Tim Rainey
Executive Director

Edmund G. Brown Jr.
Governor

Stephanie Clendenin
Acting Director

CALIFORNIA WORKFORCE INVESTMENT BOARD
HEALTH WORKFORCE DEVELOPMENT COUNCIL
MEETING NOTICE

April 16, 2012
9:00 a.m. – 12:30 p.m.

Woodlake Hotel
500 Leisure Lane, Room 302
Sacramento, CA

AGENDA

I. Introductions and Opening Remarks

II. Chair/Director/Agency Updates

III. Action Item: Approval of the December 14, 2011 Meeting Summary

IV. Presentation: Industry Sector Strategies – Building Career Pathway Partnerships

V. Discussion Item: Action Plan Process

- **a. Presentations: Action Plan Ad Hoc Committee**

VI. Public Comment

VII. Council Member Updates

VIII. Next Steps

IX. Adjournment

Meeting conclusion time is an estimate; meeting may end earlier subject to completion of agenda items and/or approved motion to adjourn. In order for the Committee to provide an opportunity for interested parties to speak at the public meetings, public comment may be limited. Written comments provided to the Committee must be made available to the public, in compliance with the Bagley-Keene Open Meeting Act, §11125.1, with copies available in sufficient supply. Individuals who require accommodations for their disabilities (including interpreters and alternate formats) are requested to contact the California Workforce Investment Board staff at (916) 324-3425 at least ten days prior to the meeting. TTY line: (916) 324-6523. Please visit the California Workforce Investment Board website at http://www.cwib.ca.gov or contact Moreen Lane at (916) 324-2988 for additional information.

Douglas Sale
Acting Executive Director

Edmund G. Brown Jr.
Governor

Stephanie Clendenin
Acting Director

CALIFORNIA WORKFORCE INVESTMENT BOARD
HEALTH WORKFORCE DEVELOPMENT COUNCIL
December 14, 2011
9:00 a.m. – 5:00 p.m.

Double Tree Hotel
2001 Point West Way
Sacramento, CA

MEETING SUMMARY

I. Introduction and Opening Remarks

Vice Chair Chad Silva opened the meeting and welcomed everybody. Mr. Silva asked that the Health Workforce Development Council (Council) members introduce themselves. Council members/designees who were in attendance are listed below:

Kevin Barnett – *California Health Workforce Alliance*
Steve Barrow – *California State Rural Health Association*
John Blossom – *California Area Health Education Center Program*
Teri Boughton – *California Legislature, Assembly Health Committee*
Diane Factor – *Service Employees International Union*
Gary Gugelchuk – *Western University of the Health Sciences*
Brian Keefer – *California Department of Mental Health*
Cathy Martin – *California Hospital Association*
Jeff Oxendine – *California Health Professions Consortium*
Bob Redlo – *Kaiser Permanente*
Chad Silva – *Latino Coalition for a Healthy California*
Wayne Sauseda – *California Health and Human Services Agency*
Abby Snay – *Jewish Vocational Services*
Sheila Thomas – *The California State University, Office of the Chancellor*
Kathleen Velazquez – *California Department of Public Health*
Linda Zorn – *California Community College Chancellor's Office*

II. Chair/Director/Agency Updates

Mr. Silva explained that, with the help of the facilitators from Unleashing Leaders, the Council will complete the process of prioritizing the numerous recommendations received throughout the planning grant process.

Mr. Silva introduced Doug Sale, Acting Executive Director, California Workforce Investment Board (State Board) who gave an update:

Mr. Sales formally announced that Tim Rainey had been appointed as the new Executive director of the California Workforce Investment Board. He noted that Mr. Rainey had participated on the State Board, Green Collar Jobs Council and on the Council as a designee for the California Labor Federation where he served as the Executive Director at the Workforce and Economic Development Program. He also worked as a policy director for California Workforce Association and as a consultant for the California State Senate Majority Caucus.

Mr. Sale thanked Council members for their participation and support during the last year. He said that by leveraging the federal health care workforce planning grant funding with the outstanding work done by many of the Council organizations, a great body of work had been accomplished.

He noted that in just over a year, the Council has been able to convene, engage stakeholders, and develop a comprehensive report outlining recommendations addressing health workforce development in California.

The Council convened 11 regional focus groups comprised of thought leaders in regions throughout California to discuss the impact of the Affordable Care Act (ACA) and their workforce needs as implementation of ACA in 2014 approaches. The Council brought together Council members and other stakeholders in the Career Pathway Sub-Committee and, utilizing the Coordinated Health Workforce Pathway developed by Jeff Oxendine, created pathways and a set of recommendations for nine occupations and set of cross-cutting recommendations.

The Council also leveraged the work of the California Health Professions Consortium's Diversity Workgroup and the extensive research of so many health workforce development experts. From all of this work, over 125 recommendations were received and have been reviewed by the Ad Hoc Planning Committee and are now being prioritized by the Council.

Mr. Sale stated that, although today's meeting is the conclusion of a three-part process of prioritizing and categorizing our extensive list of recommendations, it will trigger the next phase of the Council's. He went on to say that the Council is a permanent Special Committee of the California Workforce Investment Board and will continue to operate after the June 30, 2012 closing date for the federal health workforce development grant.

The expectation and hope is that the Council membership will embrace its next phase of work, which will include developing "action plans" around these recommendations for the Administration to consider and for our stakeholders (state and regional) to consider as they

develop responses to their health workforce shortages and prepare for health care reform implementation.

Mr. Sale thanked Office of Statewide Health Planning and Development (OSHPD) for being such an amazing partner. Their expert and support has been a critical part of the successes achieved this year. The State Board and the Council could not have accomplished what they did it without them.

- *Career Pathway Sub-Committee (Sub-Committee)*

  Mr. Sale announced that the Career Pathway Sub-Committee Final Report was sent to the Council on Monday, December 12th. He asked that members share the report throughout their networks and constituencies. He thanked Steve Barrow, Sub-Committee chair and members who participated in the work. He also thanked UC Berkeley School of Public Health, Jeff Oxendine and team, for their great work on the report and staffing this effort.

  Mr. Sale mentioned that State Board staff would be reaching out to the chair and members after the first of the year to reconvene the Sub-Committee as was requested by the Council members. State Board staff will develop timelines for reconvening the Sub-Committee and contracting of facilitators.

Mr. Silva introduced Stephanie Clendenin, Acting Director for OSHPD who thanked the Council for their ongoing support and gave an update on OSHPD's activities:

- *Proactive Health Professions Shortage Area (HPSA) Designations*

  Ms. Clendenin said that additional OSHPD staff had been hired help to prepare proactive applications for primary, dental and mental health professional shortage area designation. This could lead to the identification of more than 12.1 million Californians residing in Primary Care HPSAs versus the current 4.8 million; 5.9 million Californians in Dental HPSAs versus 1.9 million; and 18.2 million in Mental Health HPSAs versus 4.4 million.

- *Medical Service Study Area (MSSA) Reconfiguration Process*

  Ms. Clendenin explained that OSHPD is undertaking a reconfiguration process to identify Rational Service Areas (RSA) and gave a timetable for the process. California's MSSAs are recognized as RSAs by U.S. Health Resources and Services Administration for purposes of HPSAs, and Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs).

- *Cal-REACH*

Ms. Clendenin discussed the partnership between the Health Professions Education Foundation and OSHPD's Health Workforce Development Division to implement the Cal-REACH, an online grants management system. They are developing an electronic application submission and monitoring process for individuals and institutions that submit applications for scholarships, loan repayments, Song-Brown, or Mini grants. The anticipated implementation date is Fall 2013.

- *Healthcare Workforce Clearinghouse (Clearinghouse)*

  An update was given on the Clearinghouse, a central repository for health workforce and education data housed at OSHPD. The Clearinghouse helps the state identify health workforce supply, demand, by geography and identify racial/ethnic composition of the workforce as well as linguistic abilities. The Clearinghouse will be operational in June 2012.

- *Health Care Innovations Challenge Grant (HCIC) Technical Assistance Call*

  Ms. Clendenin announced that OSHPD in partnership with the State Board Board will be hosting a technical assistance call for the Centers for Medicare and Medicaid Innovation – HCIC. HCIC has three main objectives:

  1. Engage a broad set of innovative partners to identify and test new care delivery and payment models that originate in the field and produce better care, better health, and reduced cost through improvement for identified targets.
  2. Identify new models of workforce development and deployment and related training and education that support new models either directly or through new infrastructure activities.
  3. Support innovators who can rapidly deploy care improvement models (within six months of award) through new ventures or expansion of existing efforts to new populations of patient, in conjunction with other public and private sector partners.

  The call will provide prospective applicants with information on the recommendations from the state's health care reform activities and how they could possibly be integrated into the Letter of Intent and ultimately grant applications. OSHPD and the State Board will also discuss what role the State can play to support their applications.

III. Action Item: Approval of October 25, 2011, Meeting Minutes

The October 25th meeting minutes were approved.

IV. Discussion and Action Item – Next Steps for the Health Workforce Development Council

At the request of a number of Council members the agenda was revised in order to discuss an email sent by Council member Bob Redlo. The email was sent Council members and

staff from the State Board and OSHPD on December 12, 2012. In the email (which was read at the Council meeting) Mr. Redlo recommended the following action plan for discussion.

A. Development of a Healthcare Workforce Development Council work plan:

1. By Feb 15, 2012, the Council should create an ad hoc sub-committee to develop a draft work plan that leads to the implementation of the agreed upon recommendations:

    a. Council work plan should include general work stream objectives, activities, resources needed, timeline and responsible lead to develop implementation strategies.
    b. The ad hoc sub-committee should help identify the recommendations that are most aligned with the Scope of the Council's charge, the purview and influence of State Government and the capabilities and capacity of the State Board and OSHPD. They shall determine which priorities the Council, State Board, OSHPD and appropriate State agencies will have lead responsibility to implement.
    c. Profession specific recommendations should be coordinated and assigned with agreeable accountability through state agencies and contractors with implementation capacity (e.g. California Institute for Nursing & Health Care (CINHC), Health Laboratory Workforce Initiative (HLWI), etc.)
    d. Crosscutting and selected allied health activities can be assigned to California Health Workforce Alliance (CHWA) and/or other workforce intermediaries to take neutral and unbiased positions in leading the work.
    e. The work plan will contain general work streams, but implementation plans must be further developed and refined by each assigned organization/contractor (described in B below.)
    f. Establish an ongoing role for the Council in overseeing implementation and ensuring strong linkages with private led initiatives and stakeholders.

2. The Draft Council work plan should be vetted and finalized through council members. Final work plan should be presented to State Board for further approval by state administration.
3. Once approved by State Board and state administration, funding should be provided to the Council to assist assigned groups in the development of the implementation plans.
4. The Council should be recognized as an established Health Care arm of the State Board accountable for identifying Health care reform workforce gaps and solutions to increase California's economic stability in health care.
5. Reconvene the Health Career Pathways Sub-Committee to finish their recommendations and continue their subcommittee meetings to dissect and develop recommendations for other health careers such as imaging, physician assistant, direct care, etc.

B. Implementation plan development for recommendations:

1. Funding will be provided to the assigned organizations/contractors for development of the implementation plans (State Board, OSHPD, CINHC, HLWI, CHWA, etc.)
2. Finalized implementation plans will be submitted to the Council for approval and inclusion into the Council work plan.
3. The Council will be the governing entity responsible for ensuring the implementation plans are carried out and that barriers to implementation are mitigated.
4. Funding for implementation work should be further explored through grants, state appropriations, and private contributions.

After significant discussion the Council voted to create an Action Plan Sub-Committee (Sub-Committee) with Bob Redlo as the interim chair. Council members were asked to show their interest in participating in the Sub-Committee.

V. Large Group Discussion: Review Accomplishments from the Previous Meeting

Based on feedback given during the morning part of the Council meeting, Unleashing Leaders Inc. took over the meeting and gave detailed overview of how the process for the remaining portion of the meeting has been changed to address the concerns of not moving forward with actionable items. The discussion of recommendations with members participating in the priority themes would continue, but be shortened.

This part of the discussion remained because key pieces that any group or committee moving forward will need for implementation and action were still missing. These missing items include, timelines, prerequisites to implementation, and action needed to implement. The small table groups were also charged with providing thoughts on what an ad hoc committee would look like, what actions they will need to take, key players for the committee, and champions of the project.

Mrs. Quest reminded the Council about the vision of the meeting, and told the Council the session was designed to address the concerns heard in the last meeting regarding Council members not having an an opportunity to have a voice on recommendations in their area of expertise. This section will be to complete the missing information on the recommendations. Instructions were to provide a voice on the clarity of the recommendations (but not to change the recommendations), indicate whether the recommendation is short, medium or long term, what time of action needs to be taken (legislative, regulatory, etc.), and review the prerequisites to see if they are accurate or if any were missing.

This information will inform the entire process moving forward. It will be provided to the ad hoc committee as a foundation for starting implementation and strategic plans. This information will also be put in the final report for to the state Administration.

VI. Final Report Out and Closing

Each of the groups focused on specificity, duplication of recommendations and how the recommendations are actionable. Specific comments will be reflected in the final prioritization documents.

VII. Public Comment

- Jim Cahill, a member of the public, discussed the issues related to veterans who received medical training during their military careers and are having difficulty transferring their skills to the private sector. The issues he discussed included:

  - The need increase the transferability of military training/education and experience into schools in order to enhance the future employment options for veterans
  - Decreasing the number of veteran students enrolling in private schools and increase the number of veterans enrolling in public schools.
  - The lack of understanding or awareness of the military medical training programs by the administration of the California Nursing and Licensing Boards.
  - Schools are under no compulsion to use the American Counsel of Education recommendations to award credit for military training or experiences. The faculty senates have to endorse and approve any changes to the school policies regarding credit and few do this.
  - Tax dollars have been used to train these veterans and the current policies force them to use their GI Bill on redundant curriculum that delays their entry into the workforce.

  In summary, he said that today's veterans are a readymade and experienced talent pool that should be "fast tracked" through the educational process. Not removing the current institutional barriers will force many of them to choose another career path or leave California for other places that reward their value and our investment in them.

- Michael De Rosa, Chair of Program Relations Committee, California Academy of Physician Assistants (CAPA) and Chair of the Physician Assistant (PA) training at Samuel Merritt University discussed the following issues:

  - Cultural competency is an important part of PA training and are required as part of the accreditation standards for PAs
  - The need to deploy more diverse graduates into the system which requires a more diverse applicant pool. CAPA is working with the CSU and UC systems to develop a pipeline of qualified diverse students from underserved populations.
  - There is always on focus on diverse training sites and locations for PA training. The challenge is finding qualified preceptors and the number one inhibitor to expanding PA training programs. He discussed the development of incentives for qualified preceptors.

VIII. Council Member Updates

Council members gave updates on various activities undertaken by their organizations.

IX. Next Steps

Staff will meet to discuss the development of the Action Plan Ad Hoc Committee.

X. Adjournment

The meeting was adjourned at approximately 5:00 p.m.

Health Workforce Development Council

Action Plan Ad Hoc Committee Packet

- Overview of the Committee Process
- Objectives Summary for Action Plans
- Public Comments
  - Matrix of Comments
  - Documents Received
- Action Plans

April 16, 2012

Health Workforce Development Council

Action Plan Ad Hoc Committee

Overview of the Committee Process

Background

At the December 14, 2011 Health Workforce Development Council (Council) meeting, the membership requested the formation of the Action Plan Ad Hoc Committee (Committee). The purpose of the Committee was to:

- Assist the Health Council in moving recommendations gathered as a part of federal Health Care Workforce Development Planning grant into action and implementation
- Solidify the infrastructure for California's healthcare workforce
- Utilize the recommendations developed during HWDC planning activities to establish implementation leads and plan
- Confirm the overarching Mission of the Health Council

The Committee was comprised of Council members and other subject matter experts. The Committee met three times during January and February 2012. As a result of those meetings, draft action plans were developed for the health professions and cross-cutting recommendations.

Membership

Bob Redlo, Chair
Kaiser Permanente

Kevin Barnett
California Health Workforce Alliance (CHWA)

Steve Barrow
California State Rural Health Association

Cindy Beck
California Department of Education

John Blossom, M.D.
California Area Health Education Center Program

Diane Factor
Service Employees International Union

Deloras Jones
California Institute for Nursing & Health Care (CINC)

Laura Long
Kaiser Permanente

Cathy Martin
California Hospital Association (CHA)

Chad Silva
Latino Coalition for a Healthy California

Anette Smith-Dohring
Sutter Health Sacramento Sierra Region

Abby Snay
Jewish Vocational Services

Sheila Thomas
The California State University Office of the Chancellor

Linda Zorn
California Community College Chancellor's Office

Group Assigned Action Plans

The Committee developed action plans by leveraging the work completed as a part of the Career Pathways Sub-Committee and existing work underway by groups comprised of subject matter experts. This approach was designed to ensure California coordinated work underway and supporting entities that have already begun identifying solutions to address health industries workforce issues.

The groups were asked to select one to three actionable priorities for which action plan elements (objectives, activities, timeline, etc.) were developed. The groups used an Action Plan template that was agreed upon at the initial Committee meeting. The template was utilized to align the priorities with the overarching goal, a problem statement and/or a general broad strategy.

Group Assignments

- **Profession-Specific:** Steve Barrow, Linda Zorn, and Jeff Oxendine will work with existing Pathway Subcommittee partners to select priorities and develop action plans. The partner are as follow:
    - Primary Care Physicians – CHWA
    - Nursing – CINHC and CA Action Coalition
    - CLS – CHA
    - Medical Assistants – Linda Zorn, Diane Factor and Cindy Beck
    - CHWs/Promotores (pending)
    - Public Health Professionals – California Association of Physician Assistants (CAPA)
    - Social Workers–California Social Work Education Center (CalSWEC)

- **Cross-Cutting Coordinated Infrastructure** – Office of Statewide Health Planning and Development staff and other stakeholders on data action plan

- **Cross-Cutting Education, Training Access, Capacity, and Support** –California Community Colleges, CSU, UC, K12 and other relevant stakeholders

- **Cross-Cutting Recruitment and Retention Considering Shortage Areas** – California Hospital Association members, Labor organizations, Community Clinics and other stakeholders

- **Cross-Cutting Cultural Responsiveness and Sensitivity** – Jeff Oxendine worked with Kevin Barnett, Chad Silva, and Deborah Wigely

Public Comment Process

The Committee acknowledged that there are a broad array of stakeholders throughout California that have been examining these occupations and issues. The Health Council requested the State Board provide an opportunity for broad public comment on its Action Plans. This will give entities that have similar efforts underway an opportunity to provide comments to help ensure California has the benefit of these efforts. Each action plan was provided at minimum a 10 day comment period as they were submitted by the assigned group.

HWDC Action Plan Process – *Moving Forward*

Moving forward the HWDC will remain engaged in the Action Plans that are underway through a process that ensures the State continuesto be informed of their progress, supportive through opportunities such as technical assistance, leveraged resources, advocacy, etc.), and provide insight that may inform decision-makers at all levels of government and in the private sector.

The State Board staff will manage this process to ensure these objectives are achieved while supporting the organic nature of the formation of the action plans and their implementation by their respectivestakeholder groups.

Process

State Board staff will be charged with to continue to be apprised of the progress of the various action plans and will arrange for opportunities to communicate their progress and outcomes. These opportunities may consist of activities such as webinars, using partner meetings agendas as a vehicle for updates, briefing events, and HWDC meeting updates. Staff will also rely upon suggestions made by the membership during this process to ensure opportunities are optimized.

Resources

The State Board will commit two staff to this process as their central focus. The proposed Action Plan process is intended to become the central function of the HWDC.. This will not preclude other activities such as the Career Pathway Sub-Committee. However, Career Pathways Sub-Committee and other activities should now be conducted in a manner consistent with the Action Plan process.

Health Workforce Development Council

Action Plan Ad Hoc Committee

Objectives Summary for Action Plans

Action Plan Objectives Summary/ Review

Section	Objectives
Clinical Lab Scientist: ***Health Laboratory Workforce Initiative and California Hospital Association (CHA)***	1. Provide additional capacity in specialty science courses which currently have limited availability and are over- subscribed. 2. Improve Medical Laboratory Technician (MLT) course articulation so that licensed MLTs who want to become a CLS will not have to repeat courses while obtaining their bachelor's degree that have already been completed for their MLT license, although they may have been lower division courses. 3. Allow institutions of higher learning to be approved 'training entities' enabling them to form hospital training consortiums, which under current statute is not possible. 4. Increase the number of training slots for CLS in the state.
Medical Assistant: ***Linda Zorn and Diane Factor***	1. Increase public sector's (community college) regional training capacity for medical assistant programs. 2. Support the Commission on Accreditation of Allied Health Education Programs (CAAHEP) programmatic accreditation, the highest quality accreditation for MA curricula. 3. Update community college medical assistant and ROP programs/curricula with new competencies required by primary care providers preparing for Affordable Care Act (ACA) implementation. 4. Upgrade the State competencies requirement in alignment with the needs of primary care employers, ACA, and the highest qualifications of the profession. 5. Revise the certifying exam to be in alignment with the upgraded competencies.
Nursing: ***CA Institute for Nursing Health Care and CA Action Coalition***	1. Increase the numbers of nurses with BSN degree. 2. Maintain educational capacity in schools of nursing. 3. Ensure educational programs and curriculum is aligned with evolving primary care needs. 4. Increase the # of APRN working in primary care. 5. Increase capacity of primary care clinics to incorporate RNs in staffing models. 6. Support successful implementation of the Institute of Medicine Recommendations for the Future of Nursing.

Physician Assistant: ***California Association of Physician Assistant***	1. Establish criteria under Section 128225 (g) of the Song-Brown Act to allow community clinics, in areas of unmet need, to contract with the state and receive funding contingent upon providing clinical rotation experiences for students. 2. Preservation of existing Physician Assistant Community College programs through articulation with a Master's Degree granting institution. 3. Program expansion through partnering with various CSUs to develop bridge programs, satellite campus, etc. 4. Support coordinated efforts to allow PAs to supervise Medical Assistants across all healthcare settings.
Primary Care Physician: ***California Health Workforce Alliance (CHWA)***	1. Increase residency programs and slots for primary care physicians with a specific focus on community based residencies and geographic areas of unmet need. 2. Develop the infrastructure and data and necessary to support primary care workforce development at regional and statewide level. 3. Increase recruitment and retention of primary care MDs; particularly for the safety net and underserved areas. 4. Develop supportive payment structure and policies targeted at increasing the attractiveness of primary care as a career path, retention of primary care MD's, sufficient capacity for health reform and effective use of MD's in medical homes and new delivery models.
Public Health: ***Jeff Oxendine***	1. Designate and fund entity to coordinate and implement public health workforce development in California; including priority initiatives in the Health Workforce Development Council plan. 2. Develop a short-term and ongoing plan for defining, estimating supply and demand and ongoing tracking. 3. Develop tools for estimating and tracking staffing levels and best practices for providing essential public health services and priority initiatives. 4. Ensure essential public health workforce data is collected, tracked and reported via Office of Statewide Health Poly and Development's Health Care Workforce Clearinghouse or other tracking sources. Standardize job classifications to facilitate this. 5. Invest in increasing the scale, sustainability and impact of California's public health training centers for in-person and on-line trainings. Develop innovative competency training in non-academic settings. 6. Ensure sufficient training program access for public health graduate programs in CA. 7. Increase funding and infrastructure for securing internship and post bachelors

	fellowship opportunities and provide sufficient stipend support for students. Work through proven existing programs and education institutions.
Social Work: ***David Cherin***	1. Social Work Programs need to create awareness on the part of incoming students of Affordable Care Act (ACA) opportunities and create educational opportunities, placements and support. 2. In order to maintain currency for graduated and graduating social work students courses, including Continuing Education Units, courses will have to be developed that provide info regarding ACA. 3. Through California Social Work Education Center's established AB 1440 Committee, use work with community colleges to expand Social Work's ladder of learning. This will articulate clear pathways to social work education and jobs from high school through to 4 year institutions. 4. Establish role of social work among health professionals to convey value of social work. 5. Outreach to target groups will be improved to increase rural, minority and disadvantaged potential students' access to social work education.
Crosscutting Education: ***Linda Zorn et al (CC, CSU, UC and K12)***	1. Determine, preserve, and restore funding for California's public education institutions (K-12, Community Colleges, CSU, and UC) that provide workforce preparation and education programs to meet health workforce requirements. 2. Partnerships needed to strengthen course alignment and articulation across K-12, community college, CSU, and UC educational institutions for health career pathways. 3. Strengthen academic and career counseling and advising at all educational levels. 4. Increase training and teaching opportunities in community and primary care settings, including increasing the availability of clinical sites, community rotations, and expansion of the number of teaching health centers in California.
Crosscutting Retention & Recruitment: ***CHA Workforce Coalition***	1. Improve partnership coordination and collaboration to better align education and related resources with healthcare employer workforce need. 2. Evaluate joint employer training programs that reduce recruitment cost and workforce shortage. 3. Increase the use of CHA's Repository of Promising Practices as a clearinghouse for successful partnership models and workforce planning/development projects.
Crosscutting: Cultural Responsiveness and Sensitivity (CS&R): ***CHWA***	1. Strengthen and promote an evidence-based business case to sustain and expand employer and state health workforce diversity programs and investment in pipeline diversity efforts. 2. Increase commitment and investment by educational institutions, employers and Workforce Investment Boards, in programs that have been proven to increase size,

	CR&S and diversity of the health workforce. 3. Develop and implement metrics to define success related to diversity and CR&S. Develop incentives and process for accountability. Link to existing and emerging standards and leverage points. 4. Recognize locally developed CR&S training curricula and assist with dissemination and continuous program improvement evaluation for these programs.
Crosscutting: Data Clearinghouse: ***Office of Statewide Health Policy and Development***	1. H & S Code 128051: Work with state level health licensing entities to collect data to the extent available on: **1) current supply of health care workers by specialty.** **2.** H & S Code 128051: Work with state level health licensing entities to collect data to the extent available on: **2) geographical distribution of health care workers by specialty.** 3. H & S Code 128051: Work with state level health licensing entities to collect data to the extent available on: **3) diversity of health care workers by specialty.** 4. H & S Code 128051: Work with EDD-LMID to collect data to the extent available on: **4) current and forecasted demand for health care workers by specialty.** 5. H & S Code 128051: Work with state level higher education entities to collect data to the extent available on: **5) educational capacity to produce trained, certified, and licensed health care workers by specialty and geographic distribution.** 6. H & S Code 108252: Prepare an annual report to the Legislature.
Additional Comments	

Health Workforce Development Council

Action Plan Ad Hoc Committee

Public Comments

(Matrix of Comments)

Nursing Action Plan

Broad Strategy: Education and training access, capacity, and support (Nursing: the educational pipeline provides sufficient access to educational programs that prepare nurses for the primary care workforce)			
Baseline: 24% of Associate Degree nurses obtain a BSN or higher degree in nursing; current capacity in nursing programs is 13,000 slots for admission, 60% in CC, 40% in BSN/ELM			
Objective	**Activities**	**Comment**	**Stakeholder**
Objective 1 Increase the numbers of nurses with BSN degree	2. Pilot community colleges to offer BSN in nursing, through: c. Seek legislative support that allows CC to provide programs through self-support	*I have several concerns regarding this strategy. First of all, we already have the capacity in the traditional BSN programs-however-we are constrained by budget and lack of faculty, and lack of clinical placements. How will these issues be resolved within the CCCs? The CCC faculty will have to be educated at higher levels, all students would have to complete 90 hours in community health where there is a dearth of placements, programs would have to go through restructuring, curricular revision, and accreditation—all with a current budget situation that is growth-prohibitive. The investment that would be required to bring the CCC programs up to BSN level would be notable when a smaller investment could be made in the CSU existing programs to increase collaborative models and expand capacity. By self-support – is the intent to charge actual cost of the education? If this is the case, then the cost of the program would fly in the face of the California mission for higher education. Please reconsider this strategy and I am happy to speak with you further.*	Ann D. Stoltz, PhD, RN Professor, School of Nursing Sacramento State
		The profession should be applauded for continuing to press for a larger, more educated workforce. As the labor market improves and insurance coverage broadens nursing will be positioned to address the primary care gap. I think, however, that it is time to recognize that nursing will not close that primary or	Chris Thos. Ryther, MHSA, NREMT-P Professor

	acute care gap, especially if more nurses will be taking on more responsibilities. I believe your action plan should also address the integration and increasing use of physician and nursing extenders such as MAs, Psych. Techs., LVNs, LPNs, EMTs, Advanced EMTs and paramedics. Likewise, involvement of the other providers is a powerful recruiting tool for the nursing profession but it only occurs when the other providers are allowed to work in concert or side-by-side with nurses in all healthcare areas and settings. *The delivery gap will widen and nursing will be spread too thin which will lead to an increase in unmet healthcare needs and, I believe, will force unwanted changes onto the profession. It could also lead to increased competition from other practitioners such as PAs and Pharmacists or delivery models that circumvent the expensive nursing component.*	Paramedic Department American River College

Medical Assistant Action Plan

Broad Strategy: Education and training access, capacity, and support			
Strategy: Increase Capacity to prepare Certified Medical Assistants			
Baseline: Existing Community College Clinical Medical Assisting programs – 22 + Administrative Medical Assisting programs - 32			
Objective	**Activities**	**Comments**	**Stakeholder**
		A critical portion of the Medical Asst. action plan is the job analysis. While it is important for programs to be accredited, it seems like the MA curricula and educational process needs to be simplified. In my current EMT course I have six students who either were not prepared for jobs as MAs and are seeking a new occupation or left their community college MA program because it was too long. *I have also been asked, now that the EMT scope of practice has been expanded*	Chris Thos. Ryther, MHSA, NREMT-P Professor Paramedic Department American River College

	(http://www.nhtsa.gov/people/injury/ems/EMSScope.pdf) why it does not articulate with an MA program, I am guessing the Clinical MA track.	
	On page one and two of the document there are references to CAAHEP accreditation. This cost is very expensive for a program to acquire and maintain. Once accreditation is granted, there is a $450.00 fee per year to keep the CAAHEP accreditation. The U.S. Department of Education recognizes at least two agencies: Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Accreditation Bureau of Health Education Schools (ABHES). *It seems to me you are limiting the accrediting agency to only CAAHEP. Is there a rational behind that reasoning? There are currently about 700 Medical Assisting programs accredited by these two organizations throughout the United States. If there are only 700 programs accredited, how many of those are proprietary schools? In California, approximately nine public institutions are CAAHEP or ABHES accredited. All of the other schools listed are proprietary. At a proprietary school, the accreditation costs are passed to the students unknowingly. The community college cannot pass the fees on to students. In the State of California, budgetary issues are a big concern within the public schools. Now is not the time to push for accreditation by one of the two accrediting agencies. The Medical Board of California does recognize three certifying agencies.* *American Association of Medical Assistants (AAMA)* *American Medical Technologists (AMT)* *California Certifying Board of Medical Assistants (CCBMA)* *The only certifying agency that requires CAAHEP is the AAMA. The other two agencies do not require accreditation. If the purpose is to have better trained medical assistants able to pass a national board, why does it have to be AAMA?*	Patty Bucho Program Director Long Beach City College

	Meeting local/regional needs is important; however, the decision to pursue CAAHEP accreditation is a wise move to insure that graduates of these programs have received an education that meets national entry-level standards as well. *The Medical Assisting Education Review Board (MAERB)* is available to help interpret the CAAHEP standards that would impact these efforts.* **MAERB is the only CAAHEP-recognized Committee on Accreditation (CoA) for medical assisting education programs.* *Will graduates of these programs receive certificates/ diplomas for their training and academic credit that can be transferred to educational institutions in other states?* *A CAAHEP accredited medical assisting program must demonstrate that the content and competencies included in the program's curriculum meet or exceed those stated in the latest edition of the MAERB Core Curriculum.* *To be awarded CAAHEP accreditation the content and competencies taught in these programs must meet or exceed those stated in the latest edition of the MAERB Core Curriculum.* *Will this be a state certification? If so, will it be recognized by health care entities in other states or, if the certificant moves to another state, will s/he find it necessary to also take a national certification exam for medical assistants such as the CMA (AAMA) Certification/ Recertification Examination?*	Misc. Comments

Public Health Action Plan

Baseline: There is no enumeration of the public health workforce or data on supply and demand. There is no mechanism for defining needed staffing levels to carry out increasing public health workload or for tracking changes at the same time a major portion of the workforce (30-40%) is expected to retire in 3-5 years.			
Objective	**Activities**	**Comments**	**Stakeholder**
		Having spent most of my career trying to clean up the messes caused by the de-funding of public health, it is very important to me that all other areas of healthcare are aligned with the public health effort. [This] is especially the case in mental health and emergency medical services. It is my personal opinion that public health extenders need to be created using the skills and abilities of physician and nursing extenders such as MAs, Psych. Techs., LVNs, LPNs, EMTs, Advanced EMTs, paramedics, pharmacists, dentists and the like. Everyone who sees a client or patient should have a public health mission at the beginning or end of his or her healthcare interaction. *Rather than see techniques used in developing countries, I think we can connect current providers with the outreach and intervention mission. I would like to see those provide primary, episodic and emergency care also trained as some kind of public health technician or public health practitioner. If reimbursement, even at modest levels, could cover the variable cost of these services then it would help fill the public health gap and justify the expansion of those healthcare occupations that chose to participate.* *Public health could use the equivalent of a sheriff's posse but with a focused, measurable goal and a low barrier to being involved. It would also dramatically expand the constituency for public health and create a bigger political footprint in*	Chris Thos. Ryther, MHSA, NREMT-P Professor Paramedic Department American River College

	the healthcare industry and in the communities they serve.	

Clinical Laboratory Science Action Plan

Objective	Activities	Comments	Stakeholder
		• *Application process to become a learning laboratory should be made simpler to encourage more hospitals to apply. School should provide assistance in completing the application to become a learning lab.* • *Provide financial compensation to trainers as incentive* • *MLT courses counted for CLS* • *Consider hiring foreign ASCP licensed CLS from other countries like Mexico, Philippines etc.* • *Increase the salary range of CLS to be more attractive to potential students. CLS years of schooling compared to RN, does not add up to the current starting salary(RN- two year program starts at $60/hour and CLS- five year program starts at $ 37/hour* *I believe there is lack of awareness that this career (CLS) even exist. It will be great if the Public Health Department or Institutions such as Kaiser or Sutter join forces and fund TV or radio commercials to promote CLS career(s).* *Another option to consider in order to make this career inviting to the community is to revisit the curriculum. Make the program or pre-requisites shorter to get more enrollees. I can understand how the program was intense in the early years, because of the magnitude of manual decision one has to make as a CLS. However, this is no longer the case at this time period, because of the new technology and development introduced by manufacturers in the laboratory field. In other words,*	Olive Miranda, CLS

	shorter schooling- more money-more prospective students. This is probably why I get 500 applicants for phlebotomist job? It is because it pays high with minimal schooling.(starting salary at $24.00 per hour for a maximum of four month course program) *Here's a list of the more popular courses that has high return on investment (i.e. time and money):* • *Respiratory Therapist (2 year program starting salary $ 40.00 per hour)* • *Radiology tech (2 year program starting salary $ 35.00 per hour)* • *Nursing (2 year program starting salary $ 60.00 per hour)*	
	This note is to voice my strong support for the Consortium training model to educate & train Clinical Laboratory Scientists in California. Our rural hospitals really need the help. The employment situation is getting critical and this collaborative approach is a realistic answer.	Emmet O'Connell, CLS, CIC Lab Manager & Infection Control Coordinator Mendocino Coast District Hospital

Profession Specific

Objective	Activities	Comments	Stakeholder
		A critical portion of the Medical Asst. action plan is the job analysis. While it is important for programs to be accredited, it seems like the MA curricula and educational process needs to be simplified. In my current EMT course I have six students who either were not prepared for jobs as MAs and are seeking a new occupation or left their community college MA program because it was too long.	Chris Thos. Ryther, MHSA, NREMT-P Professor Paramedic Department American River College

	I have also been asked, now that the EMT scope of practice has been expanded (http://www.nhtsa.gov/people/injury/ems/EMSScope.pdf) why it does not articulate with an MA program, I am guessing the Clinical MA track.	

Overarching Goal: *Expand California's primary care and allied health workforce to provide access to quality, affordable healthcare and better health outcomes for all Californians*

Health Workforce Development Council

Action Plan Ad Hoc Committee

Public Comments

(Documents Received)

CiMH
Helping You Make the Difference

California Institute for Mental Health

March 7, 2012

Dear California Workforce Investment Board Members,

On behalf of the California Institute for Mental Health (CiMH), a statewide organization that promotes training and technical assistance, research, and policy development in public mental health systems, I appreciate the robust effort that the Health Workforce Development Council (Council) has undertaken to lead the multi-sector effort to expand California's health workforce and identify the key occupations and drivers of change. CiMH was pleased to see the emphasis on behavioral health workforce needs and recognition that while behavioral health is oftentimes indistinguishable from and/or coincident with physical health needs functions need to be identified in addition to occupations. To that end, we were appreciative of the Office of Statewide Health Planning and Development's (OSHPD) effort to reach out to CiMH staff, county behavioral health workforce, education, and training programs, encouraging participation in the extensive needs assessment process that involved a number of regional focus groups and informed OSHPD's understanding of statewide and regional priority health workforce needs.

As CiMH continues to support county behavioral health agencies and statewide partners in developing programs that expand the diversity and improve the cultural competency of the workforce, we hope the social work action plan developed by the Ad Hoc committee of the Council will be a model for future efforts. A model that highlights how to bring leading organizations together to address service and workforce development and deployment needs and can be used to describe career and professional development among the other 22 occupations that make up the behavioral health workforce. It is with an enthusiasm about future efforts that we have summarized our feedback on the social work action plan.

Social Work Action Plan

We support the Committee's goal of increasing social work programs' enrollment by 25-30%. We would recommend that you work closely with county mental/behavioral health and provider organizations to identify local field placement opportunities to ensure quality training for graduates and maintain credibility among employers. A great example of this is happening in the Central Coast of California, with a new Masters in Social Work program. The program was developed together with CSU Monterey and the Monterey, San Benito, and Santa Cruz counties, and was designed to tackle the chronic shortage of social work professionals on the central coast to improve services to vulnerable and underserved populations in the area. Many of the nearly 60 students who are on track to obtain their MSW degrees from the tri-county area plan to return to the communities in which they grew up, with not only the commitment but the skills needed to make a difference for individuals and families in our county's underserved communities. Additionally, Health Care Reform provides a unique opportunity to fundamentally transform how behavioral health services are delivered in California. This transformation includes a move toward a county realigned system where social workers and others will have opportunities to participate in program and policy development. Consequently, we recommend investments in future curricula to include topics such as integrated healthcare, collaborations between child welfare and mental health, local criminal justice and substance use/co-occurring populations as well as management practice and policy, e.g., funding for Mental Health/Substance Use Disorder services and the Low Income Health Program.

2125 19th Street, 2nd Floor • Sacramento, California 95818 Telephone: 916.556.3480 Facsimile: 916.446.4519 www.cimh.org

Finally, while we greatly appreciate the attention the committee has given to the severe shortage of social workers in the behavioral health field, county mental health departments across the state continue to grapple with even more severe shortfalls in Psychiatrists and Psychologists, with particular difficulty in recruitment and retention of neuropsychology and other specialties. We are hopeful that the functions of these critical behavioral health occupations and the other occupations making up the delivery of mental health services at all levels of service will be documented in future findings and work by the committee.

CiMH looks forward to a continued relationship with the Health Care Workforce Council. If you have any questions or recommendations, please contact Adrienne Shilton at (916) 556-3480, ext. 148 or ashilton@cimh.org.

Sincerely,

Sandra Naylor Goodwin, PhD, MSW
President and CEO
California Institute for Mental Health

University of California
San Francisco

Center for the Health Professions
3333 California Street
Suite 410
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MEMORANDUM

TO: California Labor and Workforce Development
California Workforce Investment Board
Action Plan Ad Hoc Committee

FROM: Catherine Dower, JD, Associate Director – Research
Susan Chapman, BSN, MSN, PhD, Associate Professor, Research Faculty
Lisel Blash, MPA, Senior Research Analyst
Center for the Health Professions,
University of California, San Francisco

DATE: 27 March 2012

RE: Medical Assistants Action Plan

Thank you for the opportunity to comment on the draft action plan you have prepared regarding Medical Assistants in California. Staff and faculty at the Center for the Health Professions at the University of California, San Francisco, have been studying this workforce for many years and agree that it is important for the state to address some of the issues surrounding this growing and evolving profession.

We have organized our comments according to statements in the Action Plan.

Page 1
Stated Strategy: Increase Capacity to Prepare Certified Medical Assistants

Comments
Rather than focusing on increasing educational capacity, it may be more valuable to determine the current size of the workforce, the number of individuals in the education and training pipelines (public and private), and the estimated demand for their employment. In other words, we should conduct a supply and demand analysis, even if it needs to be rough estimates. Without knowing how many MAs we have and how many we need, it may be premature to focus on increasing preparation capacity. Although it appears that the MA profession may likely grow in the future, it has not been demonstrated by the evidence that we have shortages of MAs in California at this time.

It may also be that additional study needs to be undertaken regarding the quality and value of private sector programs compared to public sector programs.

Stated Baseline: Existing Community College Clinical Medical Assisting programs – 22 + Administrative Medical Assisting programs – 32

Comments
We should include the private sector programs as well because they are producing graduates who are going into the market and who should be counted in the supply side of the equation. Also, it appears that some programs are moving toward combining clinical and administrative curricula so that this split may be an outdated way of counting.

Stated Objective: Increase public sector's (community college) regional training capacity for medical assistant programs.

Comments
If it is determined that capacity needs to be increased because of a gap between supply and demand, public sector capacity might indeed be targeted. If that is the case, it would still be wise to consider private sector capacity by region before increasing public sector capacity. Specific regions may be saturated with programs.

Again, the quality and value of those programs might need to be evaluated so that quality choices could be offered to potential students but it may be unwise to grow public sector capacity in areas that are already well-served with educational programs.

Stated Baseline: Currently 33 CAAHEP accredited programs in California – only five are Community Colleges, one ROP program

Comments
We agree that California's community colleges would better serve students by offering programs that were CAAHEP (and/or ABHES) accredited. We support the concept of encouraging community college programs to seek and secure CAAHEP accreditation. This disparity also highlights the need to include private sector programs when conducting supply analyses, particularly, when these programs are CAAHEP accredited, indicating high quality by at least this measure.

Stated Baseline: HWI Curriculum model was last updated in 2008

Comments
We agree with recommendation to update any curricula that are being used by any MA training program. It is not clear to us why this one curriculum was noted in the action plan. If it is the only one available to community colleges, it should definitely be updated to best reflect the needs of employers and state of art and science for the profession. Other, more current, curricula may be available.

Page 2
Stated Baseline: 1996 California Certification requirements as set forth by the CA Certifying Board for Medical Assistants

Comments
It should be clarified that the California Certifying Board for Medical Assistants is not a governmental regulatory board. It is a private, non-profit corporation. Its name can be misleading to some individuals because it sounds similar to regulatory boards, such as the Medical Board of California or the California Board of Registered Nursing. The CCBMA is one of three entities recognized by the Medical Board of California for MA certification.

We are unaware of any evidence to suggest that the CCBMA certification is of any higher quality or value than the certifications offered by national entities and also recognized by the Medical Board of California. If anything, the national certifications (the Certified Medical Assistant offered by the American Association of Medical Assistants and the Registered Medical Assistant offered by the American Medical Technologists) may be of higher quality or value because they both are accredited by the National Commission for Certifying Agencies. Additionally, both national certifications offer certificants more professional mobility because they are recognized beyond California.

Stated Objective: Upgrade the State competencies requirement in alignment with the needs of primary care employers, PPACA, and the highest qualifications of the profession.

Comments
This objective (and the associated Anticipated Outcome, which reads "2012 update of competencies required by State") suggests that there are "State" competencies. However, with limited exceptions (e.g. in order to *train* other MAs, an MA must be certified by an organization recognized by the CA Medical Board. (Title 16 CCR 1366.3) there are no state regulations regarding MA certification or competencies in California for employment. MA certification is largely optional. The Medical Board of California has recognized three entities as offering certification but does not require MAs to be certified in order to work.

The CCBMA may indeed need to update its exam and certification requirements but this has little to do with state governmental regulations.
California could also look to the national certification entities for possible better alignment with the needs of employers.

Thank you again for this opportunity to comment on the action plan. We would be happy to answer any questions you have or to work with you and your colleagues on revising the action plan. We also look forward to next steps on this important matter.

BLOOD CENTERS OF CALIFORNIA

March 16, 2012

Comments on the Clinical Laboratory Science Action Plans

Background – Blood Center Laboratories

The Blood Centers of California (BCC) is an alliance of 16 non-profit blood centers, located throughout the state. (See our website – www.californiabloodcenters.org for location of centers). BCC supplies more than 1.4 million units of blood and blood products, representing over 90% of products needed, to California's hospitals, physicians and patients. The majority of blood drawn in California remains in California. Our mission is to provide safe, high quality and readily available blood and blood components for Californians. California has an all-volunteer donor blood supply and we are constantly encouraging all healthy, age and size eligible residents to donate the gift of like.

Blood centers as other health care providers have been affected by the shortage of licensed health care personnel in California – Registered Nurses (RN) and Clinical Laboratory Scientists (CLS). We have as other facilities offered bonuses and increased salaries for potential CLS applicants, but we are in competition with hospitals and industry for the limited numbers of qualified candidates. To address our shortages, we have streamlined, automated and outsourced our processes where possible. Additionally, CLS generalists have to undergo additional training (3-6 months) to qualify as specialist (limited license) in blood banking and transfusion services.

While the implementation of SB1809, Chapter 356(Medical Laboratory Technologists) was a source of increased staff for laboratories, this new legislation did not provide a significant number of qualified staff for employment in blood centers because of the high complexity and sophisticated testing that occurs in our laboratories. It was also anticipated that the MLT could serve as a career ladder; however, since the implementation of this measure, the numbers of MLTs accessing the career ladder is less than we would have hoped for.

Broad Strategy #3 – Education, training access, capacity and support

A number of the blood centers have put in place clinical experience programs that address our need for qualified licensed CLSs. Three of our members are affiliated with hospitals and those programs offer clinical experience for both MLTs and CLSs – limited and generalist. As noted previously, the generalist CLS has to have additional training to function within the blood center laboratory environment.

We also employ CLSs with a specialty (limited) license – Immunohematology and hematology. It also should be noted blood centers cannot employ a CLS trainee; all potential CLS blood center candidates must have a current CLS license in good standing.

The following are clinical experience programs offered by blood centers:

UCLA Blood and Platelet Center – funds one limited license (specialist) CLS per year; a full time position is available upon completion of clinical training

Community Hospital of the Monterey Peninsula Blood Center – is currently affiliated with DeAnza College and will be accepting one MLT intern for clinical training this spring. The prior affiliation with San Jose State University is on hold but previously 2 CLSs per year were trained in the hospital clinical laboratories. Plans are under way to take CLS students again in the future.

Long Beach Memorial Medical Center Blood Center – has an ongoing collaboration with CSU, Dominguez Hills. The newest program will train four CLS students/year as a result of a Department of Labor and Pacific Gateway Pacific Regional (local workforce agency) grant. The grant provides funding for 4 students, student stipends and funding for staff to provide the training. Acceptance into this program includes a two year commitment to the MemorialCare hospital system.

Crosscutting: Recruitment and Retention Action Plan

We concur with the activities to enlarge the collaborative relationships with employers/professional organizations that would align employer needs, clinical training and funding for meeting the need for increased CLSs in the workforce. We further believe blood center laboratories need to be included in the discussion as we have unique requirements in blood banking and transfusion services; requirements that are mandated by federal and state law to assure the safety of the California blood supply. While some hospitals have blood banks and provide appropriate testing, the majority of California's blood centers are free standing and many have their own laboratories, thus it is imperative we have an active role in addressing the CLS shortage issues.

To that end, we submit the following suggestions for your consideration:

Model the nursing experience by developing increased, ongoing industry - university partnerships

- Scholarships/Loan forgiveness for academic programs and clinical internships
- Establish increased numbers of clinical internships
- Grants to K-12 and universities to enhance career pathways through existing programs – outlined in SB 1309, Chapter 837 (2006)
- Establish a relationship with a national sponsor to get the message to the public similar to the Johnson & Johnson nursing ads.
- Develop approaches to address the dearth of qualified instructors such as loan forgiveness for a given number of years as an instructor
- Increase license fees and/or institute a special assessment to provide additional funding to assist Lab Field Services (DPH – LFS) in shortening time for licensure processing and renewal
- Advocacy is needed regarding the reimbursement process for laboratory services within hospitals; this decline has affected the availability of training programs and their status as a revenue source

Thank you for the opportunity to submit comments on the Action Plans. Should there be questions and/or issues for which we can provide further insight, don't hesitate to contact our Legislative Advocate:

Lydia Bourne
lydiabourne@sbcglobal.net
Office – (530) 758 - 4158
Cell – (916) 801- 0312

Thank you,

Steve Ferraiuolo
BCC President

Medical Assistant Action Plan

Broad Strategy: Education and training access, capacity, and support					
Strategy: Increase Capacity to prepare Certified Medical Assistants					
Baseline: Existing Community College Clinical Medical Assisting programs – 22 + Administrative Medical Assisting programs - 32					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Increase public sector's (community college) regional training capacity for medical assistant programs.	1. Document best practices in current community college MA programs that align with workforce needs for ACA. 2. Document geographic distribution of community college and ROP training programs by region. 3. Develop industry partnerships for funding for new medical assistant programs strategically located at community colleges to support regional workforce needs. Meeting local/regional needs is important; however, the decision to pursue CAAHEP accreditation is a wise move to insure that graduates of these programs have received an education that meets national entry-level standards as well. 4. Expand clinical sites to allow for program expansion.	1. Create five regional partnerships between quality MA programs and local primary care employers who are willing to provide support and clinical sites The Medical Assisting Education Review Board (MAERB)* is available to help interpret the CAAHEP standards that would impact these efforts. *MAERB is the only CAAHEP-recognized Committee on Accreditation (CoA) for medical assisting education programs. 2. Provide programs for 500 new medical assistant students Will graduates of these programs receive certificates/ diplomas for their training and academic credit that can be transferred to educational institutions in other states?	FY 2012 - 2013	Nursing and Allied Health Division - CCCCO CAWIB Regional WIB healthcare sector partnerships Regional Healthcare workforce intermediaries MAERB	OSHPD will evaluate the representation, equity, and strategies of the regional partnerships

Continued on next page…

Baseline: Currently 33 CAAHEP accredited programs in California – only five are Community Colleges, one ROP program					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Support the Commission on Accreditation of Allied Health Education Programs (CAAHEP) programmatic accreditation, the highest quality accreditation for MA curricula. A CAAHEP accredited medical assisting program must demonstrate that the content and competencies included in the program's curriculum meet or exceed those stated in the latest edition of the *MAERB Core Curriculum.*	1. Provide technical assistance for community colleges to achieve CAAHEP accreditation. 2. Partner with ROP and secondary schools on accreditation standards.	1. Ten community colleges with CAAHEP accreditation, could be regional consortiums.	FY 2012 - 2104	▪ Community colleges ▪ CAAHEP ▪ MAERB	

Baseline: HWI Curriculum model was last updated in 2008					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Update community college medical assistant and ROP programs/ curricula with new competencies required by primary care providers preparing for PPACA implementation. To be awarded CAAHEP accreditation the content and competencies taught in these programs must meet or exceed those stated in the latest edition of the *MAERB Core Curriculum.*	1. Conduct DACUM job analysis to update current HWI Community College Model Curriculum. 2. Convene primary care employer panel to validate the DACUM job analysis. 3. Convene curriculum writers to update curriculum. 4. Explore hybrid instruction for underserved and rural populations for medical assistant training programs as part of the curriculum process.	1. Updated model curriculum. Please note comments regarding the *MAERB Core Curriculum.*	2. FY 2012-2012	3. HWI ▪ MAERB	

Baseline: 1996 California Certification requirements as set forth by the CA Certifying Board for Medical Assistants					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Upgrade the State competencies requirement in alignment with the needs of primary care employers, PPACA, and the highest qualifications of the profession	1. Prepare white paper based on review of current employer demands, community college curriculum and CAAHEP competencies with recommendations on how to improve and upgrade the competencies required by State of CA	2012 update of competencies required by State	2012	CAWIB – Healthcare Sector committee MAERB	OSHPD
Revise the certifying exam to be in alignment with the upgraded competencies	1. Work with the Board to rewrite the exam in alignment with the updated competencies	New certifying exam . Will this be a state certification? If so, will it be recognized by health care entities in other states or, if the certificant moves to another state, will s/he find it necessary to also take a national certification exam for medical assistants such as the *CMA (AAMA) Certification/ Recertification Examination*?	2012	CAWIB Healthcare Sector Committee	OSHPD

Health Workforce Development Council

Action Plan Ad Hoc Committee

Action Plans

Clinical Laboratory Science Action Plan

Broad Strategy #1: ***Education, training access, capacity and support:*** Utilize distance education and other innovative delivery models in order to expand statewide access to special courses required for licensure as a Clinical Lab Scientist (CLS). Courses include, but are not limited to Medical Microbiology, Hematology, and Immunology. Replicate current successful models. For example, CSU Sacramento (CSUS) offers Hematology via distance education to various regions. Labs are offered on Saturdays and didactic portion is provided via web access. San Diego State University (SDSU) also has its own online Hematology offering with Saturday Labs. The CSUS program is so impacted that they have closed the class to southern California students, directing them to the SDSU offering. Hence, the need for additional access through expansion of this model.

Baseline: Looking into this further, but as of now, only two programs have been identified, CSUS and SDSU.

Objective	Activities	Anticipated Outcome	Timeline	Lead and Resources	Evaluation Method
Provide additional capacity in specialty science courses which currently have limited availability and are over- subscribed.	➢ Increase access to current successful model at CSUS for Hematology. The following will be required: - Identify hospital and other partners willing to hold the labs. (Fresno and Kaiser have already inquired). - Local CSUS and Concurrent Enrollment Student access would still be capped, but Extended Learning student capacity is wide open. Promote Extended Learning option. - Increase CSUS Site license to accommodate additional students. - Promote model. - Replicate at other CSU campuses. - Roll out to other courses, Micro-Med, Immunology.	1. Increased capacity of current CSUS distant Hematology course by 25%. Currently serving an average of 60 students per year. 2. Increase capacity of other specialty courses by X% in the next 5 years.	1-2 years 3-5 years	CSUS Program Other interested CSUs CSU Extended Learning LFS Resources: Students taking these courses through Extended Learning pay about $900 for a 3 unit course. Cost could be offset by other sources. These students are typically Post Bach coming from concurrent enrollment in another CSU or coming from a UC and who want to get into a training program and need this course. Also, additional labs are needed. If CSUS expands enrollment via distance learning, their lab will not have	Compare number of students served via current distance education programs for these specialty programs with outcomes when new models are up and running.

Broad Strategy #2: *Education, training access, capacity and support* : Improve MLT to CLS course articulation so that certain science courses taken at a California Community College by MLT students are recognized by the California State University System as upper division, thereby allowing MLTs to more efficiently earn a bachelor's degree and enter a CLS program if they choose. This strategy supports the concept of "stackable" credentials and provides a career pathway from MLT to CLS.

Baseline: Non-existent

Objective	Activities	Anticipated Outcome	Timeline	Lead and Resources	Evaluation Method
Improve MLT course articulation so that licensed MLTs who want to become a CLS will not have to repeat courses while obtaining their bachelor's degree that have already been completed for their MLT license, although they may have been lower division courses.	1. Build a strong coalition within the profession, industry and education with the will to improve articulation 2. Articulate the issue to CSU and CCC System 3. Legislation if necessary?	1. Increase course capacity by X%. 2. Reduce MLT to CLS coursework redundancy by 100%	3-5 years	CSU Chancellor's Office CCC Chancellor's Office CSU Campuses/programs Faculty Funding required unclear	Compare CSU course recognition today for CCC science offerings for MLT program with result of improved matriculation.

Broad Strategy #3: *Education, training access, capacity and support:* For CLS, current law requires that "approved training entities" be the laboratory where the clinical experience takes place. Current law (B&P 1222.5) has been interpreted to preclude an institution of higher learning to be the approved training entity. This statute, adopted in the 1970s, has limited CLS training program capacity in California because it prevents many smaller labs from participating in training. If an institution of higher education is allowed to be the approved training entity and acts as the central administrator by coordinating and providing a full, rich training environment through a group or consortium of hospitals, small and rural hospitals would then be in a better position to train because the responsibilities would be shared over multiple sites.

Baseline: MLT regulations adopted in 2005 allow both institutions of higher education and laboratories to serve as the approved training entity.

Objective	Activities	Anticipated Outcome	Timeline	Lead and Resources	Evaluation Method
1. Allow institutions of higher learning to be approved 'training entities' enabling them to form hospital training consortiums, which under current statute is not	1. Data collection and an inventory of approved sites and current locations. 2. Further research the role of accreditation by WASC and NAACLS in site	1. Increase the number of CLS training slots in the state by 15-20% (?) 2. Two – four CLS training consortiums	1-3 years	HLWI/CHA CSUs/UCs Funding required minimal	1. Is legislation enacted? 2. Do schools step up to be approved

possible. 2. Increase the number of training slots for CLS in the state.	approval. 3. Introduce and enact legislation allowing schools/programs to be the approved "training entity" for CLS. 4. Promote, educate schools, hospitals, CLS community about the use of a training consortium model for CLS.	formed.			training sites? 3. Number of consortiums formed. 4. Increased number of clinical slots.

Community Health Worker/Promotores Action Plan (Draft)

Broad Strategy: To address need for <u>expanded training opportunities</u> for Community Health Worker(CHW)/Promotores, including development of standards, ultimately leading to credentialing in conjunction with community colleges and/or at state level for multiple sets of roles.

Integrating CHW/Promotores within the provider setting and in communities and for vulnerable populations has been associated with improvements in access to care, health status, and health screening behaviors. To address the need for such workers and train them to assume bothexisting roles and new roles developed as part of health care reform (ACA), training opportunities must be expanded, needed core competences must be assessed, and curriculum standards must be developed consistent with such competencies. It is also essential that career ladders be in place, buttressed by continuing education. Finally, it is critical that thousands of non-citizen (generally legal resident) promotores, practicing in paid and volunteer roles in community agencies throughout the state, be offered opportunity for basic skill development and support to expand their roles to serve millions of currently uninsured in California as part of health care reform. CHWs have seen expanding roles in the areas of disease-related education and prevention. To ensure their place as part of the Patient Care Team, State of California through the Health and Human Services Agency (HHS) and its designated CA Workforce Development Council (CWHDC)- needs to promote a formal training curriculum and courses of study that improve and ensure the competency of the CHWs.

Baseline: Promote training venues for CHW/Promotores based on standard setting and ensure longevity for these roles through continuing education and career ladders.

Objectives	Activities	Anticipated Outcome	Timeline	Lead and Resources	Evaluation Method
1. Improve CHW training capacity 2. Assess core competencies in care team & external engagement 3. Develop & assess curriculum standards 4. Identify &/or design career ladders 5. Support skill	• Convene CHW users with CHW/Promotores training groups to assess training capacity. • Convene CHW training programs, including community colleges to establish a *CHW Partnership.* • Formalize a network of university-based researchers to support CHW user agencies & training groups. • Educate State Legislators on the value-benefits of CHW/Promotores • Review of literature & conduct survey of CHW /Promotores in CA, including non-citizen CHWs, to assess best practices	1. Compendium of CHW training programs, including their core components. 2. A partnership of CHW groups and training programs supported by the *CHW Research Network.* Key products: - Core competency set -Curriculum standards for CA - career ladder study 3. Identify best practice models to be used as baseline assessment for training & career ladder activity across California. 4. Forum in State Capitol promoting training of CHWs &	Fall, 2012 Early Summer 2012 Summer Fall 2012 Winter 2013 Winter 2012-13	*CPAC* *VyC* *CHW partnership* *CPAC, VyC, HIA*	Completion Establishment Products completed & disseminated Foundation &/or Fed support for timely completion

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training for non-citizen, Spanish language dominant promotores		joint public-private efforts to support CHW deployment. 5. Support for annual forums by Vision y Compromiso (VyC) & Hlth Initiative of Americas-UCB (HIA) to provide basic skills & continuing training for Spanish Speaking & volunteer promotores	Spring 2013 December2012 March 2013	*CPAC, CHW Partnership* *VyC* *HIA*	Successful Forum in timeframe Expanded support for respective events
Broad Strategy: To develop <u>additional resources</u> to expand availability and use of CHW/Promotores in community-based agencies, public health systems and in the private sector, among providers and health plans. Historically, CHWs have been an essential (and originally mandated) component of community health centers nationwide and of public health outreach-interventions at the county, regional and state levels. (Witness recent successful response to the H1N1 pandemic.) In recent years, the private sector, including through physician group practices, hospitals and health systems, and the coverage strategies implemented by health plans have greatly expanded the use of CHWs for internal and external purposes. Various fund reductions from the federal level, within State agencies and at the county level, have led to cut backs in CHWs over the last few decades in community clinics and county health departments. In recent times, the availability of CHWs has had to depend too often on "soft" money from sporadic government grants and from health care foundations active in California. Health care reform and its rapidly expanding implementation impacting all levels of the health care industry portends the availability of expanded resources for the use of CHWs.					
Baseline: Ensure that every avenue for resource development to support the deployment of CHWs is cultivated during this era of health reform implementation.					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
1. Promote expanded embrace of CHW/Promotores Model by health plans for outreach & navigation 2. Promote & expand info alerts by State	• Conduct meetings with CA Assn of Hlth Plans (*CAHP*) to assess use of CHWs by hlth plans in CA & nationally; do briefing(s) re: CHW role in ACA at *CAHP* regional & state meetings. • Continue funding alerts by *OSHPD* & *CHWDC* to alert interested parties re: fed & other funding	1. Funding to support *CHWDC* or *CHW Partnership* to promote use of CHWs by hlth plans contracted under ACA. 2. Convenings & briefings with *CAHP* health plan members & larger contracted providers.	Ongoing starting in Summer 2012 Ongoing starting in Fall 2012	*CHW Partnership, CHWDC* CHW Partnership	Funding of Partnership Convening of events Expanding State

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agencies to identify public & private support for CHW best practice projects. 3. Assess CHW benefit-value & development of reimbursement for CHW services. 4. Promote collaboration with State Dept. of Ed (DOE) for support thru Adult Ed. & other likely venues. 5. Assist provider community in identifying operating/internal support approaches for funding CHWs.	RFPs; expand alert network to include CHW user & training groups. • Assemble studies on CHW cost benefit value & approaches for reimbursement for para-professional workers incl. CHWs • Conduct dialogue between *DOE* & *CHWDC* to support Secondary & Adult Ed cooperation, incl. pilot projects promoting entry level hlth industry jobs, incl. CHWs • Assemble studies describing & assessing use of CHWs in the care team & in external roles, wholly or in large part, supported	3. Expanded alerts re: federal & possibly foundation funding to support ACA implementation; expanded alert list including CHW users & training groups. 4. Studies leading to State legislation & Executive Branch actions for CHW reimbursement pilots for Medi-Cal & contracted plans under Exchange, both public and commercial. 5. Agreements & understandings between *DOE* & *HHS* dept's to support training for entry-level hlth industry jobs, incl. CHWs. 6. Best practice reviews leading to expanded use of CHWs in physician groups & hospitals and health systems.	Ongoing; expanding in Spring 2012 Fall 2012 & Spring 2013 Fall 2012 & ongoing Fall 2012 & ongoing	*OSHPD,CaWIB* *OSHPD, CAWIB,* *CHWDC* *CHW Research Network,* *UCSF Ctr for Hlth Professions* *CHWDC, HHS DOE* *CHWPartnership, CHW Research Network*	Funding Alerts Funding & completion of studies Initial agenda of completed joint activities Best practice CHW reviews disseminated to private providers

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Broad Strategy: to <u>develop policy</u> at the state and county levels to expand availability of government resources, improve knowledge base for CHW development and serve as a catalyst to new program innovations leading to expanded use of CHW/promotores in internal and external roles for provider groups, and in public and privately supported health plans. In this current environment, State agencies and private health industry are planning for expanded coverage for up to five million currently uninsured enrollees and over one million persons currently served by public and private coverage programs who will see their coverage transform by 2014. In California, up to 70% of this newly insured population will be people of color from vulnerable communities. These are communities and populations traditionally classified as "hard to reach". Too often these populations reside in communities that are deficient in both public and private sector services. It is these very populations which are particularly amenable to engagement by CHWs acting in various external roles, i.e., navigating, educating, and implementing care interventions, and internal roles as valued members of the care team. The official decision makers that are responsible for implementing the various components of ACA in California include: the State Legislature, the California Health Benefits Exchange, State Department of Insurance, Managed Risk Medical Insurance Board (Healthy Families) and the Governor through the Departments of Health Care, Managed Health Care, and the California Health Workforce Development Council. It is these bodies that will make crucial decisions, particularly over the next three years, to make complementary State policy to address federal mandates, to allocate resources (federal and state), and to direct and/or collaborate with private sector partners to address this state's diversity through an efficient and effective delivery model.					
Baseline: Collaborate with elected officials, including the State Legislature and lead State agencies, to support the CHW concept and framework reaching the needs of California's diverse populations leading to the introduction of policy actions supporting the use of CHW/Promotores in this era of health reform.					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

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1. Strengthen role of immigrant workers in CHW & other entry level health careers. 2. Mandate inclusion of CHWs in allenrollment & outreach efforts in all portions of ACA. 3. Ensure voices representative of CA's diverse groups are part of governing & staff makeup of all parts of ACA. 4. Mandate use of safety net providers, CBOs & consumer-activist groups in outreach & health delivery for each of CA's diverse populations. 5. Ensure funding of CHW pilot projects to ensure client driven ACA implementation	• Expand state based naturalization programs. • Support state and federal legislation which strengthens protections for immigrant workers • Promote thru state's legislative & executive branches mandates & other means to ensure CHW use in all portions of ACA: Medi-Cal Adult expansion, Exchange hlth plans & their providers & integrated child health programs. • Assess Exchange & Medi-Cal planning to complete web based enrollment & outreach with direct CHW based contacts. • Secure federal, industry-based & foundation resources to support CHW pilot projects tied to community clinics, rural area special needs & best practices in clinics, hospitals & health plans.	1. New, redesigned naturalization programs (based on CA models from '90s) with state & federal support. 2. State government protections against discrimination against immigrant workers, e.g., non-citizen drivers' licenses, maintaining State-only programs. 3. Legislative resolutions & bills & Executive Actions urging partnerships with CHW user agencies & CBO advocates to promote client & community-oriented solutions in ACA incl. using CHWs. 4. Analyses & White Papers assessing the "Single Door" approach adopted by ACA State leadership is addressing challenges of linking web-based, IT methods with prospective client realities in low-income, diverse populations. 5. Medi-Cal & Exchange joint effort to secure resources, State & national, to fund CHW pilot projects with emphasis on community clinics, best practices &, special need populations.	Mid-2013 Mid 2012 & ongoing thru 2014 Mid 2012 thru 2013 Spring 2012 thru Fall 2012 Mid 2012 thru 2014	*HHS*, Legislature incl. *Tri-Caucuses, CHW Partnership* Same as above *Tri-Caucuses*, *HHS*, *Exchange* Board *CHW Partnership, CHW Research Network, Latino Hlth Alliance-LHA* *Medi-Cal*, *Exchange,CHW Partnership LHA* Same as above	Passage of legislation, by Executive Order, fed $$ Same as above. Completion of actions prior to ACA implementation Summer 2013 Analyses reviewed by *Exchange, Medi-Cal* in July'13 start-up Securing joint fed, foundation & hlth industry funds for pilot projects.

Overarching Goal: *Expand California's primary care and allied health workforce to provide access to quality, affordable healthcare and better health outcomes for all Californians*

Crosscutting: Cultural Responsiveness and Sensitivity Action Plan

Broad Strategy: Cultural Responsiveness and Sensitivity					
Baseline: There is no organized approach to promote the value of CR & S among key target audiences.					
Objective #1	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method (deliverables)**
1. Strengthen and promote an evidence-based business case to sustain and expand employer and state health workforce diversity programs and investment in pipeline diversity efforts	1. Assemble existing evidence that makes the case for increased workforce diversity and CR&S 2. Develop statewide communication strategies and tool kits; make tool kits available 3. Customize messaging and strategies for key stakeholder audiences 4. Coordinate statewide and regional campaign to link with overall goals of HWDC Plan 5. Prioritize targeted stakeholders and develop schedule for campaign. 6. Select and fund lead entity to organize campaign and provide technical assistance to spokespersons	1. Creation of evidence-based statements that substantiate the value of investments and policies that support CR & S and workforce diversity. Customized statements and associated messaging are directly linked to priorities of multiple important stakeholder groups and increase their awareness and action. 2. Increased investment, institutional commitment and policy change to advance top CR&S priorities 3. Availability of consistent, effective messaging for all spokespersons 4. Increased ability of advocates, programs, legislators and employers to make the case for investing in CR & S 5. On-going solicitation of investments in CR & S and workforce diversity strategies.	April-Dec 2012 (assuming funding is provided)	California Health Professions Consortium/CHWA in conjunction with: Fenton Communications, statewide /regional advocacy groups & employer groups Resources TBD	1. Business Case Statement, and supporting data 2. Copies of Campaign messages/toolkits in accessible repository 3. Roster of spokespersons and programs actively promoting value of CR & S 4. Roster of promotion & solicitation activities conducted 5. Increase in institutional investment, policy change and support to create CR & S and increase workforce diversity 6. Recognition of CR & S as an industry norm within the health care sector in California

Crosscutting: Cultural Responsiveness and Sensitivity Action Plan

		5. Mobilization of broad public/private support through engagement of most effective spokespersons for each stakeholder audience 6. Cohesive promotion of CR & S and effective solicitation of investments.			
Broad Strategy: Cultural Responsiveness and Sensitivity					
Baseline: There is no organized approach to make the case to key target audiences in a way that results in needed investments.					
Objective #2	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method (deliverables)**
2. Increase commitment and investment by educational institutions, employers and WIB's, in programs that have been proven to increase size, CS&R and diversity of the health workforce.	1. Identify priority programs for increased investment based on ability to address targeted need with evidenced based strategies. Examples: UC Riverside Medical School, PRIME, Post-Bac Program sustainability/expansion, HCOPs, USC Primary Care and Prevention Program, and UC Merced Medical School. 2. Align/sequence investments based on level of contribution to goals of HWDC Plan	1. Identification of priorities for investment based on potential for return on investment. 2. Plan for sequencing of investments over realistic time frame. 3. Unified advocacy strategy and resources for broad-based public and private support of CR & S and workforce diversity 4. Increased investment in priority programs linked to HWDC Plans and evidence based gaps	April 2012 May 2013	CHPC/CHWA in conjunction with HWDC and agency staff	1. List of priority programs 2. Roster reflecting schedule and sequence of investments 3. Roster of promotional efforts conducted by BHC sites and regional workforce development initiatives,

Crosscutting: Cultural Responsiveness and Sensitivity Action Plan

	3. Develop initiative with TCE/BHC sites and other regional workforce development initiatives, to promote career opportunities, strengthen pipeline programs and integrate proven CR & S strategies into local education/employment training programs.				

Broad Strategy: Cultural Responsiveness and Sensitivity					
Baseline: There is no organized approach to make the case to key target audiences in a way that results in needed investments.					
Objective-# 2	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method (deliverables)**
(con't) 2. Increase commitment and investment by educational institutions, employers and WIB's, in programs that have been proven to increase size, CS& R and diversity of workforce.	4. Develop strategy to advocate for investment that is supported by business case 5. Implement advocacy strategy 6. Mobilize investment in proven pipeline programs statewide and in regional areas.	5. Systematic promotion of increased investment in CR & S 6. Policy changes to support investment in priority programs and strategies, increased level of investment and measureable progress toward the goals of the HWDC plan 7. Increase in CR & S, career opportunity awareness and workforce diversity in BHC sites, and areas served Plan to replicate models	April 2012 May 2013	CHPC/CHWA in conjunction with HWDC and agency staff	4. Outline of advocacy strategy 5. Roster of policy changes enacted and Roster reflecting increased investments 6. Summary of data gathered from priority sites reflecting increases in CR & S, career opportunity awareness, and workforce/pipeline

Crosscutting: Cultural Responsiveness and Sensitivity Action Plan

	7. Replicate success in additional areas.	and successes in other areas of need.	June 2013-TBD		program diversity as a result of increased investments.

Broad Strategy: Cultural Responsiveness and Sensitivity					
Baseline: There is no organized approach to make the case to key target audiences in a way that results in needed investments.					
Objective-# 3	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method (deliverables)**
3. Develop and implement metrics to define success related to diversity and CR&S. Develop incentives and process for accountability. Link to existing and emerging standards and leverage points.	1. Assemble current metrics from CA and other areas 2. Develop central repository of metrics and strategies for implementation. 3. Link with AAMC project in CA and nationally to implement metrics and dashboard for CA Medical Schools. Replicate in other health professions. 4. Develop community benefit investment metrics	1. Clear metrics to focus efforts of health employers and educational institutions and for overall HWDC plan. 2. Support employers and educational institutions to achieve goals. 3. Greater incentive and accountability. 4. Policy change 5. Increased investment and improved performance.	June 2012-Dec 2013	CHWA/CHPC	1. Metrics in place 2. Accountability in place 3. Increased investment and performance according to metrics

	and promising practices related to CR&S, diversity and pipeline investment. 5. Tie metric fulfillment to continued funding from State funds for health professions schools and employers and WIBS. 6. Provide technical assistance to meet metrics. 7. Develop pilot programs 8. Promulgate promising practices to assist in meeting metrics. 9. Create public reporting of metric and dashboard results.				

Crosscutting: Cultural Responsiveness and Sensitivity Action Plan

Broad Strategy: Cultural Responsiveness and Sensitivity					
Baseline: There is no organized approach to formally recognize and support existing CR & S training programs.					
Objective # 4	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method (deliverables)**
Recognize locally developed CR & S training curricula and assist with dissemination and continuous program improvement evaluation for these programs	1. Convene quarterly meetings with CBO's implementing health workforce development activities and cultural brokers, in order to facilitate an on-going dialogue with HWDC focused on continuous improvement/sustainability of cultural competency trainings for California's health workforce	1. Stakeholder collaboration with Council through workgroup meetings and implementation of effective and locally relevant cultural competency trainings	April 2012 May 2013	CHWA BHC sites, other workforce development initiatives, Fresno County Cultural Brokers, and other ethnic community representatives	1. Summary of concerns from all meetings forwarded to Council as an agenda item and Abstract of Council discussion of concerns forwarded to all Stakeholders
	2. Develop "Characteristics of Effective CR & S Training Models"	2. Objective standards for recognition & promotion of models by HWDC	April 2012 June 2012	2. CHWA and workgroup representing stakeholders above	2. List of Characteristics
	3. Define implementation clusters based on characteristics of contexts in which trainings will take place; rural-urban; hospital-clinic; private-public; primary socio-economic profile of patients; other defining characteristics	3. Authors/developers of training models will select/describe the context(s) that their model is targeted to address when submitting them for vetting	April 2012 June 2012	3. CHWA and workgroup representing stakeholders above	3. List of contexts

Crosscutting: Cultural Responsiveness and Sensitivity Action Plan

Broad Strategy: Cultural Responsiveness and Sensitivity					
Baseline: There is no organized approach to formally recognize and support existing CR & S training programs.					
Objective # 4	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method (deliverables)**
(con't) Recognize locally developed CR & S training curricula and assist with dissemination and continuous program improvement evaluation for these programs	4. Solicit submission of locally developed cultural competency trainings for vetting against "Characteristics"	4. Roster of vetted curriculums that includes a resource guide to assist providers in selecting a vetted training that will be most relevant to their primary context for providing care	July 2012 May 2013	4. CHWA and workgroup representing stakeholders above	4. Roster of models that passed vetting process
	5. Select 1-3 models from each cluster, to initiate training implementation.	5. Improved understanding of the requirements for effective replication/scaling up of CR & S trainings in the context of each cluster	Sept 2012 May 2013	5. CHWA and workgroup representing stakeholders above	5. Roster of trainings provided, summary of post-training participant survey findings and recommendations from trainers
	6. Partner with all stakeholders to assist with promotion and resource development needed to implement all vetted training models	6. Increase in availability of CR & S trainings and increase in number of providers whose staff receive CR & S training	April 2012 May 2013	6. HWDC	6. Increased awareness of vetted training programs and increase in resources to train providers' staff.
	7. Compile all learnings from 1-6 above, to prepare guidelines for mandating cultural competency training in post-secondary health related disciplines.	7. Cultural Responsiveness and Sensitivity becomes an integral part of the skills required for certification in the health professions and becomes a professional norm among California's health care providers	3-5 years	7. HWDC, CHWA, BHC sites, other workforce development initiatives, Fresno County Cultural Brokers, and other ethnic community representatives	7. CR & S is a generally accepted standard for doing business in the health care industry in California.

Health Care Workforce Clearinghouse Program

Broad Strategy: Coordinated Infrastructure - Develop and Maintain a Central Repository for Health Workforce and Education Data in California						
Objectives	**Activities**	**Challenges Anticipated or Outcome**	**Timeline**	**Lead and Resources**	**Performance Measure**	**Broad Recommendations**
H & S Code 128051: Work with state level health licensing entities to collect data to the extent available on: 1) current supply of health care workers by specialty	**Conduct research to identify sources of data for health worker supply**	• Identified 22 health licensing authorities in the state and OSHPD met and received data related to the supply of health workers from the following: MBC, OMB, NMC, BVNPT, RCB, PAC, DBC, DHC, BRN, CDPH L&C, and CDPH LFS;	• 2008-ongoing	After June 2012, OSHPD will work with the following data providers to collect information: Board of Acupuncture, Board of Behavioral Sciences, Board of Chiropractic Examiners, Board of Occupational Therapy, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Podiatric Medicine, and Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board), Department of Social Services, and EMSA	• The ability to collect information from as many licensing entities as possible will increase the amount of data the Clearinghouse can display for various aspects of supply	• Work with state licensing entities and professional membership organizations to begin collecting and sharing data
		• OSHPD is unilaterally unable to collect data related to supply that is considered personal and confidential such as names, social security numbers and home addresses	• 2008-ongoing		• The ability to uniquely identify health care providers is vital in order for OSHPD to link data received from multiple data providers and conduct longitudinal studies	
		• Data is not collected in a uniform manner	• 2008-2010		• The ability to collect data in a uniform manner can be achieved with a standardized survey for all licensing entities, which OSHPD has developed	• Advocate for a uniform collection via a standardized survey
		• There is no mandate requiring entities to collect or provide OSHPD data	• 2008-ongoing		• The Clearinghouse Statute must be strengthened in order for OSHPD to collect all of the data needed to report to the legislature on the supply of health care workers by specialty	• Partner with DCA and CDPH to assist with data collection via surveys
			• 2008-ongoing			• Encourage partnerships with state and local membership organizations to assist with data collection
	Identify total number of providers in the State	• License status (active or inactive) is provided by all data providers	• 2008-ongoing	• OSHPD met with and received this data from MBC, OMB, NMC, DBC, DHC, BRN and CDPH L&C, and CDPH LFS	• License status (active or inactive) will provide a total number of health care providers in the State	
		• Licensee hours worked is limited because it is only collected by some data providers via the survey	• 2008-ongoing	• OSHPD met with and received this data from MBC, OMB, NMC, DBC, DHC, and BRN	• Licensee hours worked will provide information related to how many full-time equivalent health care providers are currently working	• Require that health care providers complete surveys at the time of licensure renewal

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
		• Employment status (full-time or part-time) is limited because it is only collected by some data providers via the survey	• 2008-ongoing	• OSHPD met with and received this data from DBC	• Employment status (full-time or part-time) will provide information related to how many full-time equivalent health care providers are currently working	• Advocate to increase response rates during conventions or other meetings • During health training, emphasize the importance of collecting this data once they become licensed • Advocate for authority to share social security numbers from licensing entities
	Identify type of setting and services delivered by providers	• Licensee activity is limited because most data providers do not collect this information	• 2008-ongoing	• OSHPD met with and received this data from MBC, NMC, and BRN	• License activity will provide information relate to what type of services the health care provider is performing (i.e. administrative, direct patient care, etc.)	
		• License setting is limited because most data providers do not collect this information	• 2008-ongoing	• OSHPD met with and received this data from BRN	• License setting will provide information related to what type of facility a health care provider is working at (i.e. hospital, clinic, etc.)	
		• Licensee primary and secondary practice location activity is limited because it is only collected by some data providers via the survey	• 2008-ongoing	• OSHPD met with and received this data from MBC, OMB, NMC, and BRN	• Primary and secondary practice location activity will provide information related to what type of services the health care provider is performing (i.e. administrative, direct patient care, etc.) at a particular facility	
	Identify supply of providers by specialty	• Licensee primary or secondary specialty is limited because it is only collected by some data providers	• 2008-ongoing	• OSHPD met with and received this data from MBC, OMB, NMC, DBC, DHC, BRN and CDPH LFS	• Licensee primary or secondary specialty will allow us to further break down the data by specialty	

Health Care Workforce Clearinghouse Program

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
H & S Code 128051: Work with state level health licensing entities to collect data to the extent available on: 2) geographical distribution of health care workers by specialty	**Identify the geographic distribution of health workers**	• Address of record is not provided by all data providers	• 2008-ongoing	• OSHPD met with and received this data from OMB, NMC, PAC, RCB, DBC, DHC, BRN and CDPH L&C, CDPH L&C and CDPH LFS	• Address of record will provide information related to where a health care provider receives communication via mail	• Work with licensing entities and professional associations to develop or implement survey tools that collect uniform data on practice location (city, state, zip, county)
		• Licensee primary and secondary practice location is limited because it is only collected by some data providers via the survey at varying levels of specificity (i.e. city, county, state)	• 2008-ongoing	• OSHPD met with and received this data from MBC, BRN, OMB and NMC by the county level only	• Primary and secondary practice location will provide information related to where a health care provider is working	
H & S Code 128051: Work with state level health licensing entities to collect data to the extent available on: 3) diversity of health care workers by specialty	**Idenitfy the diversity of health workers**	• Year of birth is collected by most data providers	• 2008-ongoing	• OSHPD met with and received this data from MBC, BRN, PAC, RCB, BVNPT, DBC, DHC, NMC, CDPH L&C, and CDPH LFS	• This data will help to identify the demand for health care workers; assist with recruitment, retention and succession planning and help to assess the health delivery system's ability to meet the cultural and linguistic needs of the state's population	• Work with licensing entities/professional associations to collect demographic data tht will inform program and policies needed to provide Californians with culturally sensitive and responsive healthcare.
		• Sex/gender is limited because it is only collected by some data providers	• 2008-ongoing	• OSHPD met with and received this data from MBC, BRN, PAC, RCB, BVNPT, and NMC		
		• Licensee race/ethnicity is limited because it is only collected by some data providers	• 2008-ongoing	• OSHPD met with and received this data from MBC, BRN, DBC, DHC, and NMC		
		• Licensee birthplace (by city, state and county) is limited because it is not collected by most data providers	• 2008-ongoing	• OSHPD met with and received this data from DHC for city only		
		• Licensee foreign language fluency is limited because it is only collected by some data providers	• 2008-ongoing	• OSHPD met with and received this data from MBC, BRN and DBC		

Health Care Workforce Clearinghouse Program

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
H & S Code 128051: Work with EDD-LMID to collect data to the extent available on: 4) current and forecasted demand for health care workers by specialty	**Conduct research to identify sources of data for the current and forecasted demand of health care workers**	• Identified all of the health industries that employ occupations	• 2008-2009	• OSHPD has met with and received data from EDD-LMID related to the current and forecasted demand of health care workers for the June 2012 roll-out	• Identifying the health industries which employ the occupations currently targeted by the Clearinghouse will assist with narrowing down the information needed for analysis	• Encourage partnerships between EDD-LMID and organizations such as the California Health Workforce Alliance, California Workforce Investment Board and industry associations in an effort to increase the response rates on surveys
		• Determined that EDD-LMID reports data on licensed and non-licensed health care workers	• 2008-2009		• The ability to report on licensed and non-licensed workers will provide unique information to each type of health care provider	
		• Determined that EDD-LMID uses Metropolitan Statistical Areas (MSAs) to capture and display their data in order to maintain confidentiality; this measurement is not used by all Clearinghouse data providers	• 2008-2009		• Using MSAs will provide the Clearinghouse with prescribed regions for displaying data received from EDD-LMID	
	Project current and forecasted demand	• Employment projections are limited because there is a limited response rate from the health care industry sectors on the Occupational Employment Statistics (OES) survey since there is no mandate for employers to complete them; in addition, demand estimates for most health personnel categories in California pre-date the Affordable Care Act and do not take into account service delivery models of the future	• 2008-ongoing	OSHPD met with and received this data from EDD-LMID	• Employment projections will provide information related to the estimated number of health care workers needed in future years as well as identify where shortages may currently exist	• Encourage employers to complete the OES surveys in order to improve the reliability of projections and other data
		• Employment wages are limited because there is a limited response rate from the health care industry sectors on the Occupational Employment Statistics survey since there is no mandate for employers to complete them	• 2008-ongoing	OSHPD met with and received this data from EDD-LMID	• Employment wages will provide information on the varied scale of compensation received by health care workers in different areas of the state	• Discuss more uniform measurements of tracking data (i.e. identifying a SOC code for all physician specialties)

Health Care Workforce Clearinghouse Program

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
		• Staffing patterns are limited because there is a limited response rate from the health care industry sectors on the Occupational Employment Statistics survey since there is no mandate for employers to complete them	• 2008-ongoing	OSHPD met with and received this data from EDD-LMID	• Staffing patterns will provide information on which industries employ certain occupations	
	Idenitfy health worker specialties	• Defined "specialty" for EDD-LMID using nationally recognized occupational categories from the U.S. Department of Labor, Bureau of Labor Statistics - Standard Occupational Classification (SOC) Codes; SOC codes are not used by all Clearinghouse data providers and in addition, they only identify a limited number of physician specialties	• 2008-ongoing	OSHPD met with and received this data from EDD-LMID	• Using SOC codes will provide the Clearinghouse with prescribed categories for displaying data received from EDD-LMID	

Health Care Workforce Clearinghouse Program

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
H & S Code 128051: Work with state level level higher education entities to collect data to the extent available on: 5) educational capacity to produce trained, certified, and licensed health care workers by specialty and geographic distribution	**Conduct research to identify sources of data for educational capacity**	• Identified four sources of state higher education entities: California Postsecondary Education Commission (CPEC), University of California Office of the President (UCOP), California State University Chancellor's Office (CSUCO), and California Community Colleges Chancellor's Office (CCCCO)	• 2008-2009	• OSHPD met with and received limited data from related to educational capacity from CPEC for the June 2012 implementation	• The ability to collect information from as many higher education entities as possible will increase the amount of data the Clearinghouse can display for various aspects of educational capacity	• Advocate for a standardized survey to pull consistent data from all campuses • Advocate for funding to conduct surveys at the campus levels • Require campuses to submit data to a state-level entity • Give OSHPD authorization to receive unitary student data • Work with the Association of Independent California Colleges and Universities (AICCU) to retrieve data on private schools
		• There is limited staffing resources to collect data at the individual campus level	• 2008-ongoing			
		• Determined there is currently no central source from which to collect private institutions data. CPEC had limited information.	• 2008-2011		• The ability to collect information from private institutions will increase the amount of data the Clearinghouse can collect to illustrate educational capacity	
		• Developed Classification of Instructional Program (CIP) list to include all health education programs	• 2008-2010		• Using CIP codes will provide the Clearinghouse with prescribed categories for displaying data received from the higher education entities	
		• Number of educational slots is not a data element that OSHPD is able to capture because it is not collected by the higher education entities	• 2008-ongoing	• OSHPD met with but was unable to capture this data from CPEC because they do not collect it and closed their office in Nov. 2011	• Number of educational slots will provide information related to the amount of students who may be permitted to enter health training programs	
		• Number of enrollments is limited because aggregated data was received from CPEC for UCOP, CUSCO and some of the private institutions but nothing for CCCCO	• 2008-ongoing	• OSHPD met with and received this data from CPEC for some higher education entities	• Number of enrollments will provide information related to the number of students who enter health training programs	

Health Care Workforce Clearinghouse Program

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
	Educational capacity	• Attrition rate is not a data element that OSHPD was able to capture from CPEC but may be obtained via survey at the individual campus level	• 2008-ongoing	• OSHPD met with but was unable to capture this data from CPEC because they do not collect it and closed their office in Nov. 2011	• Attrition rate will provide information related to the number of students who drop out of health training programs	• Retrieve data from the Integrated Postsecondary Education Data Systems (IPEDS)
		• Wait time to enter a program is not a data element that OSHPD was able to capture from CPEC but may be obtained via survey at the individual campus level	• 2008-ongoing	• OSHPD met with but was unable to capture this data from CPEC because they do not collect it and closed their office in Nov. 2011	• Wait time to enter a program will provide information related to the average length of time a student may wait to enter a health training program as well as help to understand which health training programs may be too impacted	
		• OSHPD has identified a total of 223 data elements related to student, faculty, institution and financial data which the Clearinghouse is attempting to capture	• 2008-ongoing	• The availability of data for all 223 data elements will vary depending on the education entity and year of collection	• The ability to collect as much information from as many higher education entities as possible will increase the amount of data the Clearinghouse can display for various aspects of educational capacity	

Health Care Workforce Clearinghouse Program

Objectives	Activities	Challenges Anticipated or Outcome	Timeline	Lead and Resources	Performance Measure	Broad Recommendations
H & S Code 108252: Prepare an annual report to the Legislature to include:	**Education and employment trends in health care professions**	• OSHPD will be able to report on some education trends as they relate to enrollments, number of graduates, degree types, and the location of educational institutions with data received from CPEC; these data may be compared by institution or by year in order to compile some trend analysis	• 2012-ongoing	• OSHPD will review and analyze the data received from CPEC, DCA's health licensing boards, CDPH and EDD-LMID to report on the education and employment trends of health providers	• Data related to education trends will show where training programs exist, types of degrees offered and how many students are enrolled versus graduated; these data will give the legislature information necessary to look at what has historically taken place in higher education entities as a means of planning for the future	• (Recommendations listed above for all individual categories)
		• Education data cannot be linked to employment data due to the fact that OSHPD does not have a unique identification number for individuals; therefore it is not possible to conduct a trend analysis of health care providers from their education through employment	• 2012-ongoing		• The ability to link data from all data providers via a unique identification number would allow OSHPD to conduct an accurate trend analysis related to the education and employment of health care providers; these data will give the legislature information necessary to use historical data as a means of planning for the future by identifying workforce shortages in employment and opportunities to expand training in education programs	
		• OSHPD will be able to provide limited reports on employment trends with data received from DCA's licensing boards, CDPH and EDD-LMID	• 2012-ongoing		• Data related to the current and forecasted demand of health care workers will provide information related to employment trends from a historical perspective; these data will give the legislature information necessary to review industries in which health care providers have worked and the size of the workforce	

Crosscutting: Education, Training Access, Capacity and Support Action Plan

Broad Strategy: Education and training access, capacity, and support					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Determine, preserve, and restore funding for California's public education institutions (K-12, Community Colleges, CSU, and UC) that provide workforce preparation and education programs to meet health workforce requirements.	1. Educate industry partners on the specific budget and funding issues so they can engage in advocacy in support of the educational institutions. 2. Develop action plan for education and advocacy of key legislators.	1. Industry partners implementation of advocacy plan.	1. Begin process summer 2012.	1. Industry partners with established legislative advocacy programs.	
Partnerships needed to strengthen course alignment and articulation across K-12, community college, CSU, and UC educational institutions for health career pathways.	1. Support and participate in the Course Identification Numbering System (C-ID) process 2. Support the development of the statewide nursing curriculum model based on the C-IDs for nursing and the work of the Faculty Discipline Review Group (FDRG) 3. Support the implementation of the AB 1295 nursing collaboratives for ADN to BSN and MSN pathways. 4. Recommendation 1 Improving Health Professions Pathways and Best Practices – CSU – Establish a CSU-HPEI (Health Professions Education Institutions) Joint Health Sciences Committee, or	1. Completion of C-ID process for ADN and BSN courses. 2. Completion of articulated Statewide Nursing Curriculum ADN to BSN. 3. Completion of articulation pathways in other key allied health programs in collaboration with other stakeholders (ie Health Laboratory Workforce Initiative (HLWI).)	1. December 2012 2. Spring 2013 3. Collaboration with HLWI to being Summer 2012. 4. ADN to BSN Collaboratives are on-going.	1. Academic Senates – CSU and CA Community College. 2. Jane Patton – Lead with Academic Senates – CSU and CA Community College. 3. CHA, HLWI, CSU, and CCCCO. 4. ADN and BSN program directors.	

	become a full and active participant in an existing one. 5. Participate in alignment of curriculum, courses and activities in health careers pathways with education institutions.	4. Continuation of currently funded ADN to BSN Collaboratives 5. Improved program articulation and student preparation and success in pathway programs.			
Broad Strategy: Education and training access, capacity, and support					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Strengthen academic and career counseling and advising at all educational levels.	1. Recommendation 2.2 Student Success Task Force – Require all incoming community college students to 1) participate in diagnostic assessment and orientation and 2) develop an education plan. 2. Recommendation 2.3 Student Success Task Force – Community colleges will	1. Legislation required to make activities 1-3 a system wide requirement for all community college students and all programs.	1. Based on legislation – EC 78211.5 and EC 78212. 2. As budget allows, expand health professions advisors networking opportunities, knowledge, resources.	1. CCCCO Governmental Affairs. 2. HPEI admissions offices (lead).	

	develop and use centralized and integrated technology, which can be accessed through campus or district web portals, to better guide students in their educational process. 3. Recommendation 6.1 Student Success Task Force – Community colleges will create a continuum of strategic professional development opportunities for all faculty and staff and administrators to be better prepared to respond to the evolving needs and measures of student success. 4. Recommendation 3 Improving Health Professions Pathways and Best Practices – CSU – Create better communications pathways among all health professions advisors so that students seeking careers in health are provided with more seamless and comprehensive advising with respect to health career options. Where possible, a health career advisor should be appointed at each CSU campus, community college and high school. 5. CA health professional schools should assume a leadership role in improving the quality and consistency of pre-health advising (e.g., informational materials should be developed by HPEIs and provided to advisors to ensure that reliable	5. Pre-health advising programs will be strengthened through partnerships with HPEIs and shared best practices.			

Crosscutting: Education, Training Access, Capacity and Support Action Plan

	information is available about health professional education, the admissions process, and the range of resources available to students; host annual conferences for pre-health advisors - emphasis on CCC/CSU advisors; and improved partnerships with undergraduate advisors at their own campuses).				
Increase training and teaching opportunities in community and primary care settings, including increasing the availability of clinical sites, community rotations, and expansion of the number of teaching health centers in California.	1. Explore central repository (regional or statewide) for primary care clinical sites, including ability to contract centrally. 2. Community clinics should become eligible to apply for federal funding to expand or become teaching health centers or nurse-managed health centers .	1. Process and organization identified. 2. Enhanced teaching quality and training capacity for primary care providers, particularly those that wish to work in underserved communities.	1. Fall 2012. 2. Present-2014.	1 and 2. CPCA, CA nursing schools, and other non-profit health or social services agencies.	

Crosscutting: Recruitment and Retention Action Plan

Broad Strategy: Recruitment and Retention					
Baseline: In certain allied health professions, healthcare employers encounter lack of required skills or a low supply of qualified recent grads to employ into open positions					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Improve partnership coordination and collaboration to better align education and related resources with healthcare employer workforce needs	1. Work with current groups such as BACCC and professional organizations that are focused on alignment of education resources and employer needs 2. Identify gaps in partnerships to support innovative workforce solutions (such as partnerships between regulatory agencies and healthcare employers) 3. Identify high priority allied health professions with gap in skill/experience requirement and document root causes of gap (curriculum, clinical time) 4. Explore funding opportunities & policy changes for hospitals offering on site employer based training and residency opportunities (WIA, LMP Trusts, etc)	Strengthened effort in the state by combining forces between CHA members and other working groups Modifications of curriculum to match employer skill requirements Subsidized funding to offset cost of training intern or training new grads	Year 1	Lead: CHA Workforce Coalition Partners: healthcare employers, ed providers, WIBS, labor partners	CHA members will evaluate the value and outcomes of partnerships
Baseline: CHA members incur high cost of training that can be reduced by increasing scalability through joint employer training programs					
Evaluate joint employer training programs that reduce recruitment cost and workforce shortage	1. Establish a CHA working group of interested hospitals to assist in coordinating activities 2. Identify 1-3 high trend priority areas among CHA members 3. Document any promising practices in the focus areas and promote expansion and replication (e.g. internal staffing registry) 4. Promote known ROIs related to training incumbent workers for priority areas	Documented reduced employer cost of training in at least 1 allied health profession	Yrs 1-2	Lead: Interested CHA Workforce Coalition Members	Cost and quality comparison of training solo versus jointly

Baseline: The recent CHA Repository of Promising Practices may is not widely known as a resource to access or submit promising and best practices					
Increase the use of CHA's Repository of Promising Practices as a clearinghouse for successful partnership models and workforce planning/development projects	• Determine the Repository sections needing to be further developed or added • Identify resources required to update and maintain the Repository • Establish mechanism for collecting and disseminating best practices • Promote the repository and its content with stakeholders • Explore the use of a listserv for selected high interest areas where members could upload reports or post links	Recognition of the Repository as the healthcare employer source for workforce best practices Increase by 20% the number of submissions	Years 1-3	Lead: CHA Workforce Coalition	Measurement of increased submissions Measurement of increased web hits and downloads Documented replication due to Repository

Medical Assistant Action Plan

Broad Strategy: Education and training access, capacity, and support					
Strategy: Increase Capacity to prepare Certified Medical Assistants					
Baseline: Existing Community College Clinical Medical Assisting programs – 22 + Administrative Medical Assisting programs - 32					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Increase public sector's (community college) regional training capacity for medical assistant programs.	1. Document best practices in current community college MA programs that align with workforce needs for ACA. 2. Document geographic distribution of community college and ROP training programs by region. 3. Develop industry partnerships for funding for new medical assistant programs strategically located at community colleges to support regional workforce needs. 4. Expand clinical sites to allow for program expansion.	1. Create five regional partnerships between quality MA programs and local primary care employers who are willing to provide support and clinical sites 2. Provide programs for 500 new medical assistant students	FY 2012 - 2013	Nursing and Allied Health Division - CCCCO CAWIB Regional WIB healthcare sector partnerships Regional Healthcare workforce intermediaries	OSHPD will evaluate the representation, equity, and strategies of the regional partnerships
Baseline: Currently 33 CAAHEP accredited programs in California – only five are Community Colleges, one ROP program					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Support the Commission on Accreditation of Allied Health Education Programs (CAAHEP) programmatic accreditation, the highest quality accreditation for MA curricula.	1. Provide technical assistance for community colleges to achieve CAAHEP accreditation. 2. Partner with ROP and secondary schools on accreditation standards.	1. Ten community colleges with CAAHEP accreditation, could be regional consortiums.	FY 2012 - 2104	Community colleges CAAHEP	
Baseline: HWI Curriculum model was last updated in 2008					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Update community college medical assistant and ROP	1. Conduct DACUM job analysis to update current HWI Community	1. Updated model curriculum	2. FY 2012-2012	3. HWI	

programs/curricula with new competencies required by primary care providers preparing for PPACA implementation.	College Model Curriculum. 2. Convene primary care employer panel to validate the DACUM job analysis. 3. Convene curriculum writers to update curriculum. 4. Explore hybrid instruction for underserved and rural populations for medical assistant training programs as part of the curriculum process.				
Baseline: 1996 California Certification requirements as set forth by the CA Certifying Board for Medical Assistants					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Upgrade the State competencies requirement in alignment with the needs of primary care employers, PPACA, and the highest qualifications of the profession	1. Prepare white paper based on review of current employer demands, community college curriculum and CAAHEP competencies with recommendations on how to improve and upgrade the competencies required by State of CA	2012 update of competencies required by State	2012	CAWIB – Healthcare Sector committee	OSHPD
Revise the certifying exam to be in alignment with the upgraded competencies	1. Work with the Board to rewrite the exam in alignment with the updated competencies	New certifying exam	2012	CAWIB Healthcare Sector Committee	OSHPD

Action Plan Template

Broad Strategy: Education and training access, capacity, and support (Nursing: the educational pipeline provides sufficient access to educational programs that prepare nurses for the primary care workforce)					
Baseline: 24% of Associate Degree nurses obtain a BSN or higher degree in nursing; current capacity in nursing programs is 12,643 slots for admission, 53% in CC, 47% in BSN/ELM (School Year 2011)					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
OBJECTIVE 1 Increase the numbers of nurses with BSN degree. (This includes providing opportunities to build a more diverse professional healthcare workforce, building upon the diversity represented in community colleges (CC) and reflecting the diversity of communities served.)	1. Implement the collaborative model of nursing education (CMNE) to provide for seamless progression from AD to BSN education, through: a. Provide technical assistance (TA) to community college (CC) and CSU collaboratives to develop the CMNE based on Best Practices already developed in existing collaboratives. b. Implement requirements of AB1295 to remove duplicate courses in CC and CSU nursing programs. c. Seek funding to hire coordinators for the start-up of and to guide implementation of the CMNE within collaboratives. 2. Pilot CC to offer BSN in nursing, through: a. Work with industry partners to align stakeholders for non-opposition. b. Work with Assemblyman Marty Black to re-introduce legislation to pilot BS in nursing only in CC in San Diego, Sacramento, and San Francisco Bay Area. c. Seek legislative support that	. 1. All nurses graduating from community colleges will have access to a BSN through a partnering CSU and be able to obtain the BSN in one more year of full time study. 2. Pilot will be another way to demonstrate an alternative route to BSN for AD students; pilot will include an evaluation component to determine quality of BSN education provided in CC.	1.a. TA available through Dec 2013 1.b. AB1295 to be implemented by fall 2012 in all CCC and CSU schools of nursing 1.c. underway; regional and statewide meetings planned 2. TBD	1.Chancellors' offices CACC and CSU; CINHC; CA AC Work Group #4…Need financial resources for collaboratives to hire coordinator for each new collaborative during development stage …access RWJF grant funds to action coalitions 2. Chancellor Office for CACC; Health Workforce Initiative; CA AC Work Group #4; ANA\C	1.a. Inventory schools of nursing to determine # participating in the CMNE; 1.b.Measure # of nurses continuing on to obtain a BSN 2. Inventory progress…design evaluation component to determine quality of nursing education provided and cost and resources required for this model

Action Plan Template

	allows CC to provide programs through self support. d. Consider model offered in other states where the BSN portion is given at the CC, but conferred by an accredited BSN granting university. 3. Increase access to fast track BSN or entry level master's (ELM) for students with pre-existing baccalaureate degrees, through: a. Support testing of new models, e.g. Contra Costa CCC and SFSU b. Market current programs offered through public and private universities, both non-profit and for profit accredited schools c. Create a user-friendly comprehensive web-based inventory of the various types of nursing education programs available in CA with program and contact information d. Expand Health Professions Education Foundation scholarships to include ELM e. Provide access to student loans for second degree students f. Approve new ELM programs through the BRN	3. Access to self support/tuition funded ELM programs are readily visible to prospective students and financial barriers to education are eased by expanded access to financial aid.	3. TBD TBD pending funding to develop web site	3. Individual schools of nursing; OSHPD HPEF; BRN; CA AC Work Group #4… Funding needed to implement new model e.g. Contra Costa College, grant funding pending CINHC/schools of nursing $25,000 to create web site and conduct inventory…grant submitted	3. Inventory progress
OBJECTIVE 2 Maintain educational capacity in schools of nursing	1. Educate policy makers on importance of maintaining capacity in state supported nursing schools and not subject nursing programs to budget cuts.	1. Capacity in public nursing schools maintained at 2011 level. 2. 50 new clinical educators	1. on-going	CHWC; CINHC; ANA\C; chancellor's offices; resources for staff to do research and to convene stakeholders.	1. BRN Annual School Survey

Action Plan Template

	2. Offer training programs for clinical educators to ensure faculty resources	prepared through CINHC offered programs	2. through 2013	2. grant funding secured	2. evaluate effectiveness of clinical faculty training program and impact on meeting faculty needs
	3. Ensure sufficient clinical training sites to meet educational demand.	3. New models of providing clinical education are tested and used to expand training sites.	3. focus of Magic in Teaching conference Nov 2012	3. Identify schools willing to try new approaches…provide mini grants to test new models. Need funding for mini grant	3. Inventory results of mini grants
	4. Explore strategies that address improved salaries of nursing faculty so they are more aligned with industry salaries. May also include incentives linked to loan repayment programs for graduate education with the proviso that recipients teach in nursing programs.	4. Strategy defined	4. TBD	4. CINHC, CACN, CAADN: resources for staff to do research and to convene stakeholders.	.
	5. Explore new partnerships that promote educational capacity available through private colleges using innovative approaches to expand as need is demonstrated.	5. Explore opportunities	5. TBD	5. CINHC, ACNL, private schools	5. Inventory results
OBJECTIVE 3 Ensure educational programs and curriculum are aligned with evolving primary care needs.	1. Increase access to graduate programs to prepare nurses for APRN roles through: a. Identfy current capacity and target increase based on forecasted need (see Objective 4) b. Funding such as traineeship through HRSA and National Service Corp	1.a targets established and # of APRN educated increase	1.a target set 2013	1. CA AC Work Groups #1, #2, #9; seeking funding from Blue Shield Foundation	

Action Plan Template

	c. Matriculating students at private colleges/universities that have additional capacity for MSN/doctoral students	1.c. Identfy schools with capacity; assist in marketing programs	1.c. Ongoing	1.c. Schools of nursing/CINHC	
	2. Provide for interprofessional educational opportunities that better align nursing education with emerging need for interdisciplinary practice models by activities such as: a. Colleges and universities offer interdisciplinary classes at points of interface for training of healthcare professionals b. Interprofessional simulation classes and clinical training programs, patient rounds, & QI activities	2. Interprofessional education becomes the norm	2. Ongoing	2. Colleges and universities; CA AC Work Group #2; CMA and CAFPP… resources for staff to do research and to convene stakeholders.	
	3. Provide educational opportunities that are more aligned with evolving primary care such as increase clinical education in primary care clinics. a. BRN to approve ambulatory care clinical nursing faculty without in-patient requirement…may consider program flex through OSHPD	3. New models of clinical education are adopted by schools of nursing, beginning with those schools that are ready to test new approached	3. Beginning 2013, on going	3. Schools of nursing; CINHC; BRN; OSHPD… resources for staff to do research and to convene stakeholders.	
	4. Consider alignment of career colleges with both private and public schools of nursing to ensure educational curriculum in career colleges will be accepted by accredited schools and students are on a college trajectory	4. Provide a new feeder system for higher education	4. TBD	4. Career colleges; Schools of nursing; CINHC; CHWC	

Action Plan Template

Broad Strategy: Coordinated infrastructure (Nursing: Increase capacity of RN workforce to help close the gap in available primary care providers)					
Baseline: Insufficient data available to determine gap					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
OBJECTIVE 1 Increase the # of APRN working n primary care…to also include geriatrics and behavioral health	1. Determine the gap of primary care providers with data that defines expected demand that will impact primary care and safety net providers and the current supply and pipeline of primary care providers (MDs, APRN, PA) to determine gap 2. Increase utilization of APRN as primary care providers through: a. Education with funding for sufficient capacity in graduate programs b. Residencies for APRNs such as those being piloted by UCSF/Glide Health and UCLA, Santa Rosa community pilot c. Promote effective models of care such as nurse run clinics including as Glide Health as well as new programs e.g. UCI and Charles Drew University d. Design model that incorporate primary care provided by APRN in behavior health clinics e. Identify and remove barriers to scope of practice and determine where changes need to be made to increase the effectiveness of	1. Accurate data available for planning 2. Increase number of APRN staffing and leading primary care clinics	1. TBD 2. TBD	1. CA AC Work Groups #2 & #8; CHWC; UCSF; CMA; CAFPP 2. a./b. Graduate schools of nursing; CA AC Work groups #1, #2…access to federal funds from CMS, HRSA, etc. 2.c. Partners with community based agencies and primary care clinics to develop nurse run clinics and new practices models incorporating nurses and seek grant funding to support development 2.e./f. CAAC Work	

Action Plan Template

	APRN in primary care f. Reimburse APRN for services provided 3. Develop white paper for Blue Shield Foundation to define nursing's contribution to closing the gap in primary care, with a focus on safety net health facilities in CA response to health care reform	3. White paper prepared	3. LOI March 2012 for funding fall 2012	group #1 3. CAAC Executive Team; Work group #1; CMA; CAFPP	
OBJECTIVE 2 Increase capacity of primary care clinics to incorporate RNs in staffing models	1. Design new practice modes utilizing RNs in expanded roles, building upon preliminary discussions with CPAC, CRHA, consortiums of primary care clinics and encourage schools of nursing to utilize clinics that have a nurse-managed model for clinical training. 2. Design educational models for RNs to prepare them for new roles in primary care through new clinical education models and transition to practice programs 3. Explore reimbursement for services provided, including Medi-Cal and Medicare reimbursement for education and counseling 4. (as above) Develop white paper for Blue Shield Foundation to define nursing's contribution to closing the gap in primary care, with a focus on	1. New practice models designed 2. Education models in place 3. Plan in place for seeking new reimbursement models 4. White Paper developed	1. TBD 2. Under way 3. TBD 4. see above	1. CA AC Work Group #2, CINHC, CPAC, CRHA, CHA 2.Schools of nursing, CINHC, CA AC Work Groups #2 and #3; BRN 3. TBD 4. CA AC Executive Team	

Action Plan Template

	safety net health facilities in CA response to health care reform. 5. Design practice models that utilize non-RN extenders such as MA, psych techs, LVN, EMT, etc to maximize skill utilization of all health care workers.	5. Skills of all health care workers and professional staff is maximized to have human resources to increase access to primary care.	5. TBD	5. Primary care clinics, CAAC Work Group #2	
OBJECTIVE 3 Support successful implementation of the IOM Recommendations for the Future of Nursing	1. Build inter-organizational support and engagement in Work Group efforts, including state agencies 2. Build broad-base community engagement 3. Inform state policy makers 4. Inform national conversations	IOM Recommendations implemented in CA and nursing contribution to increasing access to affordable quality care for all Californians is realized	Annual targets for progress set for next 5 years	CA AC Executive Team, CHWC	

- Overarching Goal: *Expand California's primary care and allied health workforce to provide access to quality, affordable healthcare and better health outcomes for all Californians*

Updated April 3, 2012

Physician Assistant

Broad Strategy: Increase Physician Assistant Internships/Clinical Training					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Establish criteria under Section 128225 (g) of the Song-Brown Act to allow community clinics, in areas of unmet need, to contract with the state and receive funding contingent upon providing clinical rotation experiences for students	Meet with Song-Brown Commission to discuss the process for allocating funding to community clinics Identify community clinics willing to participate	Develop rotation sites through out California in shortage areas	12 – 18 months	Song-Brown Commission	Track the number of clinics that participate
Broad Strategy: Expand Physician Assistant Education, Training and Capacity					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Preservation of existing Physician Assistant Community College programs through articulation with a Masters Degree granting institution	Work with CWIB and the legislature to communicate with the National ARC-PA to address health workforce implications of new language in eligibility standards	ARC-PA clarifies eligibility standards to allow existing PA Community College programs to articulate with a Masters Degree granting institution	12 – 18 months	CAPA	Letters to ARC-PA
Program expansion through partnering with various CSUs to develop bridge programs, satellite campus, etc.	Meet with CSUs to discuss possible partnerships	Develop 1 or more bridge programs and 1 or more satellite program in an underserved area	Within 3 years	CSU and collaborating PA Programs Faculty, staff and space	Number of programs developed

Physician Assistant

Broad Strategy: Policy Development that allows Physician Assistants to Supervise Medical Assistants Across Settings					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Support coordinated efforts to allow PAs to supervise MAs across all healthcare settings	Work with OSHPD to conduct a HWPP specific to PAs supervising MAs Support legislative efforts to allow PAs to supervise MAs	Improve care coordination	1 – 3 years	CAPA	Tracking legislative effort to allow PAs to supervise MAs
Broad Strategy:					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

- Overarching Goal: *Expand California's primary care and allied health workforce to provide access to quality, affordable healthcare and better health outcomes for all Californians*

Primary Care MD Action Plan

Broad Strategy: Primary MD Care Capacity					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
1. Increase residency programs and slots for primary care physicians with a specific focus on community based residencies and geographic areas of unmet need.	• Establish estimate of base-line primary care residency slots and distribution through CHWA residency study. Identify priority target areas and opportunities. • Implement CHWA Primary Care Initiative Residency Workgroup with leadership and participation from CAFP, CMA, AHEC, UCOP, OSHPD, UCSF, HRSA, CSRHA. CPCA etc. Will focus on setting goals, determining strategies, identifying funds and advocacy. Secure funding for expert GME consultant to support workgroup to develop recommendations and identify funding and a work plan. • Develop proposals based on findings and recommendations (phase 2). • Coordinated advocacy to sustain and expand Song Brown.	• Evidence to identify areas of need and opportunities. • Data and method for tracking. • Tangible, actionable plan that can be funded and tracked. • Work group of key stakeholders and experts to ensure buy in, completion and coordination. • Solid plan for meeting objective, including strategies for funding. • Broad Advocacy Support. • Additional PC residency slots for CA with mechanism for ongoing coordination	Phase 1- April-Dec 2012 (assuming investment provided)	CHWA working in conjunction with residency work group 100-150k for phase 1 to staff and operate workgroup and fund consultant. Phase 2 for proposals and implementation (TBD)	• Complete base line analysis • Workgroup in place with staff and consultant • Recommendations for increasing slots • Increased slots secured (phase 2)
2. Develop the infrastructure and data and necessary to support primary care workforce development at regional and statewide level.	• Formalize and invest in a Primary Care Workforce Initiative for California through CHWA (with close Council linkages) to implement the strategic plan, provide ongoing coordination, advocacy and adjust strategies as needs and solutions change.	• Single, neutral "hub" for planning, coordination, communication and advocacy among key stakeholders. Individual groups still lead respective efforts. Sufficient staffing to coordinate and support implementation.	April- Ongoing	TBD	• Initiative in place with sufficient staffing and funding and representation • Data available • Metrics and reporting in place • Funding in place

	• Develop supply and demand projections for primary care within the context of healthcare reform, health homes and HIT. Establish baseline and targeted need within defined timeframes. • Establish mechanism through the OSHPD Health Care Workforce Clearinghouse and Primary Care Workforce Initiative to provide timely ongoing tracking and public reporting to measure progress toward goals and inform adjustment of strategies. • Support OSHPD to get data needed. • Support academic researchers to analyze and report out data available from Clearinghouse and generate data from other needed sources.	• Data necessary for planning, decision-making and tracking available to stakeholders. • Clearinghouse is supported and has data needed. • Analysis and reporting meets needs to secure support, sufficient number of primary care MD's and systems change • Sufficient funds to invest in programs to meet priority target needs.			
Broad Strategy: Primary Care MD Capacity					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
3. Increase recruitment and retention of primary care MDs; particularly for the safety net and underserved areas.	• Increase loan repayment and scholarship programs and funding for primary care in California. • Explore new creative approaches to incent primary care practice in underserved areas. • Increase participation in loan repayment programs by streamlining and simplifying process. • Increase awareness and participation by sites to facilitate participation. • Increase use of Steven M. Thompson Physician Corps Loan Repayment and California State Loan Repayment	• Increased number of med students and residents choosing primary care and practicing in underserved areas. • Reduce the number of vacancies for primary care providers in primary care clinics (FQHCs, RHCs, etc.) in Health Professions Shortage Areas	June 2012-ongoing	CMA, CAFP, OSHPD?	• Increased $ for scholarship and loan repayment. • Increased use of funds for target individuals and organizations • Increased primary care MD's practicing in underserved areas

	Program funds and creative use of public and private funds for match. • Assess State Loan Repayment Program site matching guidelines to determine ways to increase participation and minimize costs. • Explore opportunities to expand training for IMG's to practice in CA such as the proven UCLA IMG Residency Program; particularly in underserved areas.				
4. Develop supportive payment structure and policies targeted at increasing the attractiveness of primary care as a career path, retention of primary care MD's, sufficient capacity for health reform and effective use of MD's in medical homes and new delivery models.	• Ensure sufficient payment by MediCal to support needed primary care capacity. • Promote Medi-Cal primary care payment increase to Medicare and advocate to sustain this increase after the federal support period (2013-2014). • Advocate for continuation of the Medicare Primary Care 10% bonus after the Federal support period (2011-2015). • Structure enhanced payment and new mechanisms for full scope of practice in new models of care (ACO, Health Home), including payment for care coordination. • Create scientific-based reimbursement system that can establish payment levels at a tipping point that attracts and retains primary care physicians, particularly in underserved areas.	• Sufficient Capacity for MediCal enrollees and participants in other ACA related programs. • Increased number of CA medical school graduates choosing primary care and underserved areas.	TBD	TBD	TBD

Public Health Action Plan

Broad Strategy:					
Baseline: There is no staffing, funding or defined responsibility for coordinating and implementing public health workforce development in CA. CA Public Health Alliance for Workforce Excellence (CPHAWE) is a volunteer coalition that has identified the needs and solutions but needs the resources to implement and achieve goals					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
1. Designate and fund entity to coordinate and implement public health workforce development in California; including priority initiatives in the HWDC plan	Designate CPHAWE and/or the CA DPH to be responsible for Public Health Workforce Development in CA. Finalize priority 3 year plan for public health workforce development Provide sufficient staffing and resources to carry out the plan, achieve goals and respond to changing needs and opportunities.	A clear and achievable plan for public health workforce development in CA with the staffing and resources to achieve it. Successful implementation of other priority objectives and action plans	June 2012	CPHAWE and/or the California Department of Public Health 125k-200k yr for staffing or equivalent in-kind support plus 20k for meeting expense, 25k for web site and TBD$ for priority initiatives and space	Entity designated and funded for min 3 years Capable staff hired and in place Priority initiatives implemented and meet objectives
Broad Strategy:					
Baseline: There is no enumeration of the public health workforce nor data on supply and demand. There is no mechanism for defining needed staffing levels to carry out increasing public health workload nor for tracking changes at the same time a major portion of the workforce (30-40%) is expected to retire in 3-5 years.					
Objective #2	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
2. Develop a short-term and ongoing plan for defining, estimating supply and demand and ongoing tracking.	Review methods and tools available from national and other state's public health workforce enumeration, assessment and tracking efforts. Determine best plan for CA given available resources and time line.	Plan for definition of the public health workforce in CA, supply and demand estimates and tracking. (phase 1) Phase 2- understanding of needs and ongoing tracking	April-July 2012 (phase 1) Phase 2- conduct study (TBD)	CPHAWE and/or CDPH TBD	Summary of method options and recommendations Plan for implementation and resources assigned
3. Develop tools for estimating and tracking staffing levels and best practices for	Develop tools and strategies and fund entity to carry out the plan.	Evidence and strategies for public health organizations and the entities that fund them to determine	TBD	CPHAWE	Tools in place with funding to utilize

providing essential public health services and priority initiatives	Survey best practices and tools from other states	appropriate staffing levels and practices for the most efficient use of resources to meet needs.			
4. Ensure essential public health workforce data is collected, tracked and reported via OSHPD Health Care Workforce Clearinghouse or other tracking sources. Standardize job classifications to facilitate this	CPHAWE leadership and public health workforce data experts are part of OSHPD Clearinghouse implementation efforts.	Clearinghouse becomes central repository for collection and reporting Necessary data for decision-making is available.	TBD	CPHAWE and OSHPD with CDPH	Solid plan and data in place
Broad Strategy:					
Baseline:					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
5. Invest in increasing the scale, sustainability and impact of California's public health training centers for in-person and on-line trainings. Develop innovative competency training in non-academic settings	Assess the capacity and capabilities of 3 public health training centers in CA and the National Training Center network to delivery priority competency based training in a cost effective way on a large scale in CA	Current public health workforce with greater competency, capacity and performance to complete increased and changing demand with fewer resources	June-Dec 2012 (phase 1)	CPHAWE and Public Health Training Centers at UCB, UCLA and SDSU	State of the art training on-line and in person resources in place to meet the scale of need and distribution in rural and underserved areas
Broad Strategy:					
Baseline: UCOP 2007 Report indicating a 180% increase required in public health graduate program access. This is prior to health reform implementation, major public health retirements and increase in undergraduate public health majors seeking graduate education.					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
6. Ensure sufficient training program access for public health graduate programs in CA	Revisit and update UCOP analysis and projections based on current and anticipated needs. Assess current demand versus capacity of	Plan for cost effective increased capacity for public health graduate education Increased graduates to meet growing need for public	TBD	TBD	Plan in place

	public health graduate programs. Recommend cost effective strategies for increasing capacity in priority areas. Assess the scalability of current on line programs and secure resources for making degree training more accessible and affordable; particularly for underserved areas	health professionals for health reform and retirements and changing needs; particularly for underserved areas			
Broad Strategy:					
Baseline: Thousands of CA undergraduate students interested in public health and primed to be next generation of public health leaders and professionals do not have access to sufficient internship opportunities to determine that public health is the path for them, gain necessary experience and secure jobs and entry into the profession. Educational institutions are not funded to provide and coordinate internships and organizations cannot afford them.					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
7. Increase funding and infrastructure for securing internship and post bachelors fellowship opportunities and provide sufficient stipend support for students. Work through proven existing programs and education institutions	Develop a fund for providing internship stipend support for undergraduate students and recent graduates to do internships in public health and community based settings. Emphasize opportunities for under-represented students and place committed students to work in underserved areas. Ensure sufficient coordinating infrastructure to recruit students from all CA Schools, place them in internships, offer strong career and leadership development activities and connect to local graduate programs and employers Designate and fund coordinating infrastructure in statewide organizations and local educational institutions.	Increased pool of capable, diverse CA undergraduate students in the pipeline to meet current and future public health workforce needs. Greater opportunity for students from CA communities to pursue public health and have rewarding careers and jobs.	June-2012 Dec 2013 (phase 1)	CPHAWE and Public Health Training Centers, Health Career Connection. Funds for stipends 3-4k per student X desired # students- 100 in year 1.. Funds for infrastructure 1500-2500 per student plus core operating support	Increased number of internships for CA students in areas of need in CA. Sufficient coordinating entities in place and funded.

Crosscutting: Recruitment and Retention Action Plan

Broad Strategy: Recruitment and Retention					
Baseline: In certain allied health professions, healthcare employers encounter lack of required skills or a low supply of qualified recent grads to employ into open positions					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**
Improve partnership coordination and collaboration to better align education and related resources with healthcare employer workforce needs	1. Work with current groups such as BACCC and professional organizations that are focused on alignment of education resources and employer needs 2. Identify gaps in partnerships to support innovative workforce solutions (such as partnerships between regulatory agencies and healthcare employers) 3. Identify high priority allied health professions with gap in skill/experience requirement and document root causes of gap (curriculum, clinical time) 4. Explore funding opportunities & policy changes for hospitals offering on site employer based training and residency opportunities (WIA, LMP Trusts, etc)	Strengthened effort in the state by combining forces between CHA members and other working groups Modifications of curriculum to match employer skill requirements Subsidized funding to offset cost of training intern or training new grads	Year 1	Lead: CHA Workforce Coalition Partners: healthcare employers, ed providers, WIBS, labor partners	CHA members will evaluate the value and outcomes of partnerships
Baseline: CHA members incur high cost of training that can be reduced by increasing scalability through joint employer training programs					
Evaluate joint employer training programs that reduce recruitment cost and workforce shortage	1. Establish a CHA working group of interested hospitals to assist in coordinating activities 2. Identify 1-3 high trend priority areas among CHA members 3. Document any promising practices in the focus areas and promote expansion and replication (e.g. internal staffing registry) 4. Promote known ROIs related to training incumbent workers for priority areas	Documented reduced employer cost of training in at least 1 allied health profession	Yrs 1-2	Lead: Interested CHA Workforce Coalition Members	Cost and quality comparison of training solo versus jointly

Baseline: The recent CHA Repository of Promising Practices may is not widely known as a resource to access or submit promising and best practices					
Increase the use of CHA's Repository of Promising Practices as a clearinghouse for successful partnership models and workforce planning/development projects	• Determine the Repository sections needing to be further developed or added • Identify resources required to update and maintain the Repository • Establish mechanism for collecting and disseminating best practices • Promote the repository and its content with stakeholders • Explore the use of a listserv for selected high interest areas where members could upload reports or post links	Recognition of the Repository as the healthcare employer source for workforce best practices Increase by 20% the number of submissions	Years 1-3	Lead: CHA Workforce Coalition	Measurement of increased submissions Measurement of increased web hits and downloads Documented replication due to Repository

Social Work Action Plan Template

Social Work **Broad Strategy: Increase Number and Quality of Social Workers serving populations impacted by health care reform and building interdisciplinary connections with providers to build community care coordination teams**					
Cross Cutting Recommendation: Expand health career access, advising and courses throughout the California State University System					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

Social Work Action Plan Template

1.Increase fiscal support(stipends) and numbers of ACA placements for social work students.	1. Secure additional funding for student support and distribute statewide via CalSWEC funding mechanisms. 2. Create 'social work in ACA' awareness and outreach programs. 3. Promote admissions system to enroll students in these programs especially from rural and urban areas. 4. Expand capacity of schools to work with agencies for field education and employment opportunities.	1. Create additional statewide educational opportunities. 2. Enrollment increase for schools of social work by 25% overall and by 30% in rural areas.	FY 2012-ongoing	CalSWEC CADD Statewide Field Consortium of Schools of Social Work	CalSWEC through statewide presence will monitor and evaluate enrollment and placement growth.
Cross Cutting Recommendation: Offer new and expanded educational and training programs					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

Social Work Action Plan Template

2.Develop curriculum and increase course offerings to insure new students and incumbent workers are trained in ACA practice.	1. Through CalSWEC network and resource library, develop educ/training modules for use by schools and training academies throughout the state. 2. CalSWEC will partner with schools and human service agencies to disseminate educ/training material. 3. Connect online and webinar educ/training to provide for 'virtual education' access.	1. All 21 schools of social work and participating health care agencies will have access to training materials. 2. ACA material will become a part of Calif's social work curriculum and CEU program for agencies.	FY 2012-2104	CalSWEC & CADD	Schools will incorporate proficiency in their ongoing accreditation evaluation programs.
Cross Cutting Issue: Improve course articulation between California's Institutions of higher learning					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

Social Work Action Plan Template

3.Increase number of students entering the field of social work at the higher education levels via CalSWEC's established AB 1440 Committee and 'ladder of learning' work plan.	1. Complete community college articulation work to support community college students entering social work educational programs. 2. Clearly articulate pathways for interested students in social work from high school through MSW degrees. 3. Promote inclusion of the 'ladder of learning' into existing university outreach efforts and CalSWEC recruitment efforts. 4. Explore use of CalSWEC/ACA support money to assist high school and community college students to engage in ACA service learning programs.	1. Articulation agreements with community colleges completed. 2. Ladder of learning finalized. 3. Pilot service learning projects developed and implemented.	FY 2012-2013, and ongoing	CalSWEC Schools of Social Work through CADD	CalSWEC will track
Cross Cutting Issue: Support definition of new competencies and roles with emerging service models and across overlapping professions					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

Social Work Action Plan Template

4.Increase awareness of role of social work in the health profession and promote development of collaborative projects and research programs	1. Develop grant and research opportunities for social work and other disciplines to collaborate in health care. 2. Distribute research findings and best/promising practice models. 3. Use existing innovation grant models and federal funding to promote/pilot/institute interdisciplinary practice.	1. Innovation and Federal Grants will be funded. 2. Pilot opportunities will further be identified for research and evidenced based development.	FY 2012-2014	CalSWEC withCADD University contracts and grant offices	University and CalSWEC research arms
Cross Cutting Issues: Priority Focus on Outreach to Underserved and disadvantaged populations					
Objective	**Activities**	**Anticipated Outcome**	**Timeline**	**Lead and Resources**	**Evaluation Method**

Social Work Action Plan Template

5. Expand number of BSW and MSW in health care practice throughout California, representing rural, minority and/or disadvantaged populations.	1. Use CalSWEC infrastructure and university outreach to expand marketing efforts in and for underserved areas/ persons. 2. Create regional service learning opportunities to attract a wider array of potential students. 3. Expand outreach to service agency staff and build educational efforts to train and educate staff in place.	1. Increased rep of minority persons, and rural area graduates.	FY 2012-2014, and ongoing	CalSWEC with Schools and agency partners.	CalSWEC will track within existing data system.