communication, and better educational experiences for students while in training. In addition, it is well-documented that physicians from minority backgrounds are more likely to practice in Health Profession Shortage Areas and to care for minority, Medicaid, and uninsured people than their counterparts.

By 2030, communities of color will make up over 65% of California's population, yet they are severely under-represented in the health workforce and educational pipeline. Latinos are California's largest single ethnic group and are projected to reach 41.5% of the population by 2030. Given that these groups will make up the majority of California's working-age population, action is needed to ensure that more of them become health professionals.

Resources

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UC Programs in Medical Education (UC PRIME) | UCOP

California Physicians, 2021: A Portrait of Practice (chcf.org)

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