



The Affordable Care Act & Racial and Ethnic Health Equity Series

Report No. 3 Enhancing and Diversifying the Nation's Health Care Workforce

Final Report

September 2013

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To obtain a copy of the report online, visit:
<http://www.texashealthinstitute.org/health-care-reform.html>

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Preface

Data, research, and experience have demonstrated longstanding and extensive disparities in access to, quality, and outcomes of care for racially, ethnically, and linguistically diverse patients and communities in the U.S. health care system, despite efforts to address them. While lack of health insurance is a well established and major contributor to these disparities, children and adults from diverse racial and ethnic heritage often face significantly poorer care and health outcomes than white patients even when insured.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (together the Affordable Care Act or “ACA”) offer an unprecedented opportunity to bridge this divide. While expanding health insurance is a centerpiece in achieving this goal, the ACA includes dozens of provisions intended to close these gaps in quality and outcomes for racially and ethnically diverse and other vulnerable populations. In so doing, the new law provides important incentives and requirements to create a more equitable health care system by expanding the number of health care settings nearer to where people live and work, increasing diversity among health professionals, and addressing language and culture in delivery of services through innovative, clinical, and community-based approaches. But taking this vision and its well intentioned goals to reality in the short and longer-term will determine ultimate effectiveness and success.

The Texas Health Institute (THI) received support from the W.K. Kellogg Foundation and The California Endowment to monitor and provide a point-in-time portrait of implementation progress, opportunities, and challenges of the ACA’s provisions specific to or with relevance for advancing racial and ethnic health equity. Given that the ACA was intended to be a comprehensive overhaul of the health care system, we established a broad framework for analysis, monitoring and assessing the law from a racial and ethnic health equity lens across five topic areas:

- Health insurance exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research and quality; and
- Public health and prevention.

This report is one of five THI has issued as part of the *Affordable Care Act & Racial and Ethnic Health Equity Series*, and it focuses specifically on provisions in the ACA for ***Enhancing and Diversifying the Health Care Workforce***.

Executive Summary

I. Introduction

Research to date reveals that the lack of diversity in the health care workforce is a significant challenge to meeting the needs of racially and ethnically diverse populations who experience clear and persistent disparities in health and health care. There is emerging consensus that a health care workforce that is reflective of the patients it serves is essential for high quality and culturally competent care. However, much work still needs to be done to achieve the goal. As recent data confirm, the composition of the health care workforce is not reflective of the changing and diversifying population dynamics and many diverse population groups (e.g., African Americans, Hispanics, and Native Americans) remain significantly under-represented in the health professions.

With the advent of health care reform, renewed opportunities for enhancing and expanding existing programs as well as explicitly addressing workforce diversity have emerged. The ACA includes numerous provisions that reauthorize various programs under Titles VII and VIII of the *Public Health Service Act* as well as authorize several new initiatives to support a diverse and culturally competent workforce. Understanding the status and progress of such provisions in terms of support, funding, and implementation is critical to assuring this priority is fully realized to advance and achieve health equity.

The purpose of this report is to provide a point-in-time status and progress update on the implementation of the ACA's provisions for supporting a more diverse and culturally competent health care workforce. As such, it describes the opportunities presented by the new law, along with challenges, lessons learned, and potential next steps for successfully implementing major provisions of the law critical for advancing diversity and equity in health care. Embedded within this report are emerging programs, best practices, and resources that address workforce diversity, cultural competency training, and related efforts.

II. Methodology

We identified and monitored 19 provisions which explicitly mention or have significant relevance for advancing racial and ethnic health equity. The provisions were organized into five topic areas:

- A. Increasing supply and diversity in the health professions;
- B. Workforce support for the health care safety net;
- C. Cultural competency education and training;
- D. Health care workforce investment in academic settings; and
- E. Health workforce evaluation and assessment.

For each topic area, we reviewed: peer-reviewed literature and national reports; emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. Findings on progress, opportunities, and challenges identified through our review were synthesized with information and perspectives obtained through a series of key informant interviews with numerous thought leaders, experts, and community advocates in the field.

III. Implementation Progress

This section describes the implementation progress, opportunities, challenges, and road ahead for 19 provisions in the ACA critical to advancing racial and ethnic health equity. These provisions are discussed in context of the aforementioned five topic areas.

A. Increasing Supply and Diversity in the Health Professions

Despite changing population dynamics, many racial and ethnic groups (e.g., African Americans, Hispanics/Latinos, and Native Americans) remain underrepresented in the health professions. The Institute of Medicine's seminal report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, sought to bring attention to this important issue, underscoring that "increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits." Here we summarize the ACA's provisions and progress in addressing diversity across a range of health professions.

- **Physicians and Physician Assistants.** The ACA reauthorizes the Primary Care Training and Enhancement Program to support training in family medicine, general internal medicine, and general pediatrics. The law authorizes \$125 million in funding for FY 2010, along with such sums as necessary for FYs 2011-2014, of which 15% is designated for the Physician Assistant Training Program. Funded for more than the ACA had intended, these programs are training an estimated 889 new physicians and 700 new physician assistants by 2015. A review of funded programs indicates that at least 40% explicitly acknowledge that they will expand their programs to include more racially and ethnically diverse trainees or address cultural competency. The large majority of these programs have created opportunities for primary care residents to serve in underserved communities, either through their own institution or in partnership with health centers, community hospitals, and other community-based health care settings. However, there is widespread acknowledgement that the expansion funded through this provision is only a small portion of what will be needed to adequately meet the nation's primary care workforce needs.
- **Dentists.** A new grants program for training in general, pediatric, and public health dentistry is established by the ACA. Among other criteria, priority for grant awards is given to entities that have a record of training individuals from underrepresented and disadvantaged groups that provide training in "cultural competency and health literacy," and have a record of placing trained professionals in settings experiencing health disparities. While the ACA explicitly authorized \$30 million in FY 2010 and such sums as necessary for FYs 2011-2014, a total of \$71 million has been funded between FYs 2010-2013, with another \$21 million requested for FY 2014. A review of funded programs reveals that many aim to address health disparities by merging didactic learning in public health dentistry with training in community settings, such as health centers, to heighten practical knowledge and application of cultural competency and health literacy principles.
- **Nurses.** The ACA modifies the original Nursing Workforce Diversity Program "to include advanced education preparation, stipends for diploma or associate degree nurses to enter

a bridge or degree completion program, and student scholarships or stipends for accelerated nursing degree program students.” In 2011, HHS awarded \$3.6 million to 11 Nursing Workforce Diversity grantees. A review of grantee programs reveals that, by their very intent, all incorporate a focus on diverse, underrepresented, and disadvantaged nursing students. This goal is achieved through activities such as pipeline programs, improving nursing retention in college, financial stipends to increase graduation rates, and enhancing existing cultural competency and cultural awareness strategies. In 2011, HHS also awarded other grants for enhancing the nursing workforce generally, some of which also address diversity and equity. For example, roughly 40% Nurse Education, Practice, Quality and Retention program grantees explicitly mention that they address health professions diversity or cultural competency.

- ***Mental Health Providers.*** The ACA authorizes grant funding to academic institutions or professional training programs to recruit students into education programs for social work and psychology, programs that are developing or expanding internships or field placement opportunities in child and adolescent mental health, and training programs for paraprofessional child and adolescent mental health workers. Diversity in race, ethnicity, culture, geography, language, religion, socioeconomic status, gender, or sexual orientation is among criteria for eligibility for a grant award. In September 2012, HHS awarded nearly \$10 million to 24 graduate social work and psychology academic institutions. At least 10 grantees cite that they explicitly address racial and ethnic diversity. These grantees describe a number of strategies to enhance training for their students and interns with a specific focus on recognizing and addressing mental health needs of individuals in professional shortage areas.
- ***Long Term Care Providers.*** The law funds a novel program that provides grants to higher education institutions for the training of direct care workers. While there is not explicit language related to diverse populations, this provision holds promise for advancing the health of such communities as a significant percentage of the direct care workforce is made up racially and ethnically diverse individuals. No funding has been appropriated for this provision, to date. Nonetheless, the development of the direct care workforce and related priorities are being addressed under other funded provisions of the ACA. For example, Section 5507 established demonstration projects for six states which are currently being implemented.
- ***Community Health Workers.*** The ACA establishes a novel grants program to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of Community Health Workers (CHW). This provision has not been funded, although opportunities and priorities for community health workers have been funded through other sections of the ACA, such as Community Transformation Grants (Sec 4201). Many community health worker initiatives being implemented with support beyond the ACA serve as models and best practice examples for successful strategies to reach, engage, and serve diverse patients. A common characteristic of these programs which is essential to caring for underserved communities is a close connection to the target population (whether it be through shared race, ethnicity, language or other experiences). There are several challenges that continue to undermine the CHW workforce. These include, for example, limited funding, uncertainty around sustainability

of funded programs, lack of reimbursement for services provided by CHWs, and limited training standards or certification, among others.

B. Workforce Support for the Health Care Safety Net

While the large majority of workforce provisions discussed in this report have implications for the health care safety net, there are at least three that explicitly target programs within public hospitals, community health centers, and other safety net settings. In this section, we discuss the implementation status, progress, and challenges related to these provisions.

- ***National Health Service Corps.*** The ACA reauthorizes the National Health Service Corps (NHSC) as well as increases the amount of funding for the program by authorizing new dedicated funding in the amount of \$1.5 billion for FYs 2011-2015. Through funding from the ACA, the NHSC has grown approximately three times, training a growing proportion of underrepresented minorities and expanding care to underserved communities. Based on self-reported data by nearly 10,000 NHSC clinicians currently providing care, 13% are African American, 10% are Hispanic, 7% are Asian or Pacific Islander, and 2% are American Indian or Alaska Native. And in FY 2012, African American and Hispanic physicians represented 17% and 16% of the NHSC, respectively, nearly three times their representation in the national physician workforce (6.3% and 5.5%, respectively). And more recently, of the nearly 1,000 NHSC scholars in the pipeline, more than half are minorities (26% Hispanic, 19% African American, 12% Asian or Pacific Islander, and 2% American Indian or Alaska Native).
- ***Graduate Medical Education.*** The law authorizes, beginning July 1, 2011, the conversion of unfilled hospital residency positions under the Graduate Medical Education (GME) program to slots for primary care physicians, giving preference for redistributing slots to states with a low resident physician-to-population ratio or with large numbers of people living in primary care health professional shortage areas. In August 2011, excess slots were redirected to 58 hospitals, 24 of which are located in areas where over half the population is Non-White.
- ***Area Health Education Center.*** The law authorizes \$125 million for each FY 2010-2014 for grants to Area Health Education Centers (AHECs) to support community-based training and education. Awards are available for both the development of new health care workforce educational programs as well as to continue or improve upon existing AHECs. Despite being recognized as the only national program to recruit and support diverse and disadvantaged students throughout their health careers pathway, the AHEC program received less than one-fourth of the funding authorized under the ACA over the past four years. This poses significant challenges for a program that is key to fostering a diverse health care workforce.

C. Cultural Competency Education and Training

There is considerable evidence that cultural competency training improves intermediate outcomes such as knowledge, attitudes, and skills of health professionals along with patient-provider interactions and patient satisfaction. Less evidence exists on its link to health outcomes. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come

together in a system, agency, or among professionals that enables effective work in cross-cultural situations. As summarized below, three provisions in the ACA explicitly seek to support and advance cultural competency in health care.

- ***Cultural Competency in Pain Care.*** The ACA authorizes research, treatment, and education to further enhance and improve pain care management. Specifically, the ACA charges NIH to expand its aggressive research through the Pain Consortium, and it also authorizes HRSA to establish a new grants program for training in pain care. An explicit requirement of this program is that grantees include information and education on cultural, linguistic, literacy, geographic, and other barriers to pain care in underserved populations. While the HRSA program has not received funding, the Pain Consortium has made progress as evidenced by its meetings and a report released in 2011, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. The report highlights several aspects of racial and ethnic disparities in pain care. The report also explicitly cites that “enhanced continuing education and training are needed for health care professionals to address gaps in knowledge and competencies related to pain assessment and management, cultural attitudes about pain.”
- ***Cultural Competency in Geriatric and Long Term Care.*** The law authorizes grants for new demonstration projects to develop core training competencies and certification programs for personal or home care aides. In September 2010, HRSA awarded grants to six states (Massachusetts, California, Iowa, Michigan, North Carolina, and Maine) under the Personal and Home Care Aide State Training (PHCAST) Grant Program of the ACA. Grants aim to strengthen the direct care workforce by defining core competencies for direct care workers and supporting training development to further improve the standardization of such competencies. In order to target a diverse population during recruitment, states are also partnering with community colleges, current employers of direct care workers as well as workforce investment boards. All states appear to have made progress toward addressing the required competency of “understanding diversity and cultural competence.”
- ***Model Cultural Competency Curricula.*** The ACA authorizes a grants program for the purpose of the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities and aptitude for working with individuals with disabilities. As of this writing, this provision has not received funding under the ACA. However, this is an important priority for advancing the field of cultural competence.

D. Health Workforce Evaluation and Assessment

As the ACA’s coverage expansions and novel practice models are implemented, it is critical to gather and learn from concrete workforce data and analysis to make informed and accurate decisions about healthcare workforce needs and challenges, including those related to serving a growing diverse patient population. In this section, we highlight two important provisions that support improved mechanisms to evaluate and assess workforce needs.

- ***National Health Care Workforce Commission.*** The ACA authorizes the establishment of a new entity to coordinate healthcare workforce activities across federal agencies,

evaluate workforce demands and education needs, identify and propose solutions to current and future workforce challenges, and support novel programs to improve health care professions education. While a 15-member Commission was announced in September 2010, Congress has not appropriated funding for this provision as of this writing.

- ***State Health Care Workforce Development Grants.*** The ACA establishes a competitive, HRSA-administered grant program under which 25 states were awarded planning grants and 1 state received an implementation grant. In FY 2010, \$6 million was awarded from the Prevention and Public Health Fund to implement these grants. Such sums as necessary were authorized for the following years and no further funding has been appropriated. The overall goal described by grantees is to gather data and information for planning activities to create a comprehensive plan to address health care workforce shortages. Of 25 grantees, 8 outline explicit goals with a focus on immigrants, diverse, or vulnerable populations, or to reduce health disparities. Virginia, the single implementation grantee, describes goals related to cultural competence.

E. Health Care Workforce Investment in Academic Settings

Initiatives to improve minority enrollment implemented at the college and graduate levels of education have shown promising results in increasing diversity in the health professions. The ACA includes at least three provisions intended to support and strengthen these and other programs at academic settings to ensure the health care workforce is more reflective of the nation's diverse patients and families.

- ***Historically Black Colleges and Universities (HBCUs) & Minority-Serving Institutions.*** The health care reform law amends the Higher Education Act by extending the authority to award funding to HBCUs and other minority-serving institutions through 2019. Mandatory funding for FYs 2008-2019 is available in the amount of \$255 million. Questions remain as to whether the increased funding from the ACA is sufficient to alleviate concerns around sustainability of minority-serving institutions. Distributed among more than 100 universities and colleges, the annual funding authorized through the law is relatively modest. Since HBCUs are critical for the educational achievements of many African Americans from college through post-graduate studies, they are an important component of ensuring a diverse healthcare workforce. Despite this promise, however, recent studies suggest that HBCUs are not playing a large enough role in educating African American health professionals. While HBCUs saw a modest increase in the graduation of African American practitioners between 2000 and 2008, this increase did not keep pace with growing need or with graduation of African Americans from comparable programs at White institutions.
- ***Centers of Excellence (COEs).*** The ACA authorizes \$50 million for each FY 2010-2015 for COEs, a federal program to enhance training opportunities for minority students and faculty administered by HRSA and originally authorized under Title VII of the *Public Health Service Act*. Over the past four years, COEs have received less than half of the funding authorized by the ACA. A review of grantees between FYs 2010-2012 reveals that 18 explicitly target Hispanics or Latinos; 4 target African Americans; 5 target Native Americans; and 12 target minorities in general (i.e., more than one racial/ethnic group). A programmatic review revealed that several institutions are adopting common strategies

and practices to train and prepare a diverse health care workforce. For example, to recruit, train, and retain minority students, many programs are increasing the pool of qualified applicants through pipeline and outreach programs designed to inspire students in diverse settings early on in their education to pursue health professions careers. Several programs are also offering cultural competency training through diverse clinical experiences in community health settings and are also committed to increasing diversity among faculty members.

- ***Health Care Professions Training for Diversity.*** The law reauthorizes two key programs for health care professions training among underrepresented minorities. First, the ACA reauthorizes the Scholarships for Disadvantaged Students (SDS) program, allocating \$51 million in FY 2010, and such sums as necessary for FYs 2011-2014. This program funds scholarships for disadvantaged students who commit to working in medically underserved areas. In FY 2010, this program received \$49 million, with appropriations declining each year to \$44 million in FY 2013. Secondly, the ACA reauthorizes the Health Careers Opportunity Program (HCOP), allocating \$60 million in FY 2010 with such sums as necessary for FYs 2011-2014. The goal of HCOP is to support individuals from disadvantaged backgrounds in entering and graduating from health professions programs. In FY 2010, HCOP received just over one-third of authorized funding (i.e., \$22 million), with funding declining each year to just \$14 million in FY 2013. Despite studies that show the benefits of tailored enrollment and retention programs for minority students, programs such as SDS and HCOP have been declining in support over the years. Though the ACA showed significant promise in changing this trend by authorizing the highest level of funding since 2005 for HCOP, for example, actual appropriations were far less.

IV. Renewed Opportunities and Remaining Challenges for the Health Care Workforce

Among other equity objectives, the ACA is committed to supporting and expanding the nation's health care workforce, including enhancing efforts to ensure providers are more representative of the populations they serve, are located in underserved areas, and possess skills to provide culturally and linguistically competent care. The ACA reauthorizes and expands a number of programs originally authorized under Titles VII and VIII of the *Public Health Service Act*, giving preference to, in many cases, underrepresented minorities and services provided in traditionally underserved, diverse communities. It also authorizes a series of novel workforce initiatives which offer the potential for further strengthening the health care workforce. Despite this momentum, these efforts may not be sufficient to match increases in demand expected from the growth in newly insured populations following the operation of health insurance exchanges and state expansions in Medicaid. Thus, while over 19 million racially and ethnically diverse enrollees may be eligible to become newly insured through the exchanges and Medicaid, lack of funding may jeopardize, if not prevent, programs from achieving their goals. Three prominent concerns and challenges exist to addressing workforce needs and diversity in an era of reform.

Continued Workforce Shortages. Significant shortages are expected across the range of health professions—including doctors, nurses, dentists, and others—potentially posing “one of the biggest threats” to the overall success of health care reform. The implementation of the ACA is projected to increase the number of insured by 30 million, over half of whom will be racially and

ethnically diverse individuals. This increase, along with an aging population and general population growth, will boost the demand for medical services. In particular, steep increases in demand for primary care are expected, along with an insufficient supply of providers to match this increase in many regions of the country.

Limited and Declining Funding for Workforce Diversity Initiatives. Funding continues to be an overarching challenge for supporting the health care workforce, generally, and particularly to advance diversity and cultural competency. Among the 19 provisions reviewed in this report, the six explicitly focused on enhancing primary care capacity—such as increasing the number of primary care physicians, physician assistants, and the National Health Service Corps—have seen the greatest level of federal support and commitment. The other nearly dozen provisions have either been severely under-funded or have not received any funding to date. Among critical programs supported in intent by the ACA, but with declining funding are the Centers for Excellence, Scholarships for Disadvantaged Students, and the Health Careers Opportunity program. Minority-serving institutions have also only modestly been supported by the ACA despite the fact that they train a large proportion of minorities in the health professions and generally do not differ in performance of training from other academic institutions.

Reluctance to Pursue Diversity and Cultural Competency as a Priority. Despite considerable progress in addressing health disparities, promoting a diverse and culturally competent health care workforce largely remains a “tough sell”—politically, institutionally, and within the health care system. Reasons are varied and range from diversity and cultural competency not being a priority to limited data and evidence linking such efforts to better outcomes, and a narrow mindset on what diversity essentially means or encompasses. As one key informant noted, “...things that are not a priority, like cultural competency, get put on at the very end...it’s not in the ‘urgent’ category.” Some suggested that the reason cultural competency efforts have not made it to the forefront of priorities is that they are still trying to figure out how to implement broader provisions around delivery and payment reform: “It’s evident that no one understands what is happening broadly. There is no discussion of diversity and cultural competency because they’re still struggling with what broader change means.”

V. Moving Forward: Ensuring Diversity and Cultural Competency in the Health Care Workforce

We identify at least six areas of priority in working to ensure the nation’s workforce is adequate in supply and skill to serve a growing insured, racially and ethnically diverse, and aging population. These priority areas build on common themes we identified through a synthesis of research, policy review, grant opportunities, grantee programs, and interviews around the implementation of the ACA, but also reflect longstanding challenges, needs and roles.

Expanding scope of practice. While the expansion of insurance coverage created through the ACA will open doors to care for millions, great concern remains around the capacity of health care settings and systems to meet the demand for services, especially for diverse, low-income, and other vulnerable populations. As health professionals’ capacity is at the center of this concern, provider organizations and policymakers are seeking ways to expand the pool of qualified practitioners. With the uncertainty around support for many of the ACA’s workforce diversity provisions, expanding scope of practice may offer new opportunities for improving provider capacity and diversity and, in turn improving access for historically underserved populations.

Scope of practice laws establish the legal framework by which medical services are delivered. These laws vary by state. Many states and advocates are looking to scope of practice laws to reassess the role that providers such as advanced practice nurses and physician assistants can play to fill shortages in primary care physicians. Emerging studies show that these providers can generally provide 80% of the care that primary care physicians currently provide and that their care is “as safe and effective as care provided by doctors.”

Encouraging interdisciplinary team-based care. Many of the ACA’s provisions are intended to promote patient-centered care, care coordination, and recognition of health-related circumstances beyond the clinical encounter that may significantly affect treatment adherence and outcomes. Culture and language-specific concerns, community characteristics such as child care, safety, and access to healthy foods, all contribute to the ability to deliver services efficiently and effectively. To integrate these and other priorities into treatment plans, many health care providers are testing and implementing new models of care delivery. One such model is the interdisciplinary team-based approach which involves health professionals beyond physicians—including for example, nurses, social workers, mental health professionals, and others—to coordinate care and other patient services. There are a range of team-based approaches to care, and many of which are part of the Patient-Centered Medical Home model of care. Community health workers, in particular, are seen as important players in team-based care and studies show they contribute to improved access to care, culturally competent chronic disease management, and cost-effectiveness. Team-based approaches which utilize social workers and nurse-practitioners, working alongside primary care physicians have also shown promise particularly in the care of diverse and vulnerable geriatric populations.

Integrating the Enhanced CLAS Standards into Workforce Programs. The release of the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS) in 2013 comes at a pivotal time in efforts to redress longstanding disparities and advance health equity. The CLAS standards are intended to serve as a set of guiding principles for health care organizations in serving diverse populations and were developed, in their original form in 2000, to direct cultural and linguistic competency in health care. The CLAS standards align closely with the ACA’s provisions around workforce and systems capacity including developing a culturally competent workforce, enhancing diversity, and integrating equity priorities into leadership and governance. Examples of the synergy between the ACA and CLAS standards include provisions around workforce support and diversity—e.g., tailoring CLAS Standards 1 and 4 to inform and guide primary care providers, nurses, dental and mental health providers, pain care providers and community health workers on providing culturally and linguistically appropriate care. Standard 3 addresses recruitment of a diverse workforce, an essential goal to achieving health equity that is also underscored in the ACA. Standard 13 describes community partnerships to enhance cultural and linguistic appropriateness of care, a collaboration that many ACA grantees are pursuing in training and education programs. These standards also offer clear opportunity to incorporate elements of culture and language into workforce evaluation, impact, and assessment of ACA-funded programs.

Evaluating health care workforce diversity needs, capacity, and outcomes. With the numbers of insured projected to grow exponentially as the ACA marketplaces and state Medicaid expansions roll out, understanding community, state, and national workforce capacity needs—including creating a more diverse health care workforce—will be especially critical for meeting new demands for services, for reaching historically underserved populations, and ultimately, for

eliminating disparities in access to and quality of care. To this end, evaluating national, state and local strategies to improve workforce diversity across the country as well as those within various disciplines offers the opportunity to determine progress in advancing related goals around: meeting service needs and capacity; recruitment and retention of a diverse workforce; and the effectiveness of cultural competency training and education.

Enhancing Support for Health Professions Schools and Initiatives Committed to Diversity and Equity. Medical and health professions schools, urban and minority-serving universities, community colleges, and health professional societies stand to play an important and central role in attracting and training a diverse health care workforce to meet growing need and demand expected in 2014. Several institutions—such as the Association of American Medical Colleges (AAMC) and urban universities— are beginning to take a leadership role in addressing this priority, while others do not have the support that could reinforce their important role—such as HBCUs and other minority-serving institutions. In all, there is a need to garner more widespread awareness and support for institutions committed to diversity and equity, especially given federal funding through the ACA and otherwise for many efforts is significantly compromised.

Leveraging Resources Provided through the ACA with Philanthropic Support. Given the many financial and ideological challenges to advancing health equity across states and communities, advancing workforce diversity and cultural competency will require supplemental support from other funding avenues—both federally and beyond, including the private sector. Well-funded programs, particularly those with mandatory funding in the ACA, may offer some opportunity. For example, the Patient-Centered Outcomes Research Institute authorized through 2019, may offer an avenue to test the efficacy of cultural competency or other specific workforce diversity initiatives. The private sector may also fill gaps in support for such efforts. In fact, in many communities, national, state, and local philanthropies and foundations are beginning to fill an important void to support the health care workforce, particularly where sufficient support from the ACA and other federal sources has not occurred.

VI. Conclusion

The ACA's numerous provisions reaffirm many existing workforce efforts and intend to advance new initiatives—although not funded or underfunded in some cases—such as creating a national workforce commission, promoting cultural competence education, and supporting underrepresented minorities in health professions. At its core, this emphasis seems to acknowledge the formidable challenges that lie ahead in redressing limitations and disparities of the past affecting access to timely, high quality health care, and assuring that the intent of the new law to truly enfranchise new populations is fulfilled. The related demand for a high quality, diverse workforce will only grow, but will require significant resources and political will. What remains much less clear in moving into the fifth year of ACA implementation is whether the resources and political will to support a broad spectrum of critical programs and actions will be sufficient to meet service goals and people's needs.

I. Introduction

Enhancing racial and ethnic diversity in the health professions is vital to advancing and achieving an accessible and equitable health care system. Despite recent efforts, racial and ethnic health disparities in access, quality, and outcomes persist and remain entrenched in health care. In fact, four out of ten African Americans and Hispanics/Latinos continue to receive worse care than Whites on a set of quality measures.¹ Hispanics/Latinos also face worse access to care than Whites for nearly two-thirds of access measures.² While a complex set of factors contribute to these disparities, well-established research cites the lack of diversity in the health care workforce as being a major contributing factor.

Growing evidence suggests that workforce diversity—and related cultural competency efforts—are associated with higher patient satisfaction, improved patient-provider communication, and better treatment adherence.^{3,4} However, much work still needs to be done to achieve the goal. As recent data confirm, the composition of the health care workforce is not reflective of the changing and diversifying population dynamics.⁵ Whereas racially and ethnically diverse communities comprise one-third of the U.S. population, they only account for one-fifth of physicians and nearly 17% of registered nurses.^{6,7} Particularly underrepresented in medical, nursing, and other health professions are African Americans and Hispanics/Latinos. For example, while over 15% of the population is Hispanic/Latino, only 5% of physicians and 4% of registered nurses are Hispanic/Latino.⁸ Similarly, African Americans comprise about 12% of the population, but only 6% of physicians and 5% of registered nurses.⁹

Studies over the years have shown that racially and ethnically diverse practitioners are more likely to practice in medically underserved areas, and to disproportionately serve low-income, uninsured, and underinsured patients from diverse racial and ethnic heritage.¹⁰ As summarized in a recent publication:

Diversity is a critical part of the mission of health care and the national challenge of preparing our nation's future workforce. America's success in improving health status and advancing the health sciences is wholly dependent on the contributions of people from a myriad of diverse backgrounds and cultures, including Latinos, Native Americans, African Americans, European Americans and Asian Americans. The lack of diversity is a key barrier to ensuring a culturally competent health care system at the provider, organizational, and system levels. It diminishes our nation's capacity to eliminate racial and ethnic health disparities and compromises our national capacity to advance the health sciences.¹¹

Racially and ethnically diverse populations face clear and persistent barriers to entering and succeeding in the health professions. Students of color report higher rates of financial setbacks, racism, lack of professional role models and diverse faculty, and fewer educational resources,^{12,13} contributing to greater challenges in embarking on and completing the educational pathways required for a career in health care.

Federal efforts have sought to expand, diversify, and improve the distribution of the health care workforce through the alignment of funding priorities with the nation's health care needs. Title VII and Title VIII programs, authorized by the Public Health Services Act, for example, encourage health professionals to care for those in medically underserved communities, provide grants to health professions schools and institutions, and support health professions students with

scholarships and loans.¹⁴ While these programs generally have succeeded in enhancing cultural and geographic diversity, including improving the number of underrepresented minority graduates among health professionals,¹⁵ in recent years they have witnessed declining support and funding challenges. For example, federal funding for programs such as the Centers of Excellence (COE) and the Health Careers Opportunities Program (HCOP), which both include explicit goals to recruit and retain minority students, was reduced significantly in 2006 resulting in dramatic challenges to their sustainability. Since 2006, funding has gradually increased each year, but has not yet reached its prior levels.¹⁶

With the advent of health care reform, renewed opportunities for enhancing and expanding existing programs as well as explicitly addressing workforce diversity have emerged. The ACA includes numerous provisions that reauthorize various programs under Titles VII and VIII of the *Public Health Service Act* as well as authorize several new initiatives to support a diverse and culturally competent workforce. Understanding the status and progress of such provisions in terms of support, funding, and implementation is critical to assuring this priority is fully realized to advance and achieve health equity.

Purpose and Rationale

The purpose of this report is to provide a point-in-time status and progress update on the implementation of the ACA's provisions for supporting a more racially and ethnically diverse, as well as culturally and linguistically competent health care workforce. As such, it describes the opportunities presented by the new law, along with challenges, lessons learned and potential next steps for successfully implementing major provisions of the law critical for advancing diversity and equity in health care. Embedded within this report are emerging programs, best practices, and resources that address workforce diversity, cultural competency training, and related efforts. We identified and monitored 19 provisions which explicitly mention or have significant relevance for advancing racial and ethnic equity and cultural competency in the health professions.

Organization of Report

This report is organized into the following four sections:

- I. **Introduction:** This section provides an overview of the goals, objectives, target audience, and value and use of this report. It also describes the *Affordable Care Act & Racial and Ethnic Health Equity Series* in greater depth.
- II. **Methodology:** The framework and design is discussed in this section, along with specific activities that were undertaken in developing this report.
- III. **Implementation Progress:** This section describes the legislative context, implementation progress, emerging progress and models, and challenges and next steps for the 19 provisions, organized by five key priorities:
 - A. Increasing supply and diversity in the health professions;
 - B. Workforce support for the health care safety net;
 - C. Cultural competency education and training;
 - D. Health care workforce investment in academic settings; and
 - E. Health workforce evaluation and assessment.

- IV. ***Renewed Opportunities, Remaining Challenges for the Health Care Workforce:*** Discussed in this section are the common and distinct themes that emerged on implementation progress and opportunities, along with challenges that must be considered to ensure a culturally and linguistically diverse and competent health care workforce.

- V. ***Moving Forward:*** The report is rounded out with a discussion of recommended next steps for ensuring that diversity, equity, and cultural competency are integrated and reflected in the health care workforce—both generally, and as envisioned by the ACA.

Given that health care reform is rapidly evolving, with new information and policies emerging almost daily, we reiterate that this report offers a point-in-time snapshot of information, perspectives, and resources that were available during the time this project was undertaken.

Affordable Care Act & Racial and Ethnic Health Equity Series

Series Background and Context

We have been monitoring and analyzing the evolution of health care reform and its implications for reducing disparities and improving equity since shortly after the inauguration of President Obama in 2009. With support from the Joint Center for Political and Economic Studies in Washington, D.C., the project team tracked major House and Senate health care reform bills, identifying and reviewing dozens of provisions with implications for racially and ethnically diverse communities. A series of reports and issue briefs were released, providing a resource for community advocates, researchers, and policymakers seeking to understand and compare the significance and implications of these provisions. Following the enactment of the ACA, a major, comprehensive report--entitled *Patient Protection and Affordable Care Act: Implications for Racially and Ethnically Diverse Populations*¹⁷--was developed and released in July 2010 describing nearly six dozen provisions in the law core to advancing health equity. The report covered ACA's opportunities and new requirements related to health insurance, the safety net and other points of health care access, workforce diversity and cultural competence, health disparities research, prevention and public health, and quality improvement.

Series Purpose and Objectives

The overall purpose of the *Affordable Care Act and Health Equity Series* is to provide an informative, timely, user-friendly set of reports as a resource for use by health care organizations, community-based organizations, health advocates, public health professionals, policymakers, and others seeking to implement or take advantage of the ACA to reduce racial and ethnic health disparities, advance equity, and promote healthy communities. The *Series* is funded by W. K. Kellogg Foundation and The California Endowment. The *Series* is intended to:

- Provide a point-in-time snapshot of implementation progress—or lack thereof—of over 60 provisions in the ACA with implications for advancing racial and ethnic health equity, detailing their funding status, actions to date, and how they are moving forward;
- Showcase concrete opportunities presented by the ACA for advancing racial and ethnic health equity, such as funding, collaborative efforts, and innovation that organizations can take advantage of;
- Highlight any threats, challenges, or adverse implications of the law for diverse communities to inform related advocacy and policy efforts; and
- Provide practical guidance and recommendations for audiences working to implement these provisions at the federal, state, and local levels, by documenting model programs, best practices, and lessons learned.

Series Design and Methodology

The project team utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities, and challenges of roughly 60 provisions in the ACA across five topic areas:

- Health insurance exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research and quality; and
- Public health and prevention.

For each topic area, the project team conducted a comprehensive review of literature and reports, along with an in-depth assessment of the legislation, emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. To complement research, programs, and policies identified through this review, the team conducted telephone-based interviews with nearly 70 national experts and advocates, federal and state government representatives, health care providers, health plans, community organizations, and researchers in the field. A full list of participants and contributors can be found in Appendix A. Interview questions were tailored to the sectors that respondents presented (e.g., state agencies, hospitals, health plans, community organizations, and others) and were intended to fill important information gaps as well as reinforce themes around emerging progress, opportunities, challenges, and actions not otherwise discussed in written sources. Findings from the literature review, policy analyses, and interviews were synthesized into five topic-specific reports.

Given each report is topic-specific and part of a larger *Series*, every attempt was made to cross-reference subtopics across the *Series*. For example, support for the National Health Services Corps is highlighted under the “Workforce” topic, although it has direct relevance for the “Safety Net” report. Organizing and cross-referencing the reports in this manner was important to streamlining the large amounts of information and ensuring the reports remained user-friendly.

Series Audience and Use

With the latest policy updates and research, complemented by voices and perspectives from a range of sectors and players in the field, the goal of this *Series* is to offer a unique resource and reference guide on the implementation status of the ACA’s diversity and equity provisions along with emerging opportunities and actions to reduce disparities. However, given the health care arena is rapidly evolving and expanding, with new guidance, policies, and actions emerging almost daily at all levels, this *Series* offers a point-in-time snapshot of information, perspectives, and resources that were readily available and accessible during the time this project was undertaken.

Reports issued as part of this *Series* are intended for broad audiences and use. For example, federal government agencies may utilize information on best practices, resources, and concerns in the field to inform the development of ACA-related rules and regulations addressing equity, diversity, language, and culture. Nonprofit and community organizations may look to the reports for concrete opportunities for involvement, collaboration, or funding. Health care providers, public health agencies, state exchanges, and health plans may draw on models, best practices, and resources to implement or enhance their own efforts to tailor and ensure racial and ethnic equity and diversity are core to their plans and actions. Advocacy organizations may use data or findings to advocate for appropriations, funding, or support for a variety of equity priorities supported by the ACA.

II. Methodology

We utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities and challenges of the Affordable Care Act's (ACA) workforce diversity and cultural competency provisions. In this section, we provide a brief overview of our methodology.

Literature and Policy Review. We conducted a comprehensive review of literature on the health care workforce as well as issues of diversity and cultural competency, generally and in context of the ACA. This was complemented by a review of emerging federal regulations, guidance, and funding opportunities for implementing each of the 19 workforce related provisions. Given the constantly evolving nature of the field, information and research included in this report is current as of July 2013. In addition, we conducted an extensive review of research and articles on state activities along with programs and models emerging in academic, safety-net, and other health care settings, with the intent of identifying information and guidance that can inform what is required to effectively implement the 19 provisions.

Key Informant Interviews. To obtain the most recent information and perspectives from individuals currently working on these issues, we interviewed state and county health officials, hospital and health center representatives, academic researchers, and representatives from several community and advocacy organizations. We gathered names and contact information for people to interview from various sources including meetings we attended, reports we reviewed, and references from other people we spoke to. Following are questions covered through the interviews:

- How are states and organizations concertedly addressing workforce needs through the ACA, and are there broader state or local efforts to leverage these actions?
- What opportunities in the ACA are states and organizations taking advantage of to enhance their health care workforce? How are diversity, equity, and culturally competency being addressed through these vehicles?
- Are there any specific programs or other efforts that states and organizations are participating in to improve workforce diversity and/or cultural competency that are occurring in parallel or in context of the ACA's objectives?
- What challenges are states and organizations facing in taking advantage of workforce diversity and cultural competency opportunities under the ACA?
- What are thoughts moving forward, or recommendations, for ensuring diversity and cultural competency remain integral to workforce enhancement efforts?

Given the range of roles, expertise, and perspectives represented by key informants, not all questions were posed to each informant. Rather, those that applied most directly with an individual's area of expertise and knowledge were asked.

Synthesis and Analysis. Based on common themes and issues that affect the major players in the health care workforce, the 19 provisions were organized into five themes as follows:

A. Increasing Supply and Diversity of Health Care Professionals

- Section 5203. Health care workforce loan repayment programs
- Section 5301. Training for primary care physicians and physician assistants

- Section 5302. Training opportunities for direct care workers
- Section 5303. Training in general, pediatric, and public health dentistry
- Section 5306. Mental and behavioral health education and training grants
- Section 5309. Nurse education, practice, and retention grants
- Section 5404. Workforce diversity grants
- Section 5313. Grants to promote the community health workforce

B. Workforce Support for the Health Care Safety Net

- Section 5207. Funding for National Health Service Corps
- Section 5403. Interdisciplinary, community-based linkages
- Section 5503. Distribution of additional residency positions

C. Cultural Competency Education and Training

- Section 4305. Advancing research and treatment for pain care management
- Section 5307. Cultural competency, prevention, and public health
- Section 5507. Demonstrations to address health professions workforce needs

D. Health Workforce Evaluation and Assessment

- Section 5101. National health care workforce commission
- Section 5102. State health care workforce development grants

E. Health Care Workforce Investment in Academic Settings

- Section 2103. Investment in minority-serving institutions
- Section 5401. Centers of excellence
- Section 5402. Health care professionals training for diversity

For each provision, the project team compiled research, latest policy updates, regulations and funding opportunities and announcements, along with synthesized key informant interview findings to address the following areas of inquiry:

- **Legislative context** of each provision, both as authorized by the ACA and also by any prior legislation.
- **Implementation status and progress** as documented in the Federal Register, peer-reviewed literature, reports, funding announcements, grantee reports, and related.
- **Emerging models and programs**, including those established prior to the ACA that can inform current implementation, as well as those that have emerged post-ACA.
- **Challenges and next steps** to realizing the objectives of the provision.

Information from the interviews can be found throughout the sections of the report, and respondents were told that their responses would not be attributed or quoted without their permission. Responses were not statistically analyzed and are not intended to be a representative sample of states, hospitals, health centers, or other health care providers. Rather, this information is qualitative in nature and serves to fill any knowledge gaps, as well as add further depth, dimension, and perspective to further inform the implementation of the specific ACA provisions.

III. Implementation Progress

The ACA presents a range of opportunities for supporting and creating a more diverse and culturally competent healthcare workforce. This section describes the implementation progress, opportunities, challenges and road ahead for realizing the 19 provisions in the new law, organized by the following themes:

- Increasing the supply and diversity of health care professionals;
- Workforce support for the health care safety net;
- Cultural competency education and training;
- Health workforce evaluation and assessment; and
- Health care workforce investment in academic settings.

Appendix B provides an “At-A-Glance” summary of these provisions, along with their funding allocations, implementation status, and progress.

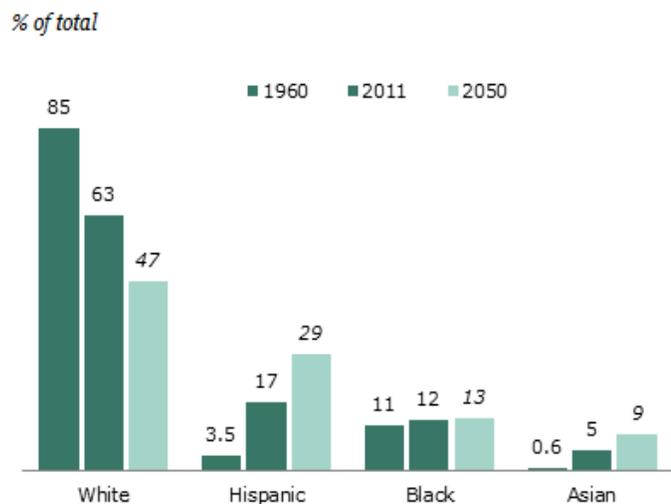
A. Increasing Supply and Diversity of Health Care Professionals

Background

The racial and ethnic composition of the United States is rapidly evolving. By 2050, Non-White racial and ethnic groups will constitute more than half the nation’s population.¹⁸ Hispanic and Asian populations, in particular, are expected to almost double between now and 2050 (Figure 1).¹⁹ Despite these changing population dynamics, however, many diverse population groups (e.g., African Americans, Hispanics/Latinos, and Native Americans) remain underrepresented in the health professions. The Institute of Medicine’s seminal report, *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce*, sought to bring attention to this important issue, underscoring that “increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits.”²⁰

Figure 1

Population by Race and Ethnicity, Actual and Projected, 1960, 2011 and 2050



Note: All races are non-Hispanic; American Indian/Alaska Native not shown. Projections for 2050 indicated by light green bars.

Source: Passel, Jeffrey and D’Vera Cohn. 2008. “U.S. Population Projections: 2005-2050.” Washington, D.C.: Pew Hispanic Center, February; Census Bureau 2011 population estimates.

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This underrepresentation is both broad and deep. Whereas African Americans comprise 12% of the U.S. population, they account for approximately 6% of medical doctors, 5% of registered nurses, 8% of physician assistants, and 3% of dentists (Tables 1 and 2). Similarly, Hispanics/Latinos comprise over 15% of the population, but only 5% of medical doctors, nearly 4% of registered nurses, 8% of physician assistants, and 6% of dentists.

Table 1. Total U.S. Registered Nurses, Medical Doctors, and Physician Assistants by Race and Ethnicity, 2007/2008

	RNs* (2008)		MDs** (2008)		PAs*** (2007)		Percentage of U.S. Population
	No.	%	No.	%	No	%	
White	2,549,302	83.2%	353,311	75%	75,408	77.2%	65.6%
Black	165,352	5.4%	29,775	6.3%	7,606	7.8%	12.2%
Asian	169,454	5.5%	60,090	12.8%	5,382	5.5%	4.5%
Hispanic	109,387	3.6%	25,717	5.5%	8,053	8.2%	15.4%
AI/AN	18,099	0.6%	2,515	0.5%	470	0.5%	0.8%

*Source: 2008 National Sample Survey of Registered Nurses as cited in: The Registered Nurse Population, Findings from the 2008 National Sample of Registered Nurses. September 2010. HHS/HRSA

**AAMC Data warehouse: Minority Physician Database, AMA_Masterfile_R,App_Bio_R,asof11/30/2009 as cited in: Diversity in the Physician Workforce: Facts & Figures 2010, AAMC.

***U.S. Census Bureau as cited in: Xiaoxing, H., Ellen, C., & Mark, S. National trends in the United States of America physician assistant workforce from 1980 to 2007. *Human Resources for Health*, 7.

Table 2. Total U.S. Dental Professionals by Race and Ethnicity, 2007

	Dentists		Dental Hygienists		Dental Assistants		Percentage of U.S. Population
	No.	%	No.	%	No	%	
White	138,866	76.3%	137,795	88.9%	217,288	69.2%	65.6%
Black	637	3.5%	3,410	2.2%	20,410	6.5%	12.2%
Asian	235	12.9%	4,340	2.8%	14,758	4.7%	4.5%
Hispanic	116	6.4%	7,440	4.8%	55,892	17.8%	15.4%

Source: U.S. Census Bureau, American Community Survey, 2007 as cited in: National Healthcare Disparities Report, 2009, Agency for Healthcare Research and Quality

Note: There are a total of 182,000 dentists, 155,000 dental hygienists, and 314,000 dental assistants. Data for American Indians/Alaska Natives was not available.

For nearly 50 years, Titles VII and VIII of the *Public Health Service Act* have been working to increase racial and ethnic diversity in the health care workforce and encourage health care providers to practice in medically underserved areas.^{21,22,23} Both Titles VII and VIII were established in response to a severe shortage of health care providers. Title VII, enacted in 1963, was designed to “encourage health care workers to practice in underserved areas, increase the number of primary care providers, increase the number of minority and disadvantaged students enrolling in health care programs, and increase the number of faculty in health care education and training programs.”²⁴ Title VIII, established in 1964, was primarily aimed at training advanced practice nurses and increasing the number of minority and disadvantaged students enrolling in nursing programs.²⁵

The federal Health Resources and Services Administration (HRSA) administers Titles VII and VIII programs, and has been a major funder of health professions training, including programs geared toward expanding diversity and increasing the number of providers from underrepresented minorities. Over the years, these titles have been amended to provide grants to support traineeships in other health professions. For example, in 1988, Title VIII was amended to “authorize student loan repayment and scholarship programs to fund education and training for public health nurses, registered nurses, nurse midwives, and other nurse specialties.”²⁶

Outcomes of many Title VII and VIII programs were successful in meeting the goal of diversifying the health care workforce. For example, according to a 2009 report issued by the American Public Health Association, physicians who had graduated from the Title VII programs were two to four times more likely than other graduates to serve in a medically underserved community.²⁷ In fact, on average, annually, these programs support the education and training of over 10,000 underrepresented minority graduates, residents, and faculty. Title VII programs have proven particularly important to achieving workforce diversity in university settings. In many cases, these programs were initiated with federal funding and were subsequently sustained by academic institutions.

The ACA reauthorizes and provides additional support for many of the Title VII and VIII programs, while also creating new opportunities to increase diversity in a range of health professions. In this section, we describe the implementation progress of the ACA’s workforce provisions which explicitly aim to increase racial and ethnic diversity and the number of providers from underrepresented minority communities. These include provisions addressing the following health professions:

- Physicians and physician assistants (§5203, §5301);
- Dentists (§5303);
- Nurses (§5309, §5404);
- Mental health providers (§5306);
- Long term care providers (§5302); and
- Community health workers (§5313).

Physicians and Physician Assistants

Legislative Context

Section 5301 amends Section 747 of the *Public Health Service Act* to authorize additional support and funding for the previously established grant program for accredited primary care training and enhancement in family medicine, general internal medicine, or general pediatrics. The ACA lengthens the timeline of the program, expands the program’s scope and activities, and amends funding priorities. This provision authorizes the U.S. Department of Health and Human Services (HHS) Secretary to make 5-year grants to, or contracts with, an eligible entity—which may include public and nonprofit private hospitals, medical schools, academically affiliated physician assistant training programs, and other public and nonprofit private entities to:

- Develop and operate an accredited professional training program in family medicine, general internal medicine, or general pediatrics, and provide need-based financial assistance for these programs;

- Develop and operate a training program for physicians who plan to teach in family medicine, general internal medicine, or general pediatrics, and provide need-based financial assistance for these programs;
- Develop and operate a program for training physicians teaching in community settings; and
- Develop and operate a physician assistant education program.

Among other criteria, priority is given to eligible entities that have a record of training individuals from underrepresented minority groups and familiarity in providing training in “cultural competency and health literacy.” The law authorizes \$125 million in fiscal year (FY) 2010 and such sums as necessary for FY2011 to FY 2014 for primary care providers as well as 15% of that amount appropriated for physician assistant training.

Section 5203 amends Section 775 of the *Public Health Service Act* by adding a new program—the pediatric specialty loan repayment program—under which the eligible physician agrees to be employed full-time for no less than two years in a pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health specialty. The law explicitly states that priority is given to applicants that, among other criteria, have familiarity with “cultural and linguistic competence” in health care services. The law authorizes \$30 million for pediatric medical specialists and pediatric surgical specialists for year FY 2010 through FY 2014, and \$20 million for child and adolescent mental and behavioral health professionals for each FY 2010 through FY 2013.

Implementation Status and Progress

Programs under Section 5301 include the Primary Care Residency Expansion Program (PCRE), the Expansion of Physician Assistant Training Program (EPAT) and Grants for Primary Care Training and Enhancement (PCTE). On September 27, 2010, HRSA awarded \$167.3 million to fund 82 primary care residency training programs for 5 years under the PCRE program. Over this period, the program is expected to train 889 new primary care residents. Primary care physician assistant training programs also received funding for 5 years under the EPAT program. Twenty-eight programs were awarded a total of \$30.1 million which will fund 700 physician assistants by 2015.²⁸ In subsequent years, the programs under this provision received \$39 million for PCTE grants and in FY 2013 a 30% increase of \$51 million was requested.

According to the PCRE opportunity announcement, the program provides funding in the amount of \$80,000 per resident, per year, for three years. In addition, the announcement also specifies that at the end of the grant period, each grantee should be able to demonstrate, along with other metrics, that trainees are able to deliver “high quality, culturally and linguistically appropriate care.”²⁹ Programs are encouraged to monitor and track trainees for 5 years following the end of the training program to gauge their effectiveness in providing such care; the ACA also authorizes these programs to fund such analysis. However, the establishment of guidelines to carry this out is subject to future appropriated funding. All funding was awarded in 2010 and recipients are restricted in how much funding they may draw each year. No new funding for this program was provided following FY 2010. For the PCRE program, which has received funding each year, priorities outlined in the funding opportunity announcement include having a high rate of placement of graduates in medically underserved communities, while the announcement for EPAT specifies that evaluation criteria should address “the extent to which the applicant can

measure if PAs can deliver “high quality, culturally and linguistically appropriate care.” See Table 3 for details on originally authorized dollars in the ACA, the amount actually received for the programs, and the requested amount for FY 2014.

Table 3. Authorized Funding in the ACA and Actual Funding for Primary Care Providers, FY 2010-2014

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
Primary Care Training	\$125 m	\$237 m*	SSAN	\$39 m	SSAN	\$39 m	SSAN	\$37 m	SSAN	\$51 m

Note: Auth = Authorized; SSAN = Such Sums as Necessary

*In FY 2010, \$198 million was awarded from the Prevention and Public Health Fund in addition to the annual discretionary amount of \$39 million.

Finally, to date, no funding has been appropriated for the pediatric subspecialty loan repayment program outlined in Section 5203. Funding in the amount of \$5 million has been requested for FY 2014 to support this program.³⁰

Emerging Programs and Models

A review of the 82 program descriptions funded under Section 5301 of the ACA reveal that virtually all are targeting services to underserved populations, and at least 32 (40%) explicitly mention expanding their programs to include more racially and ethnically diverse trainees or addressing cultural competency. The large majority of these programs have created opportunities for primary care residents to serve in underserved communities, either through their own institution or in partnership with Federally Qualified Health Centers, community hospitals, and other community-based health care settings. These programs typically also include experience related to serving in a patient-centered medical home. Other common elements described include offering incentives to graduates to stay and practice in the underserved settings in which they were trained and providing didactic curricula in cultural competency to supplement the diverse training experiences received. In order to recruit students who are committed to serving such populations, many programs describe recruiting medical students who are originally from the area with high unmet needs. Following are examples of primary care residency programs funded under the ACA that aim to expand diversity, improve cultural competency, and expand service in underserved communities:

- Baylor College of Medicine’s Department of Family Medicine (Houston, Texas)** received \$640,000 to expand the number of primary care residents it trains, particularly following financial setbacks which led the program to reduce the number of trainees in 2010. Recognizing that Non-White racial and ethnic residents are more likely to remain in primary care practice, the program has made a concerted effort to promote ethnic diversity and increase minority representation among its learners.³¹ As the program abstract cites, “since 2004, underrepresented minorities comprise 47% of the total number of residents in the program and provide 50% of their care in medically underserved communities.”³² Funding through the ACA will be used to re-grow the department, as well as ensure that primary care residents provide care to medically underserved patients within the Harris County Hospital District (HCHD) for at least 6 months at every Post-

Graduate Year (PGY) level. Along with tracking residents' placement, as an incentive, the program offers “graduates the ability to retain employment within the department and continue serving patients of the HCHD.”³³

- ***The Crozer-Keystone Health System Family Residency Training Program (Springfield, Pennsylvania)*** received \$1.92 million to expand its program to meet increasing demand for primary care services at its new outpatient training facility in Upper Darby, Pennsylvania, a medically underserved area. Residents will receive outpatient training and experience to serve a largely urban, uninsured, and diverse patient population. “Darby has emerged as a resettlement location for immigrants and refugees in the region, and at least 15% of the population is composed of immigrants, including most recently large numbers of West Africans, Central and South Americans, and Mexicans.³⁴ The program has a track record of placing 100% of its residents, to date, in primary care settings. Through new funding the project intends to develop resident competencies needed to provide quality care to underserved populations upon graduation.³⁵
- ***Children’s Hospital of Pittsburgh of UPMC (Pittsburg, Pennsylvania)*** received \$1.92 million to expand its pediatric residency program and create a new pathway, Primary Care-Advocacy-Leadership-Service (PALS)—designed to train its residents to care for underserved children in rural and urban communities. The program description states the grantee will provide “learning experiences that enhance residents’ understanding of key community health issues, such as health disparities, cultural competence, and health policy. [...] Residents will also be engaged through didactic and experiential curricula that support the provision of culturally competent and effective care to children living in poverty.”³⁶
- ***University of California, San Diego (San Diego, California)*** received \$2.88 million to expand its Family Medicine Residency Program to better meet the needs of the surrounding community, a border population experiencing an inadequate number of Spanish-English bilingual and culturally competent health care professionals. Over six months of training is provided in a Federally Qualified Health Center—i.e., Chula Vista Family Clinic. In addition, the University carefully screens its applicants for qualities demonstrating a commitment to providing care to medically underserved and under-insured patients such as experience with community outreach. As such, the program actively recruits medical students who attended high school in the San Diego border area. By implementing these activities, the school places a large number of graduates who are providing comprehensive primary care to such populations in the region and plans to maintain this record with new funding.

Challenges and Next Steps

The ACA’s commitment to supporting primary care providers represents an important step to meeting provider shortages, particularly in rural and inner city areas with large and growing diverse populations.^{37,38,39} With an emphasis on increasing the number of underrepresented minorities and ensuring new residents are trained in culturally and linguistically diverse settings—such as medically underserved areas, community health centers, and new care arrangements such as the Patient-Centered Medical Homes—these efforts have great potential to improve access, quality, and outcomes of care for diverse patients. However, there is widespread

acknowledgement that the expansion funded through this provision—an estimated 889 new physicians and 700 new physician assistants by 2015— is only a small portion of what will be needed to adequately meet the nation’s primary care workforce needs. The Association of Medical Colleges estimates that an additional 21,000 primary care physicians will be needed by 2015.⁴⁰ And without appropriated funding for Section 5203, the pediatric subspecialty workforce is likely to continue to face shortages and be insufficient to meet new demands. As it is, pervasive and persistent racial and ethnic disparities exist across a range of pediatric health and health care measures, including mortality, access to care, utilization of services, adolescent health, chronic diseases and special needs care.⁴¹ This provision offers an important opportunity to improve access to pediatricians and pediatric subspecialists in underserved areas, while ensuring diversity and promoting cultural competence and linguistic access—efforts which are core to effectively caring for a growing racially and ethnically diverse pediatric patient population.

Dentists

Legislative Context

Section 5303 establishes a new grants program for training in general, pediatric, and public health dentistry by amending Section 748 of the *Public Health Service Act*. Grants or contracts are awarded for 5 years and available to schools of dentistry, hospitals, and non-profit organizations to develop and operate dentistry training programs with an emphasis on general, pediatric, or public health dentistry as well as to provide financial assistance to students who plan to work in these fields. Among other criteria, priority for grant awards is given to entities that have a record of training individuals from underrepresented and disadvantaged groups that provide training in “cultural competency and health literacy,” and have a record of placing trained professionals in settings experiencing health disparities. The law authorizes \$30 million for FY 2010 and such sums as necessary for FY 2011 through FY 2015.

Implementation Status and Progress

Grants under this provision were funded in FY 2010 to FY 2013. In FY 2010, \$15 million were appropriated, in FY 2011 \$17 million were appropriated, in FY year 2012, \$20 million were appropriated, and in FY 2013, \$19 million were appropriated. (Table 4). For FY 2014, \$21 million were requested.

Table 4. Authorization and Actual Appropriation of Section 5303 Funding

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
Sec. 5303	\$30 m	\$15 m	SSAN	\$17 m	SSAN	\$20 m	SSAN	\$19 m	SSAN	\$21 m

Note: Auth = Authorized; SSAN = Such Sums as Necessary

Emerging Programs and Models

A review of active programs reveals that virtually all express a priority for targeting racially and ethnically diverse dental students, focusing on culturally competent training, and delivering dental services to diverse patient populations. These programs aim to address health disparities

through a range of actions. First, for example, many grantees are offering a dual Master of Public Health and Dentistry degree program with the intention of bridging the knowledge gap between oral health and general health, as well as to expand the number of dentists with public health training. Some programs offer stipends and tuition support to encourage completion of the public health degree. Many of these programs explicitly incorporate health disparities in their curriculum.

Secondly, grantees are using funding to enhance their training curricula to include an increased focus on vulnerable and underserved populations and their unique oral health needs. For example, some programs underscore the importance of risk assessments for certain oral diseases among specific vulnerable and diverse communities. The merging of such didactic learning with training in community settings such as Federally Qualified Health Centers is affording the unique opportunity for trainees to gain heightened awareness and practical knowledge of the application of cultural competency and health literacy principles. Some programs are making these community-based trainings in underserved communities a requirement rather than an elective to ensure maximum participation.

Following are examples of programs which highlight actions and efforts specifically addressing diversity, equity, and cultural competency:

- **Case Western University:** Through funding from the ACA, Northeastern Ohio Predoctoral Training in Dental Public Health is offering additional training to its students through its dual Doctor of Dental Medicine Degree and Master's of Public Health Degree. Under this program, second year students are trained to identify oral diseases among underserved populations as well as receive training in cultural competency and health literacy curricula. The program description states: "The training sites have been carefully chosen to increase residents' cultural sensitivity and understanding, particularly about two underrepresented minority groups: African-Americans and Hispanics. The program will make a concerted effort to recruit trainees from the aforementioned minority groups, and the trainees will be working with the homeless and migrant farm workers."⁴²
- **University of Pittsburgh:** The University aims to improve its number of graduates practicing in underserved areas by expanding training opportunities in underserved areas. The grantee is augmenting the current curricula to incorporate cultural competency objectives and include community-based clinics. According to the program description, the University understands that "the inclusion of advanced students in our program will increase their level of comfort in the delivery of dental medicine to high-need and low-access populations, and heightened cultural competency will dismantle existing barriers that impede graduates from having the skills and desire to practice dental medicine in rural and other underserved communities."⁴³
- **University of Texas Health Science Center at San Antonio:** The San Antonio Dental Public Health and Diversity Pre-Doctoral Education Program is continuing its comprehensive dental public health curriculum. The program description states, "It is through the education of a competent and culturally responsive workforce that this program seeks to address these ever-widening gaps in oral health and disparities in access to oral health services."⁴⁴ This objective is achieved through community-service learning opportunities and a focus on cultural competency training. Among the program's goals is

to increase student diversity through “pipeline” programs for students expressing interest in dental public health with the intention of serving the communities in South Texas who experience substantial disparities in oral health needs.

Challenges and Next Steps

While grants and contracts have been awarded under this provision, the funded amount did not equal the total amount authorized under the law in the first year. The ACA authorized \$30 million in FY 2010, but only \$15 million were appropriated. Nonetheless, the program has received continued support over the years, and given the large disparities in oral health and shortage in dental providers, particularly in underserved areas, adequate funding for this provision is required. In fact, it has been suggested that without aggressive intervention to ensure that an adequate supply of dentists are available and willing to serve in vulnerable and diverse communities, the current incongruence in representation of race and ethnicity will be exacerbated as our population demographics quickly change.⁴⁵

Nurses

Legislative Context

Section 5404 of the ACA amends Title VIII, Section 821 of the *Public Health Service Act*, modifying the original Nursing Workforce Diversity Program “to include advanced education preparation, stipends for diploma or associate degree nurses to enter a bridge or degree completion program, and student scholarships or stipends for accelerated nursing degree program students.”⁴⁶ This provision also adds the National Coalition of Ethnic Minority Nurse Associations as a consultant organization to the HHS Secretary on issues related to nursing diversity. No funding specifications are provided in the ACA.

Section 5404 complements a series of other programs in the ACA to enhance the nursing profession, including:

- Section 5308, which modifies the Advanced Nursing Education Program;
- Section 5309 which amends the *Public Health Service Act* to authorize funding for Nurse Education, Practice, and Retention Grants through FY 2014;
- Section 5310, which modifies eligibility for the Loan Repayment and Scholarship Program;
- Section 5311, which amends the *Public Health Service Act* to authorize new funding for the Nurse and Faculty Loan Program through FY 2014; and
- Section 5312, which makes available \$388 million for nurse workforce development for FY 2010 and such sums as may be necessary for FY 2011 through FY 2016.

Given that these programs do not explicitly cite or mention details related to diversity and cultural competency in the ACA, a comprehensive review and analysis of these nursing provisions is beyond the scope of this report. Nonetheless, we provide identified updates, particularly in the context of their role and promise in enhancing nursing opportunities among racially and ethnically diverse communities.

Implementation Status and Progress

In December 2010, HRSA released a Funding Opportunity Announcement (FOA) to support its Nursing Workforce Diversity initiative and train disadvantaged students, including racial and ethnic minorities, to enter nursing professions at various levels. The FOA was intended to support students at eligible institutions to become registered nurses, assist diploma or associate degree registered nurses to become baccalaureate-prepared registered nurses, and prepare registered nurses for advancing nursing education. The FOA was explicitly geared toward increasing the number of individuals who are from “disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses)” in these programs.⁴⁷ Eligible applicants included accredited schools of nursing, nursing centers, academic health centers, state or local governments, and other private or public entities determined appropriate by the HHS Secretary, including faith-based and community-based organizations, and tribes and tribal organizations.

On July 29, 2011 HHS announced that it had awarded approximately \$3.6 million to 11 grantees as part of the Nursing Workforce Diversity program. These grantees are listed in Table 5. Appendix B details the total number of active grants each year as well as the appropriated funding amount.

Table 5. Nursing Workforce Diversity Grants, FY 2011

Grantee	State	Amount
University of Connecticut	Connecticut	\$334,802
Albany State University	Georgia	\$311,875
Allen College	Iowa	\$312,490
University of Maryland, Baltimore	Maryland	\$304,073
Regents of The University of Michigan	Michigan	\$390,853
Montana State University	Montana	\$277,535
University of North Dakota	North Dakota	\$515,631
Community College of Allegheny County	Pennsylvania	\$399,031
Alvernia College	Pennsylvania	\$110,880
University of Tennessee Health Science Center	Tennessee	\$269,012

Source: Health Resources and Services Administration. “Nursing Workforce Grants by State and Grantee.” Available at: <http://www.hrsa.gov/about/news/2011tables/nursingbyrecipient.html>

Also on July 29, 2011, HHS announced \$67.7 million additional in grant awards for Nursing Development Programs.⁴⁸ As cited in its press release, the following programs and awards were made by HHS:

- Nurse Education, Practice, Quality and Retention (\$10.9 million – 33 awards):**
 Strengthens nursing education and practice capacity by supporting initiatives that expand the nursing pipeline, promote career mobility for nurses, prepare more nurses at the baccalaureate level, and provide continuing education training to enhance the quality of patient care. The ACA modified the program to enhance its focus on activities that help improve nurse retention.

- **Nurse Faculty Loan Program (\$23.4 million – 109 awards):** Assists registered nurses in completing their graduate education to become qualified nurse faculty. Through grants to eligible entities, offers partial loan forgiveness for borrowers that graduate and serve as full-time nursing faculty for the prescribed period of time. The ACA increased the annual loan limit to \$35,500 from \$30,000 and established a priority for doctoral nursing students.
- **Advanced Nursing Education Program (\$16.1 million – 55 awards):** Supports advanced nursing education specialty programs that educate registered nurses to become nurse practitioners, clinical nurse specialists, nurse anesthetists, nurse-midwives, nurse educators, nurse researchers or scientists, public health nurses and other advanced nurse specialists.
- **Advanced Education Nursing Traineeships (\$16 million – 349 awards):** Funds traineeships at eligible institutions for registered nurses enrolled in advanced education nursing programs. Traineeships prepare nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse administrators, nurse educators, public health nurses and nurses in other specialties requiring advanced education. The ACA removed the 10% cap in this program that limited the amount of support that could go to nursing students pursuing doctoral degrees.
- **Nurse Anesthetist Traineeships (\$1.3 million – 76 awards)** Supports traineeships at eligible institutions for licensed registered nurses enrolled as full-time students in their second year of a two-year nurse anesthetist Master's program.

Emerging Programs and Models

In a Nursing Workforce Diversity FOA issued in December 2010, HRSA explicitly required eligible entities to describe their commitment and activities related to advancing diversity and cultural competency.⁴⁹ In addressing diversity, institutions were required to report: (1) their strategic commitment to increasing the number of culturally competent and diverse health professionals; (2) their successful strategies for recruiting and retaining diverse students; (3) provision of resources to promote matriculation of individuals from disadvantaged and diverse backgrounds; and (4) provisions of financial assistance to these students. On the topic of cultural competence, entities were required to describe the institution's strategic commitment to this priority particularly in the provision of services and in developing a culturally and linguistically competent staff, faculty, and program. In addition, institutions were required to report on their past experience recruiting and retaining health care staff with experience in cultural competence, along with existing programs, training and technical assistance and future plans addressing:

- Cross-cultural communication to foster healing relationships;
- Self-awareness of multicultural and health literacy issues;
- Engagement of individuals, families, and communities from diverse social, cultural, and language backgrounds in self-managing their health care; and
- Knowledge and appreciation of how culture and language influences health literacy; and the delivery of high quality, comprehensive, culturally competent, effective health care services.⁵⁰

A review of the Nursing Workforce Diversity Grants program descriptions reveals that, by the nature of the provision, all incorporate a focus on diverse, underrepresented and disadvantaged nursing students. This goal is achieved through activities such as pipeline programs, improving nursing retention in college, financial stipends to increase graduation rates, and improving upon cultural competency and cultural awareness strategies. The University of Maryland, for example, provides culturally specific information about opportunities in nursing to pre-college students—the grantee prepares high school students from low-performing high schools for enrollment in a college pre-nursing program. Albany State University aims to improve graduation rates for minority and disadvantaged students by 50%, and college retention rates for nursing students by fostering a learning community with peer tutoring and mentoring activities. The Community College of Allegheny County describes strengthening cultural competency initiatives through “cultural competence assessments and in programs and presentations designed to increase cultural awareness and the importance of cultural competence in health care.”⁵¹

In a review of active grant programs for the Nurse Education, Practice, Quality and Retention program, all programs address vulnerable populations such as minorities, geriatric populations, and individuals in rural areas. Of these, at least 40% explicitly address inclusion of racially and ethnically diverse populations or the provision of culturally competent care. For example, George Washington University School of Nursing targets racially and ethnically diverse baccalaureate nursing students, or those from rural areas to participate in its “Teaching and Transforming through Technology Program” by breaking down geographic and access barriers through eLearning and blended format teaching strategies. Ashland University has outlined its program objectives to include improved marketing to minority students to increase diversity in enrollment, to improve the retention of such students by 3%, to ensure that simulated learning opportunities include culturally appropriate examples as well as to increase diversity among faculty to encourage the recruitment of minority students and to encourage faculty development in diversity issues. The University of Texas Health Science Center is developing a bridge program by partnering with the pre-nursing program at University of Texas San Antonio, and enhancing the mentoring program to that University for better student retention. An added focus on community is utilized to reach its goals of culturally competent nursing practices.

Challenges and Next Steps

There is growing recognition of the need for a nursing workforce that is representative of the country’s changing demographics. Nursing schools have typically addressed this challenge through two pathways: increasing the number of racially and ethnically diverse nursing students and faculty, and enhancing their cultural competence.⁵² Both of these avenues face unique barriers. In general, there is little consensus regarding the efficacy of individual retention strategies for matriculating diverse nurses. One study reported that financial assistance and computer technology support strategies were most promising, while mentoring programs were less successful.⁵³ Understanding the degree to which curricula related to cultural competency is effective in training a workforce that is sensitive to the needs of patients from diverse heritage is even more challenging. In fact, being from a racially or ethnically diverse background does not necessarily translate to practicing culturally competent nursing care. It has been found that varying levels of acculturation, proficiency in the English language, education, and literacy affect the degree of a provider’s cultural competence.⁵⁴

There exists limited research to date evaluating the efficacy of cultural competence training in nursing. However, the current available evidence shows that there are still improvements to be made in cultivating educational environments that foster trust and cultural awareness. In an evaluation comparing the educational environment of a baccalaureate nursing program and that of a recipient of a Nursing Workforce Diversity grant, it was found that the climate of the grantee ranked more highly in survey domains such as “caring and respect” and “atmosphere.” Although students reported general satisfaction with both programs under study, cultural competency and tolerance were areas students indicated needed improvement.⁵⁵

Several prominent barriers stand to slow the progress of assuring cultural and linguistic competency in nursing curricula. For example, there is a lack of consistency and standardization in content, process, and outcomes of such curricula across nursing programs and schools. This challenge is exacerbated by the presence of numerous programs for entering the nursing profession.⁵⁶ It has also been reported that competing priorities exist among schools that face increasing demand to increase enrollment of nurses in order to address workforce shortages. Academic institutions may funnel resources to “enrollment management” and away from programs aimed at enhancing their cultural and academic environments, including efforts to recruit and retain a racially and ethnically diverse student body.⁵⁷ This point is also highlighted in the Nursing Community Consensus Document, undersigned by numerous nursing organizations:

While nursing has made great strides in recruiting and graduating nurses that mirror the patient population, more must be done to keep pace with the changing demographics of our country to ensure that culturally sensitive care is provided.⁵⁸

Mental Health Providers

Legislative Context

Section 5306 of the ACA amends Sections 750 and 756 of the *Public Health Service Act* which authorizes the Mental and Behavioral Health Education and Training Grants (MBHETG) Program. Under this program, grants are made to academic institutions or professional training programs to recruit students into education programs for social work and psychology, programs that are developing or expanding internships or field placement opportunities in child and adolescent mental health, and training programs for paraprofessional child and adolescent mental health workers. Diversity of individuals participating in the institution, including diversity in race, ethnicity, culture, geography, language, religion, socioeconomic status, gender, and sexual orientation, is among the criteria for eligibility for a grant award. Furthermore, according to the law, the eligible institution should demonstrate that “any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency.” Under the law for FY 2010 to FY 2013, \$8 million are authorized for social work programs, \$12 million are authorized for training in graduate psychology programs, \$10 million are authorized for training in professional child and adolescent mental health, and \$5 million are authorized for training in paraprofessional child and adolescent mental health.

Implementation Status and Progress

On September 25, 2012, HHS Secretary Sebelius announced that nearly \$10 million dollars were awarded to 24 graduate social work and psychology academic institutions ranging from \$121,000 to more than \$480,000 per school (Table 6).

Table 6: Mental and Behavioral Health Education and Training Grantees, FY 2012

Grantee	State	Award
Western Interstate Commission for Higher Education	Colorado	\$354,253
University of Florida	Florida	\$251,999
University of Hawaii	Hawaii	\$331,201
University of Kansas Medical Center Research Institute	Kansas	\$240,000
University of New England	Maine	\$480,000
Hugo W. Moser Research Institute at Kennedy Krieger Inst.	Maryland	\$121,096
Trustees of Boston University	Massachusetts	\$480,000
Regents of the University of Michigan	Michigan	\$480,275
Regents of the University of Minnesota	Minnesota	\$440,000
The Curators of the University of Missouri	Missouri	\$474,174
University of Nebraska	Nebraska	\$480,000
Research Foundation of State University of New York	New York	\$480,275
RFCUNY - Lehman College	New York	\$479,973
Mount Sinai School of Medicine	New York	\$225,570
New York University	New York	\$466,666
Yeshiva University	New York	\$470,862
Children's Hospital of Philadelphia	Pennsylvania	\$192,000
Trustees of the University of Pennsylvania	Pennsylvania	\$479,331
Medical University of South Carolina	South Carolina	\$469,404
University of Texas at Austin	Texas	\$480,275
University of Houston	Texas	\$468,000
Texas State University-San Marcos	Texas	\$479,035
Norfolk State University	Virginia	\$458,277
West Virginia University Research Corporation	West Virginia	\$476,263

Emerging Programs and Models

All grantees funded under Section 5306 describe programs that are targeted to high-needs and high-demand populations, which include medically underserved communities, individuals with disabilities, veterans, low-income populations, among others. At least 10 of the 24 programs explicitly address racial and ethnic diversity. Grantees describe a number of strategies that will enhance training for their students and interns with a specific focus on recognizing and addressing mental health needs of individuals from medically underserved areas, many of whom are racially and ethnically diverse. For example, many schools are revising and augmenting current didactic curricula to emphasize mental health disparities among low-income, vulnerable, and underserved groups.

Another common theme surfaced around revising current, or providing new, clinical trainings that are targeted specifically to patients who lack access to appropriate mental health services.

This includes, for several programs, partnering with behavioral health clinics that serve vulnerable and diverse populations. Finally, the role of telehealth was a theme described among several grantees. One especially promising strategy for improving access to care among hard-to-reach populations, who are diverse in geographic location, socioeconomic status, race, and ethnicity, involves training student interns to use telehealth systems for mental health screening, assessment, and treatment.

Following are examples of grantee programs which reflect a commitment to addressing diversity, equity, and cultural competency by ensuring training opportunities are focused in serving communities of color, and professionals are better prepared to serve those individuals:

- **University of Hawaii:** Through new funding, the University plans to add 2-3 new pre-doctoral internship trainees who will specialize in treating patients of diverse racial, ethnic, socioeconomic, and geographic backgrounds. According to the program description, “the purpose is to increase the number of scientist-practitioner clinical psychologists committed to working with underserved, rural, ethnically diverse groups, who provide culturally-competent, evidence-based psychological services in an interdisciplinary team context.”⁵⁹
- **University of Michigan:** The University of Michigan’s program has extensive goals to eliminate health disparities among communities in Detroit and Wayne County. The grantee aims to implement an interdisciplinary training curriculum with emphasis on better preparing social workers to serve diverse children and adolescents. This goal is being achieved through increasing the number of internships in disadvantaged local communities in partnership with behavioral health clinics serving these groups, as well as increasing the number of social workers who will continue to serve these populations.
- **University of Missouri:** This grantee is increasing the number of psychologists who will provide services to persons with chronic disease in rural areas. Curricula and experiential training will be augmented by adding the course “Culture and Health Literacy” to students’ educational experiences in order to improve cultural and linguistic competency. This program will evaluate its outcomes through quantitative and qualitative measures, including number of interns from diverse racial and ethnic backgrounds who complete the internship, increases in cultural competencies, and number of interns who go on to practice in underserved or rural areas.
- **Children’s Hospital of Philadelphia:** This grantee is using funding from the ACA to better prepare psychology interns and fellows to treat underserved populations, especially low-income and racially and ethnically diverse children with mental health problems. Culturally competent practices are emphasized with students training in sites such as urban primary care practices and schools. According to the program description, “clinical training will be complemented by participation in a progressive series of didactic seminars. Each seminar series focuses on issues related to individual and cultural diversity, particularly working within medically underserved communities.”⁶⁰

Beyond these programs and the ACA, several states have explicitly recognized the importance of cultural competency training and require or recommend that mental health professionals receive such education through their degree curricula, continuing education, or requirements for

licensure.⁶¹ At least three states have implemented legislation requiring these objectives. New Jersey enacted legislation in 2005 requiring a pre-specified number of hours of cultural competency training to receive medical licensure. It also requires medical schools to incorporate learning objectives into their curricula focusing on racial and gender disparities in medical treatment. California passed a law in 2005 that mandates integrated cultural competency objectives into health care degree curricula moving away from models that require singular classes or set number of training hours. Washington passed legislation in 2006 requiring health professional schools to provide education in multicultural health by a specific deadline. The regulatory agency for health professions is also required to implement education programs in multicultural awareness under the law. Maryland has enacted voluntary legislation for cultural and linguistic competency and at least nine states have introduced but not passed laws around these competencies in program curricula, continuing education, and licensure processes.⁶²

Challenges and Next Steps

The HRSA Office of Shortage Designation has identified 3,059 Mental Health Professional Shortage Areas, which includes 77 million residents, many of whom are racially and ethnically diverse. To achieve the recommended population-to-practitioner ratio, 5,145 providers are required.⁶³ It is clear that while these funded grants are an important start to meeting the needs of diverse populations experiencing disparities in mental health services, a continued commitment to this goal is necessary to fill the immense void. Furthermore, not all funded programs have clear goals for cultural competency training among mental health providers. Much can be learned from the few states that have taken innovative steps to integrate cultural competency into mental health professional training and licensure.

In an analysis of regulatory and legislative actions for cultural competency in 14 states, several common activities associated with positive outcomes and barriers to implementing these activities were identified. For example, leveraging support from the executive branch and drawing from successful lessons learned in other states proved to be indicators of positive results. Barriers identified included bill sponsorship without important, if not, essential support backing from advocacy and consumer groups or other legislators or opposition from associations representing health care professions or higher educational institutions protective of professional scope. Other challenges reported included legislative leadership that failed to view cultural competency training as a high priority as well as the incorrect association some legislators made in linking the support of cultural competence training with undocumented immigration.⁶⁴

Long Term Care Providers

Legislative Context

Section 5302 of the ACA amends Title VII of the *Public Health Service Act* by authorizing \$10 million for FY 2011 to FY 2013 to fund a novel program that provides grants to higher education institutions to train direct care workers. These institutions should have partnerships with entities such as nursing homes, skilled nursing facilities, home health care agencies or other long-term care providers. Grants will provide financial assistance to students who commit to working in the fields of geriatrics, disability services, long-term care, among others for a minimum of two years. While there is not explicit language related to diverse populations, this provision holds promise for advancing the health of such communities as a significant percentage of the direct care

workforce is made up individuals from racially and ethnically diverse heritages.

Implementation Status and Progress

No funding has been appropriated for this provision, to date.

Emerging Programs and Models

While this provision lacks funding and has gone unimplemented, the development of the direct care workforce and related priorities are being addressed under other funded provisions of the ACA. For example, Section 5507 established demonstration projects for six states which are currently being implemented. Under this provision, states receiving funds for demonstration projects are tasked with developing core competencies for direct care workers to help to strengthen their competencies explicitly related to communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills, among others. In addition, they are creating foundational trainings and protocols as well as a certification test to continue to develop and standardize such core competencies. Section 5309 provides community college and community-based training programs for nursing assistants and home health aides. The provision provides funding for the Nursing Assistant and Home Health Aide Program which supports nursing assistants and home health aides in their career development. Training programs are currently being implemented to ensure that these workers have the necessary skills to provide care in a complex health care environment. Funding also supports a “career ladder” to support nursing assistants, associate degree nurses, and others train and prepare for baccalaureate-level registered nursing programs or other advanced degree nursing programs.

Challenges and Next Steps

Residual uncertainty around the value of investment in direct care jobs has likely hindered opportunities for their funding and prioritization. Jobs classified under this profession, such as home health care aides, have been perceived as “dead end” due to high turnover and a lack of formal training requirements.⁶⁵ In addition to low wages and poor benefits, direct care workers commonly experience occupational injuries. However, developing improved training requirements and clear professional standards and guidelines for this occupation will likely improve overall job quality, thereby offering the potential for substantial improvements for its workforce, many of whom are racially and ethnically diverse, and simultaneously improve the quality of patient care.

Community Health Workers

Legislative Context

Section 5313 establishes a novel grants program to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of Community Health Workers (CHW). The CHW program is intended to educate and provide outreach in community settings regarding health issues prevalent in medically underserved and diverse areas. A CHW is defined by the Department of Labor as “an individual who promotes health or nutrition within the community which the individual resides” by, among other actions, “providing culturally and linguistically appropriate health or nutrition education.”⁶⁶ The law specifies that

grants should be used to support CHWs “to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations.” Such sums as necessary are authorized under the ACA to carry out this provision for FY 2010 to FY 2014.

Implementation Status and Progress

This provision of the ACA has not been funded, although opportunities and priorities for community health workers have been funded through other sections of the ACA, such as the Community Transformation Grants (Sec 4201). For example, the Douglas County Health Department in Nebraska, is implementing a Community Transformation Grant to enhance local initiatives to promote tobacco-free living, increased physical activity and healthy eating strategies, clinical quality and preventative services, among other objectives. OneWorld Community Health Center is partnering with the department to provide a community health worker to assist underserved populations with blood pressure and cholesterol management. The Texas Department of State Health Services is also working with CHWs to provide culturally appropriate care to underserved populations through its Community Transformation Grant titled “Transforming Texas.” The intent of this program is to work with CHWs to reduce chronic diseases, lower the cost of care, and promote active and healthy living through expanding access to care for vulnerable populations with high rates of chronic disease.

Emerging Programs and Models

There is increasing evidence of the effectiveness of using CHWs to reduce the burden of chronic disease especially among underserved, low-income, and diverse patient populations. Efforts to leverage this unique workforce are evident in cancer initiatives as the Division of Cancer Prevention and Control (DCPC) reports that 35 state cancer control plans include references to CHWs, patient navigators, outreach workers, community health representatives, *promotores*, community health advisors, lay health educators, lay health advisors, or peer educators.⁶⁷

Other community health worker initiatives being implemented outside of the ACA serve as models and best practice examples for successful strategies to reach out to and serve diverse populations. A common characteristic of these programs—which is essential to caring for underserved communities—is a close connection (whether it be through shared race, ethnicity, language or other experiences) to the target population. This is frequently seen as a central requisite needed to ensure that the services provided are culturally and linguistically appropriate, which does not always occur when receiving care through traditional health care routes. Examples of such programs include the Division for Diabetes Translation (DDT) in Rhode Island which has partnered with the Diabetes Multicultural Coalition to train CHWs to teach diabetes self-management to members of diverse populations. DCPC has also partnered with Florida, Texas, Georgia, and the U.S.-Mexico border to include CHWs (known in Spanish as *promotores*) to improve patient education and care.⁶⁸ In addition, 18 of the 40 Racial and Ethnic Approaches to Community Health (REACH) coalitions in the U.S. rely on CHWs as a grassroots empowerment strategy to reduce health inequities among various populations and to improve health outcomes.⁶⁹

The administration of CHW initiatives varies greatly across states, but several states offer promising examples for effective funding models and implementation efforts. For example, Minnesota is one of the only states that offers Medicaid fee-for-service reimbursement for these

workers since its initiation of an 1115 Medicaid Waiver to allow for such reimbursement in 2007.⁷⁰ The Blue Cross Foundation in Minnesota has promoted culturally competent care in underserved communities by funding the Minnesota Community Health Worker Alliance which oversees a standardized curriculum and certification program for community health workers.⁷¹ Massachusetts also stands out as a state making significant progress in supporting community health worker programs to target health disparities. After extending health insurance coverage to an expanded patient population in 2006, the state relied on contributions from community health workers to effectively reach out to and enroll uninsured and under-insured individuals and formally recognized such efforts in its health care reform legislation. Through this legislation, the state provided Outreach and Enrollment Grants to eligible community-based organizations for enrollment assistance into the law's new coverage options, and most grantees used CHWs to do so.⁷² The state's Massachusetts Association of Community Health Workers, in partnership with several other entities, offers specialized training and education for CHWs to provide services to Latino and African American communities with high rates of chronic diseases.

Challenges and Next Steps

There are clear challenges that continue to threaten the CHW workforce. In addition to the absence of funding for this specific provision, other funding challenges persist. Throughout the nation, grants for community health workers frequently cover limited time frames or scope causing periodic gaps in program operations or uncertainty over future programs. Many states also lack standard certification criteria for CHWs, which is a necessary component for the development of this field.⁷³ It is well-documented that CHWs are vital to implementing effective outreach to racially, culturally, and linguistically diverse populations and are leaders in providing culturally competent care. As a result, current setbacks and delays in development of this unique facet of the health care workforce may also slow broader health equity objectives.

B. Workforce Support for the Health Care Safety Net

Background

While the large majority of workforce provisions discussed in this report have implications for the health care safety net, there are at least three that explicitly target programs within public hospitals, community health centers, and other safety net settings. In this section, we discuss the implementation status, progress, and challenges related to these provisions:

- Section 5207: Funding for National Health Service Corps;
- Section 5403: Interdisciplinary, community-based linkages; and
- Section 5503: Distribution of unused residency slots.

Since 1972, The National Health Service Corps (NHSC), authorized under the *Public Health Service Act*, has encouraged residents to commit to providing care in medically underserved areas through financial incentives such as loan repayments or scholarships. Research has indicated that having participated in the NHSC independently predicts whether physicians provide care to underserved populations.⁷⁴ One source estimates that half of these providers practice in HRSA-supported health centers delivering care to a population that is largely uninsured.⁷⁵ However, this program has a history of limited funding to support as many positions as there were vacancies in shortage areas.⁷⁶ This provision of the ACA aims to address this challenge by maintaining and increasing support for the NHSC.

Another program which encourages medical practice in underserved areas is the Graduate Medical Education (GME) Loan Repayment Program. Access to care for residents of rural and medically underserved areas is a well-known challenge. It has been suggested that the problem may be worsened by a common practice: GME funding to urban teaching hospitals frequently leads to physician trainees remaining in these urban settings where they receive training.⁷⁷ This challenge is especially concerning for racially and ethnically diverse individuals residing in rural areas as barriers in access to care are greater for these populations. For example, Hispanics living in rural areas are less likely than their urban-residing counterparts to have a usual source of care (72% versus 77%).⁷⁸ It has also been found that rural areas with a Hispanic population greater than 50% had lower physician density ratios and residents faced longer travel distances to physicians and hospitals than individuals in rural areas populated predominantly by Non-Hispanic Whites.⁷⁹

Finally, the Area Health Education Center (AHEC) program supports partnerships between nursing and medical schools and community-based centers to provide training opportunities that are designed to enhance the supply and distribution of the healthcare workforce. Training opportunities largely focus on primary and preventative care and are targeted to underserved populations such as migrants, individuals in rural areas, community health clinic patients, among others. The AHECs further provide continuing education to health care providers and direct outreach initiatives addressing issues around service delivery and access for underserved populations. Community partnerships such as these have been identified as effective in recruiting, preparing, and retaining a diverse body of health professions students.⁸⁰

National Health Service Corps

Legislative Context

Section 5207 of the ACA reauthorizes the NHSC as well as increases monetary support for the program by authorizing new dedicated funding in the amount of \$1.5 billion for FY 2011 through FY 2015. Starting in 2016, funding will be adjusted based on the costs of health professions education and increases in the population residing in health professional shortage areas.⁸¹

Implementation Status and Progress

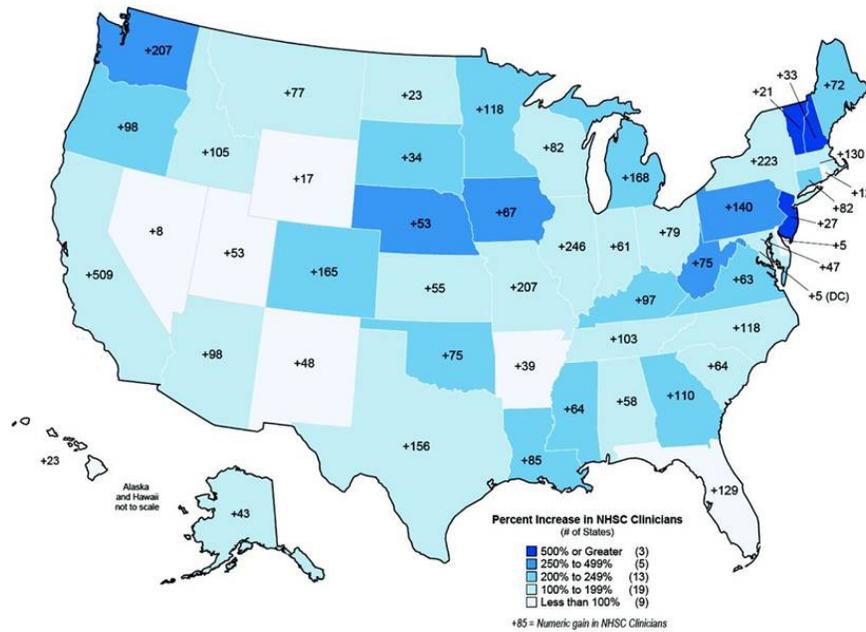
On October 13, 2011, the U.S. Department of Health and Human Services (HHS) announced grant awards for the NHSC. The ACA, along with other funding sources, funded 5,418 awards for NHSC loan repayment programs, and \$46 million in mandatory funding from the ACA went to the NHSC scholarship program.⁸² Additional funding was announced for NHSC programs on February 13, 2012: a pilot program titled “Student to Service” established loan repayment incentives up to \$120,000 to fourth year medical students in exchange for service commitments in health professional shortage areas.⁸³ On October 11, 2012 the HHS announced the ACA-funded loan repayment and scholarship awards in the amount of \$229.4 million for 4,600 awards and state grants.⁸⁴

Under the ACA, the NHSC workforce has grown approximately three times and has expanded care to underserved communities, including racial and ethnic minorities. Of the over 8,600 NHSC-approved sites, 46% are community health centers,⁸⁵ and a large proportion of program participants go onto practice in this setting.⁸⁶ In 2008, 2,600 NHSC members served 3.7 million patients which increased to more than 10,000 providers serving 10.5 million people in 2011.⁸⁷ The current NHSC members are a diverse group of clinicians: self-reported estimates show that 13% are African American, 10% are Hispanic, and 9% are Asian, Pacific Islander, American Indian, or Alaskan Native. According to 2012 estimates, both African American and Hispanic physicians made up a larger percentage of physicians in the NHSC workforce than physicians in the general population (17% versus 6% and 16% versus 5%, respectively).⁸⁸

Emerging Programs and Models

Data from a 2011 observational study of the NHSC program reveals the benefits of its expansion and commitment through the ACA. The study reveals that funding (\$300 million) provided through the American Recovery and Reinvestment Act (ARRA) of 2009 to support expansion of the NHSC fueled the largest growth of clinicians in the NHSC’s history. During the 2-year period, a 156% increase in clinicians was seen, rising from 3,017 to 7,713. Figure 2 illustrates the percent increase in number of clinicians by state following the funding expansion.⁸⁹

Figure 2. Map of percentage and numerical growth in National Health Service Corps' (NHSC) clinicians in each U.S. state during the American Recovery and Reinvestment Act funding period, March 2009 through February 2011.



Source: Data from the U.S. Bureau of Clinician Recruitment and Service's Management Information System Solution as cited in Pathman, D. E., & Konrad, T. R. (2012). Growth and Changes in the National Health Service Corps (NHSC) Workforce with the American Recovery and Reinvestment Act. *The Journal of the American Board of Family Medicine*, 25(5), 723-733.

Percentage change in clinician growth was also examined among states depending on the pre-ARRA funding ratio of NHSC clinicians to proportion of the population living in poverty. It was found that states with the lowest number of NHSC clinicians per 100,000 population experienced highest growth in NHSC clinicians (291%) and states with the highest number of NHSC per 100,000 population experienced the lowest amount of growth (111%) (Table 7).⁹⁰

Table 7. Percentage Growth in States' Total National Health Service Corps (NHSC) Clinician Numbers during the American Recovery and Reinvestment Act Period: Relationship to Baseline Number of Corps Loan Repayment Clinicians per 100,000 Population Below Poverty

State Quartile at baseline	States (n)	States' baseline NHSC Clinicians per 100,000 Population below poverty	States' Growth in NHSC Clinicians During Recovery Act Period (mean %)	SD
Lowest quartile	13	0.63 – 5.36	291%	253
Second lowest quartile	13	5.49 – 7.96	210%	146
Second highest quartile	13	8.08 – 14.50	172%	71
Highest quartile	12	15.78 – 62.92	111%	67
All states' average	51	0.63 – 62.92	197%	164

Source: Data from the U.S. Bureau of Clinician Recruitment and Service's Management Information System Solution. as cited in Pathman, D. E., & Konrad, T. R. (2012). Growth and Changes in the National Health Service Corps (NHSC) Workforce with the American Recovery and Reinvestment Act. *The Journal of the American Board of Family Medicine*, 25(5), 723-733.

Challenges and Next Steps

Continued investment in the NHSC has proved to be a promising development to better serving the needs of racially and ethnically diverse populations. Recent analyses reveal important implications in how significant increases in NHSC funding can shape and grow the workforce, especially for diverse populations. The data show that the highest growth occurred for states that had the fewest number of clinicians relative to the size of their low-income populations. This represents a promising finding in addressing disparities in health care and will be important to continue tracking as the NHSC experiences further growth under the ACA. However, challenges for African American NHSC members serving in rural areas have surfaced—these individuals have historically reported lower satisfaction in both their professional and personal lives. In addition, minority NHSC physicians in general have cited challenges in site placements, including placement away from their home states.⁹¹ It is unclear whether this challenge is being addressed, as our literature review has not revealed any more recent analysis of satisfaction among minority clinicians serving in the NHSC.

Graduate Medical Education

Legislative Context

Section 5503 of the ACA directs the Secretary of HHS, beginning July 1, 2011, to convert unfilled hospital residency positions under the Graduate Medical Education (GME) program to slots for primary care physicians. An exception is given to hospitals in rural areas with less than 250 beds. Preference for redistributing unfilled residency slots is given to states with a low resident physician-to-population ratio or with large numbers of people living in primary care health professional shortage areas. Urban hospitals that have accredited rural training programs and rural programs are also given preference.

Implementation Status and Progress

On November 2, 2010, the Centers for Medicare & Medicaid Services (CMS) issued final regulations regarding the redistribution of medical resident cap slots from hospitals that were below their caps to hospitals that applied to CMS for increased slots to expand their residency programs. This provision requires that 70% of the resident slots be distributed to hospitals in states ranking among the lowest quartile of resident-to-population ratios, and 30% be distributed to hospitals located in rural or health profession shortage areas. CMS outlined requirements for awardees in the 2011 Outpatient Prospective Payment System (OPPS) final rule⁹² which specifies that hospitals maintain a certain number of primary care residents based on the number of resident slots it had before the increase, and also specifies that at least 75% of the newly awarded slots be used for primary care or general surgery.

CMS announced on August 15, 2011 which teaching hospitals had received changes to their resident caps. Excess slots were redirected to 58 hospitals—726 direct graduate medical education (GME) resident slots, and 628 indirect graduate medical education (IME) resident slots, from 267 hospitals were redirected. Five rural hospitals received a cap increase.⁹³

Emerging Programs and Models

Table 8 lists the 58 hospitals that received resident cap increases under Section 5503 of the ACA. The number of IME and GME slots awarded is shown by hospital. In addition, the percent of the city's population that is Non-Hispanic White according to the U.S. Census is shown. Table 8 displays, in general, the proportion of diverse cities and metro areas receiving increased GME and IME slots. Although not a perfect measure of patient racial and ethnic demographics of a particular hospital, cities with populations made up of less than 50% Non-Hispanic White residents are highlighted to show the diverse areas that have seen increased opportunities to train residents, including many in primary care, under this policy change. Twenty-four of the 58 hospitals are located in diverse areas, according to this criterion. The 24 hospitals located in highly diverse areas—i.e., those with more than 50% Non-Whites—are highlighted in red (Table 8).

Challenges and Next Steps

The disconnect between current primary care challenges and the GME program has surfaced as a criticism of these federally-funded resident training programs.⁹⁴ Section 5503 represents a critical step toward aligning teaching hospitals with current healthcare needs by providing more resident training opportunities in primary care. However, oversight attached to these funds is still lacking in terms of the quality of training, performance standards for trainees, and patient outcomes. Other challenges relate to proposed funding cuts for GME programs. Though Congress has not acted on either, two proposals emerged after the passage of the ACA, threatening federal funding for indirect and direct GME payments.⁹⁵

It has also been noted that the number of slots redistributed to hospitals under this provision, while largely benefiting medically underserved areas, represents only a fraction of what will be needed to bridge the gap in health and health care disparities these populations face. As stated by Len Marquez, the Director of Government Relations at the American Association of Medical Colleges, "It doesn't get us anywhere close."⁹⁶ Calculations on the projected number of medical residents trained can be derived by dividing the number of new residency slots by 4, the length in years of most residency programs. Therefore, as stated succinctly by Marquez, the outcomes of Section 5503 clearly fall short of what is needed: "At a time when we need to be training an additional 4,000 a year, we're going to train an additional 200 a year." His organization has projected a shortage of 91,500 physicians by 2020.⁹⁷

While this provision specifies that programs receiving increased residency slots must dedicate a certain number of those to primary care, it should be cautioned that this does not necessarily indicate that these trainees will go on to practice in primary care. The Council on Graduate Medical Education (COGME) has recommended that when evaluating shortages in primary care, successful outcomes should not be measured based on the number of trainees entering primary care residencies, but rather on where physicians go to practice and train following their postgraduate medical training. In fact, data from the National Resident Matching Program, as reported by COGME, indicate that among residents matched to primary care specialties (including family medicine, internal medicine, and pediatrics), approximately 40% are likely to go on to practice in primary care.⁹⁸

Table 8. Hospitals awarded increases in IME/GME slots and Percent of Non-Hispanic White by city

Hospital Name	Location	IME Slots awarded	GME slots awarded	% Non-Hispanic White
Baptist Medical Center South	Montgomery, AL	7.7	7.7	36.1%
Huntsville Hospital	Huntsville, AL	25.6	36.82	58%
DCH Regional Medical Center	Tuscaloosa, AL	8	8	52.6%
Princeton Baptist	Birmingham, AL	11.57	14.05	21.1%
University of South Alabama Children's & Women's Hospital	Mobile, AL	0	8.34	43.9%
The George Washington University Hospital	Washington, DC	7.9	7.9	35.3%
Washington Hospital Center	Washington, DC	39.58	39.58	35.3%
Children's National Medical Center	Washington, DC	0	12	35.3%
Orlando Regional Medical Center	Orlando, FL	4.58	4.75	41.3%
Florida Hospital Orlando	Orlando, FL	31.6	37.64	41.3%
University of Miami Hospital	Miami, FL	2.43	4.36	11.9%
Medical Center of Daytona Beach	Daytona Beach, FL	8.67	9.17	54.4%
Jackson Memorial Hospital	Miami, FL	5.36	9.62	11.9%
Sacred Heart Hospital	Pensacola, FL	3	3	64.3%
Mount Sinai Medical Center	Miami Beach, FL	0.87	0	40.5%
Broward General Medical Center	Fort Lauderdale, FL	16.79	29.21	52.5%
Sylvester Comprehensive Cancer Center/UMHC	Miami, FL	0	1.09	11.9%
Tallahassee Memorial Healthcare	Tallahassee, FL	39	39	53.3%
Mayo Clinic Florida	Jacksonville, FL	3.44	7.95	55.1%
Palmetto General Hospital	Hialeah, FL	20.43	36.66	4.2%
Northside Hospital & Tampa Bay Heart Institute	Saint Petersburg, FL	5.11	9.16	64.3%
Wellington Regional Medical Center	Wellington, FL	9	9	64.8%
Westchester General Hospital	Miami, FL	6	6	11.9%
Cleveland Clinic in Florida - Weston	Weston, FL	5.38	9.66	44.8%
Miami Children's Hospital	Miami, FL	0	14	11.9%
Saint Luke's Boise Medical Center	Boise, ID	3.46	3.46	85.2%
West Valley Medical Center	Caldwell, ID	2	2	60.8%
Madison Memorial Hospital	Rexburg, ID	2	2	90.8%
Portneuf Medical Center	Pocatello, ID	3.75	3.75	86.8%
Franciscan Saint Francis Health - Beech Grove Campus	Beech Grove, IN	0.81	0	90%

Indiana University Health Methodist Hospital	Indianapolis, IN	22	22	58.6%
Memorial Hospital	South Bend, IN	3	3	55.8%
Community Hospital East	Indianapolis, IN	25.85	22.67	58.6%
Saint Vincent Indianapolis Hospital	Indianapolis, IN	18	18	58.6%
Indiana University Health Ball Memorial Hospital	Muncie, IN	12	12	82.8%
Westview Hospital	Indianapolis, IN	7	7	58.6%
Baton Rouge General - Mid City	Baton Rouge, LA	18	18	37.8%
Willis-Knighton Medical Center	Shreveport, LA	4	4	40%
East Jefferson General Hospital	Metairie, LA	1.83	1.83	72.4%
Tulane Medical Center	New Orleans, LA	10.08	10.08	30.5%
Munson Medical Center	Traverse City, MI	0.53	0.53	76.4%
University of Mississippi Medical Center	Jackson, MS	32.57	32.57	18%
North Mississippi Medical Center – Tupelo	Tupelo, MS	0.95	0.76	57.7%
Billings Clinic Hospital	Billings, MT	18.88	18.43	86.9%
Saint Vincent Healthcare	Billings, MT	1	1	86.9%
Renown Regional Medical Center	Reno, NV	21	21	62.5%
University Medical Center	Las Vegas, NV	50.34	50.34	47.9%
University of New Mexico Hospital	Albuquerque, NM	24.92	24.92	42.1%
Memorial Medical Center	Las Cruces, NM	2.92	0	37.5%
Medical Center of Southeastern Oklahoma	Durant, OK	3	3	71.2%
Robert Packer Hospital	Sayre, PA	1.71	0	95.1%
Hospital de la Concepcion	San German, PR	6	6	0.6%
Saint Luke's Memorial Hospital	Ponce, PR	20.67	20.67	0.6%
Sistema Integrados De Salud Del Sur Oeste Inc	Mayaguez, PR	2.7	7.35	0.7%
Avera McKennan Hospital & University Health Center	Sioux Falls, SD	3	3	84.9%
Sanford USD Medical Center Sioux Falls	Sioux Falls, SD	21	21	84.9%
Norton Community Hospital	Norton, VA	4.52	4.52	n/a
Saint Joseph's Hospital	Marshfield, WI	16.55	16.55	93.5%
Total Pool		628.05	726.09	

Note: Highlighted in red are institutions located in diverse cities (i.e., Non-Hispanic Whites comprise less than 50% of the city's population) which have seen increased GME/IME slots. Source: Centers for Medicare & Medicaid Services. Downloads: "Section 5503 Cap Decreases and Increases." Available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html> and U.S. Census Bureau, QuickFacts, 2010.

Area Health Education Center

Legislative Context

Section 5403 of the ACA authorizes funding for grants to Area Health Education Centers (AHECs) to support community-based training and education in health. Awards are available for both the development of new health care workforce educational programs as well as to continue or improve upon existing AHECs. The legislation requires entities to recruit racially and ethnically diverse or disadvantaged individuals or residents of rural areas and to conduct training and education for individuals who commit to careers in underserved areas. Under this provision, \$125 million were authorized for each FY 2010 through FY 2014.

Implementation Status and Progress

HRSA awarded grants under two programs: the AHEC Infrastructure Development program and the AHEC Point of Service Maintenance and Enhancement program. Funding actually received for this provision represented only one-fourth of what was authorized by the ACA each year. Specifically, as opposed to receiving \$125 million each year, \$33 million was awarded in FYs 2010 and 2011, each,⁹⁹ \$27 million in FY 2012, and \$28 million in FY 2013 (Table 9).^{100, 101} While funding for FY 2014 is still uncertain, a total of \$75 million have been requested.¹⁰²

Table 9. Authorized Funding in the ACA and Actual Funding for Area Health Education Centers (AHEC), FY 2010-2014

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
AHEC	\$125 m	\$33 m	\$125 m	\$33 m	\$125 m	\$27 m	\$125 m	\$28 m	\$125 m	\$75 m

Note: Auth = Authorized

Emerging Programs and Models

At least half of the funded AHEC programs explicitly cite in their program descriptions that they target racially and ethnically diverse communities. The following programs are examples of those that have outlined goals for recruiting, training, and serving in underserved and diverse settings:

- **The University of North Dakota:** The University and its partners are using the new funding to continue the development of two of its regional centers. The program continues to promote health professional careers to rural, racially and ethnically diverse students of all levels through: summer camps and enhanced clinical shadowing opportunities; the establishment of a Health Occupation Student Association chapter; and maintained efforts to hold community-based inter-professional trainings in underserved areas.
- **Montana State University:** This grantee is recruiting and supporting programs in collaboration with its four regional centers for minority, disadvantaged, and rural students in medicine, nursing, and other health professions to ensure their success. An emphasis is

placed on primary care and public health. Rural field placements will encourage students to practice in rural areas in the state.

- **Indiana University:** The Indiana AHEC Network will support and further enhance community-academic partnerships for health professions training. The program explicitly aims to improve the representation of minorities, disadvantaged, rural or otherwise underserved individuals among health care workers by promoting awareness of health professions and strengthening academic and readiness skills. The grantee will also focus on increasing the number of health professions students who will go on to practice in medically underserved communities by increasing students' knowledge of the communities' needs and improving cultural competency training. Finally, Indiana University and its network will provide professional development training to providers serving in rural or disadvantaged communities and target goals in practice improvements and help to fulfill professional education requirements.

Challenges and Next Steps

The AHECs are uniquely positioned to develop and support a diverse and culturally competent health care workforce. Through academic-community partnerships, many of these entities are working to recruit, train, and educate a primary care workforce that is diverse and reflective of the communities they eventually serve. Strengthening the connection between AHECs and community health centers is key to improving education and training for professionals in community-based health care settings.¹⁰³ However, several challenges stand in the way of these programs' success, if not addressed. For example, The University of New Mexico Health Sciences Center partnered with several community-based entities, including an AHEC, to better connect the community's health needs with its services and resources, and described several of the challenges that surfaced. The institution's faculty in some cases expressed discomfort in participating in initiatives emphasizing the underlying social determinants of health, as they felt they were better addressed by other disciplines such as social work, health policy, or public health. Competing priorities among academic institutions—ranging from hospital beds being filled to overcrowded emergency departments—were also described as pressing issues for academic health centers which can distract leaders from recognizing urgent health needs within the community. In addition, community needs did not always sync with the AHEC's greatest strengths (such as specialty services, current research interests and agendas, and educational programs).¹⁰⁴

C. Cultural Competency Education and Training

Background

Persons of color are more likely to report experiencing poorer quality and less satisfaction with patient-provider interactions than Whites, a disparity which is particularly pronounced among individuals whose primary language is other than English.¹⁰⁵ Cultural competence training and education for health professionals has gained credibility as a strategy for improving the quality of care delivered to culturally and linguistically diverse patients.¹⁰⁶

Cultural competence is defined as:

a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).¹⁰⁷

There is considerable evidence that cultural competency training improves intermediate outcomes such as knowledge, attitudes, and skills of health professionals along with patient-provider interactions and patient satisfaction.¹⁰⁸ Two landmark reports issued by the Institute of Medicine—*Crossing the Quality Chasm* and *Unequal Treatment*—particularly highlight the importance and promise of cultural competence in improving quality and eliminating racial and ethnic disparities in health care. In addition, cultural competence at the organizational level can assist in deinstitutionalizing racism and guiding culturally competent program development and evaluation.

Despite the thrust to advance cultural competence, however, few published studies link such training to improved health outcomes.^{109,110} There is also considerable lack of consensus about effective education and training programs and approaches for teaching cultural competence.¹¹¹ Provisions in the Affordable Care Act (ACA) which aim to explicitly advance cultural competency education and training in the health care fields thus offer an important opportunity not only to improve quality, satisfaction, and outcomes among diverse patients, but to establish a base of effective curricula through rigorous research, testing, and evaluation. Following are actions the ACA supports to explicitly improve the cultural competence of health care providers:

- Section 4305. Advancing research and treatment for pain care management;
- Section 5307. Cultural competency, prevention, and public health and individuals with disabilities training; and
- Section 5507. Demonstration projects to address health professions workforce needs.

While modest, these efforts offer significant potential for improving the cultural competency of providers in areas of health care where disparities are entrenched. Studies show that Non-White racially and ethnically diverse patients frequently receive suboptimal care for pain management and are at high risk for poor pain outcomes.^{112,113} For example, in a study for analgesia therapy, Hispanics were twice as likely not to receive pain medication than Non-Hispanic Whites.¹¹⁴ Blacks

also experienced similar outcomes. Patient education, as well as physician education, is an important part of pain management. Disparities also exist in home care outcomes for diverse patients. A recent study found that racial and ethnic minorities experienced substantially worse functional outcomes than did Non-Hispanic White home health care recipients, and this disparity was most pronounced between Whites and African Americans.¹⁵ Part of the problem is a lack of cohesive standards and training requirements, particularly in established core competencies, including cultural competency.

Section 5407 offers a unique opportunity to test the impact of cultural competency training programs across a range of health professions and identify successful models for improving both process and health outcomes. It also offers an opportunity to assess efficacy (i.e., does it work?) and effectiveness (i.e., how well does it work?) of training and education programs, which is largely lacking in the field of cultural competence. A national clearinghouse on validated cultural competence measures, assessments, curricula, and other tools could help to create cohesion and consensus, as well as offer a real-time portal for exchanging information, lessons learned, and best practices. The online clearinghouse could also provide a forum for discussion of new and innovative efforts.

The narrative that follows discusses these three provisions in detail, describing their progress in implementation along with challenges and steps that lie ahead for their full realization.

Cultural Competency in Pain Care

Legislative Context

Section 4305 authorizes research, treatment, and education to further enhance and improve pain care management. The law specifically charges the National Institutes of Health (NIH) to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain. In addition, the ACA authorizes HRSA to establish a new grants program for health professional schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in the diagnosis, treatment, and management of acute or chronic pain. An explicit requirement of the award is that the applicant includes information and education on cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations. Such sums as necessary are authorized for this grant program for FY 2010 to FY 2012.

Implementation Status and Progress

To date, the new HRSA grants program to provide health professionals with education and training in pain care has not received funding under the ACA. However, the provision of the law that charges the NIH with expanding and enhancing research topics related to the diagnosis, treatment, and management of pain has moved forward. The Institute of Medicine's (IOM) Committee on Advancing Pain Research, Care, and Education held five meetings between November 22, 2010 and April 19, 2011 to address the following priorities:

- Assess the public health impact of pain;
- Review research, care, and education related to pain; and
- Identify barriers in pain care.

On June 29, 2011 the committee publicly released the resulting report titled *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. The report highlights several aspects of racial and ethnic disparities in pain care. For example, in recognizing pain as a public health challenge, the report reviews current evidence which reveals that certain subgroups, including racially, ethnically, and linguistically diverse populations, experience pain at a higher rate and are more likely to receive inadequate treatment for their pain. The authors also point out a challenge to evaluating pain among different populations is variation in how data are collected and reported on pain across various population groups. Furthermore, while there is a general consensus that pain is undertreated among different groups, the phenomenon remains poorly understood due to the lack of comprehensive and systematic research studies exploring the issue. The report reviews current evidence among African American, Hispanic, Asian, and American Indian or Alaska Native populations to highlight documented challenges these groups face in receiving pain treatment.

The report further developed a comprehensive action plan and specific recommendations in order to improve the state of pain research, education, care, and prevention. Priority recommendations include creating a comprehensive pain strategy, developing strategies to eliminate barriers to care, ensuring better collaboration among pain specialists and primary care physicians, and identifying a lead institute at the NIH tasked with advancing research in pain care. Authors also stated that “enhanced continuing education and training are needed for health care professionals to address gaps in knowledge and competencies related to pain assessment and management, cultural attitudes about pain.”¹⁶

Emerging Programs and Models

The NIH recognized health disparities in pain care as a research priority after releasing its 2011 request for new priorities for advancing pain research.¹⁷ As stated in the FOA, the following research questions were identified as priorities under the health disparities topic area:

- Differences in care for various types of pain, acute postoperative pain, treatment-related pain, cancer pain, or chronic non-malignant pain, in various settings (i.e., health clinics, physician and dental offices, institutional settings including long-term care facilities, assisted living facilities, or emergency departments), and management of pain at the end of life.
- Differences in the factors contributing to pain disparities including patient-related (e.g., communication, attitudes), health care provider-related (e.g., decision making), and health care system-related (e.g., access to pain medication) factors.
- Differences in perceptions of pain and responses to pain and how these differences impact appropriate treatment and management of pain.
- The nature and extent of disparities in the delivery of pain treatment in diverse populations.
- Existing and potential barriers to quality pain care and management including patient-related barriers, health care provider-related barriers, health care system-related barriers, and sociocultural barriers.
- Novel, evidence-based interventions to improve training for health care providers and educational interventions for minority patients.

- Measures of pain perception for those with cognitive impairment, or limited health literacy and from varied cultures.
- Assessment of the global impact, including societal and medical consequences, of pain related disparities on both individuals and society, and the potential impact of pain-related disability.
- Diverse cultural beliefs about and actions taken for pain and its management including self-care and that of lay caregivers.
- Treatment and management strategies for chronic pain in diverse populations.
- Means to identify population differences in pain perception and processing by addressing the incidence, severity, and consequences of pain in these and the general populations, and in specific disease states.
- New diagnostic tools for different pain mechanisms, and objective measures of treatment response that have validity in diverse populations.
- The prevalence and effectiveness of the use of non-pharmacological and novel (e.g. virtual reality) therapies for pain treatment in diverse populations such as ethnic minority groups and persons with disabilities.
- Pain management for special populations including infants, children, elderly, cognitively impaired, disabled, chronically and/or terminally ill, and patients with psychiatric diagnoses.¹¹⁸

Twelve health professional schools were identified as Centers of Excellence in Pain Education (CoEPEs) by the NIH Pain Consortium. These include:

- University of Washington, Seattle;
- Johns Hopkins University, Baltimore;
- University of Pennsylvania Perelman School of Medicine, Philadelphia;
- Southern Illinois University, Edwardsville;
- University of Rochester, N.Y.;
- University of New Mexico, Albuquerque;
- Harvard School of Dental Medicine, Boston;
- University of Alabama at Birmingham;
- Thomas Jefferson University School of Medicine, Philadelphia;
- University of California, San Francisco;
- University of Maryland, Baltimore; and
- University of Pittsburgh.

These centers are improving upon education for medical, dental, nursing, and pharmacy students regarding pain and pain management and will serve as central repositories for curriculum resources.¹¹⁹ Curriculum development will include a focus on how pain manifests across different groups, including racially and ethnically diverse populations.¹²⁰ In July 2012, a kickoff event and reception was held for participating centers and an introduction to the initiative was provided. Topics addressed included the type of education material to be available in the pain portal and effective efforts to incite a cultural change in pain care among health care professionals.¹²¹ The most recent activity identified is the ongoing discussion on case studies that the Centers of Excellence will use in developing educational materials.¹²² As these materials are being developed and disseminated, it will be important to continue tracking and monitoring progress in the Consortium's efforts to achieve goals in health equity.

Challenges and Next Steps

Studies show that physicians-in-training often do not receive any formal education in pain management during medical school or residency training.¹²³ In addition, there is little consensus or cohesiveness on national guidelines on pain management. There are currently different standards and recommendations endorsed by various professional associations for dispensing opiates and other narcotics which complicates appropriate management.¹²⁴ Effective care for pain patients, including those who are racially and ethnically diverse, has been slowed by the absence of clear national treatment priorities and guidelines. Evidence shows that having significant knowledge in recognizing, assessing, and treating pain appropriately is fundamental to diminishing inconsistencies in pain management among various racial and ethnic groups.¹²⁵

Cultural Competency in Geriatric and Long Term Care

Legislative Context

Section 5507 authorizes grants for new demonstration projects to develop core training competencies and certification programs for personal or home care aides. Competencies related to provider communication are outlined within this Section, including “cultural and linguistic competence and sensitivity,” problem solving, behavior management, and relationship skills. The request for proposals to establish demonstration projects stated: “Specific project outcome measures should quantitatively and qualitatively assess the degree to which the intervention increases the availability of culturally competent personal and home care aides who demonstrate the skills and attitudes necessary to improve patient health outcomes and reduce health disparities.”¹²⁶ The law authorizes \$5 million for each FY 2010 to FY 2012 for these demonstration projects.

Implementation Status and Progress

In September 2010, HRSA awarded grants to six states (Massachusetts, California, Iowa, Michigan, North Carolina, and Maine) under the Personal and Home Care Aide State Training (PHCAST) Grant Program of the ACA. Grants aim to strengthen the direct care workforce by defining core competencies for direct care workers and supporting training development to further improve the standardization of such competencies. Table 10 illustrates the authorized amount under this provision and the actual amount funded to states for FYs 2010 to 2012.

Table 10. Authorized Funding in the ACA and Actual Funding for Personal and Home Care Aide State Training, FYs 2010-2012

	FY 2010		FY 2011		FY 2012	
	Auth.	Actual	Auth.	Actual	Auth.	Actual
PHCAST	\$5 m	\$4.2 m	\$5 m	\$4.4 m	\$5 m	\$4.4 m

Note: Auth = Authorized

Emerging Programs and Models

The PHCAST *Report to Congress on Initial Implementation* reveals that all funded states are moving forward to meeting outlined goals. The majority have met with stakeholder groups to achieve buy-in from each group's respective direct care worker sector. Most funded states are also reaching out to professional associations for curricula development and trainee recruitment efforts. In order to target a diverse population during recruitment, states are also partnering with community colleges, current employers of direct care workers as well as workforce investment boards. All states appear to have made progress toward addressing the required competency of "understanding diversity and cultural competence."¹²⁷ Maine has identified a refugee population for outreach efforts. Massachusetts and California are focusing trainings in underserved populations, among individuals who have incomes at or below 200% of the federal poverty level, and are displaced workers or make up the working poor. California has developed a training competency to include goals related to English as a second language for its trainees.

Challenges and Next Steps

According to the same report, grantees face similar challenges in implementing the PHCAST program. A frequent barrier cited was short time requirements for curricula development and evaluation. All states felt it was important to involve a broad group of stakeholders, but this delayed the competency approval process. States also found that definitions and terminology varied among groups so additional time was spent to ensure standard definitions were used during curricula development. Similarly, roles and responsibilities of different direct care workers (Personal Care Aide vs. Home Care Aide) were still unclear and required addressing. Grantees are required to develop a certification process and this was also cited as a challenge across states. States have found that costs related to certification may become a roadblock to recruitment as states frequently reach out to individuals from underserved and disadvantaged backgrounds, including diverse populations.¹²⁸

Model Cultural Competency Curricula

Legislative Context

Section 5307 of the ACA amends section 741 of the *Public Health Service Act* and authorizes a grants program for the purpose of the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities and aptitude for working with individuals with disabilities. Model curricula developed under this section will be disseminated through the Internet Clearinghouse under Section 270. The legislation also amends Section 807 of the *Public Health Service Act* to establish the same program for nursing curricula. The law authorizes such sums as necessary for each FY 2010 to FY 2015.

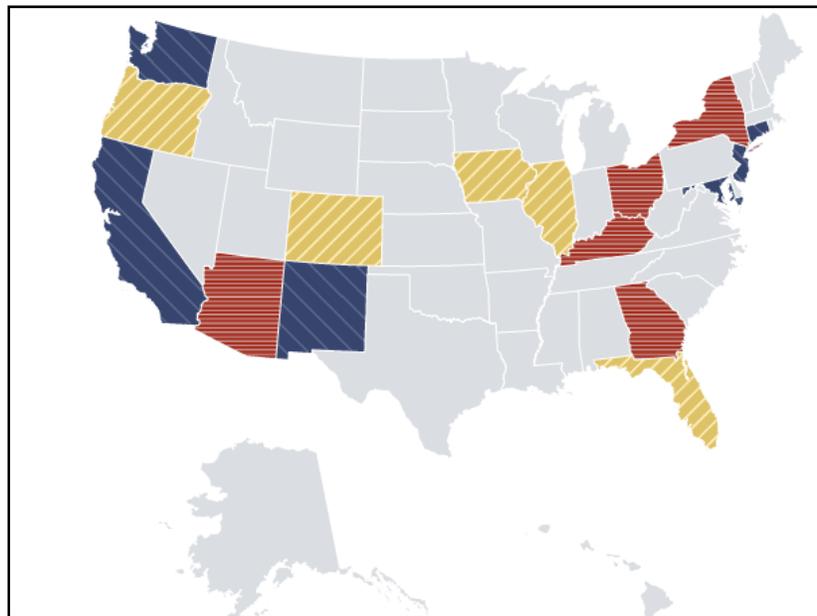
Implementation Status and Progress

As of this writing, this provision has not received funding under the ACA.

Emerging Programs and Models

At least six states (Washington, California, Connecticut, Maryland, New Jersey, and New Mexico) have enacted legislation which requires or strongly recommends cultural competency training for health care providers (see Figure 3). In states such as California, Washington, and New Jersey, these laws set standards and expectations for providers, clinics, and other health related services.

Figure 3. Cultural Competency Legislation by State, 2012



States in blue are those with enacted cultural competency legislation; states in red had legislation that was referred to committee and/or is currently under consideration; and states in yellow denote legislation that died in committee or was vetoed.

In 2005, New Jersey became the first state to enact legislation requiring medical professionals to receive cultural competency training in order to receive licensure or re-licensure. To facilitate this training, the state required that each medical school in New Jersey provide cultural competency instruction focused on “race and gender-based disparities in medical treatment decisions” through classroom instruction or other educational programs, including continuing education credit.¹²⁹ Other states, including Illinois, New York, and Arizona are addressing the issue by funding programs and initiatives to provide cultural competency training in addition to considering policy-level actions.

At the federal level, HRSA has played a leading role in supporting health professions education, training and resources on cultural competence well before passage of the ACA. Examples include: (1) offering clinical training videos on quality care for diverse populations; (2) courses on cultural and linguistic competence in diagnosis and treatment of depression; (3) cultural competence curricula enhancement modules; (4) cultural and linguistic competence education programs through its Centers of Excellence; (5) diversity in dentistry and medicine programs; (6) cultural competency in geriatric programs; among other efforts. HRSA also offers a series of web-based trainings through its grantees. These include, for example, online training on cross-cultural communication and building organizational diversity and capacity. The National Center for

Cultural Competence (NCCC), a major grantee of HRSA, offers a web-based portal of information, resources and best practices.¹³⁰

Finally, the federal Office of Minority Health has also played an important role in advancing the field of cultural competence. Among its major efforts are:

- ***Enhanced National Standards on Culturally and Linguistically Appropriate Services***, also referred to as “CLAS Standards” and originally issued in 2000, with updates released in 2013, explicitly provide a framework for health professionals and organizations to effectively and appropriately serve patients from diverse backgrounds. “The CLAS Standards are a collective set of mandates, guidelines, and recommendations intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The CLAS Standards provide guidance on improving quality care under three areas in particular: Culturally Competent Care, Language Access Services and Organizational Supports.”¹³¹
- ***Think Cultural Health*** is a Web-based portal which offers the latest resources and tools to promote cultural and linguistic competency in health care.¹³² It features free and accredited continuing education programs targeting physicians, nurses, and other health professionals. Among its recognized tools are: “A Physician’s Practical Guide to Culturally Competent Care” targeting physicians, physician assistants, and nurse practitioners¹³³, and “Culturally Competent Nursing Care: A Cornerstone of Caring” accredited for nurses and social workers.¹³⁴

Challenges and Next Steps

While provisions in the ACA reflect a modest commitment to addressing cultural competence through federal initiatives, questions remain regarding the extent to which these efforts will be embraced. As it is, funding for two out of three initiatives was not appropriated. This limitation may be compounded by challenges at the organization and practitioner level. At the organization level, there is still considerable reluctance to make a concerted effort to invest in and address cultural competence, despite its proven benefits. In a survey of 82 urban academic institutions participating in a collaborative aimed at developing a more diverse and prepared workforce, it was found that goals around diversity and cultural competency were present in the strategic plans of essentially all the universities. However, many schools were not prepared to collect the appropriate data to measure progress, and despite having innovative programs in place, they were unable to reliably report on progress made.¹³⁵ At the practitioner level, time-strapped health care professionals may be reluctant to participate in cultural competency training or to use Web-based education materials unless they are provided with financial incentives or continuing education credits. Moreover, without model development and related assessment—including documentation of effects on processes and outcomes of care—questions will continue to arise about what works and the value of investment in time, money, and staff.

D. Health Care Workforce Evaluation and Assessment

Background

The scarcity of research, data, and information describing current and future workforce capacity and shortages is a well-recognized challenge to developing effective healthcare workforce policy. As the ACA's coverage expansions and novel practice models are implemented, it is critical to gather and learn from concrete workforce data and analysis in order to make informed and accurate decisions about healthcare workforce needs and challenges. This is especially critical for the health status of racially and ethnically diverse populations as they will make up a large percentage of the newly insured.¹³⁶ In this section, we highlight two important provisions that support improved mechanisms to evaluate and assess workforce needs, including the needs of diverse populations:

- 5101. National health care workforce commission; and
- 5102. State health care workforce development grants.

In 2007, the Council on Graduate Medical Education recommended the creation of a National Health Care Workforce Commission to make recommendations to Congress on workforce issues such as the number of Graduate Medical Education (GME) positions, payment rates for such positions, and future research priorities.¹³⁷ The ACA creates such a commission for the first time, and also provides funding and support for states to project, plan for, and address workforce demands within the state as the healthcare landscape changes under the ACA.

National Health Care Workforce Commission

Legislative Context

Provision 5101 authorizes the establishment of a new entity, the National Healthcare Workforce Commission. The Commission is charged with coordinating healthcare workforce activities across federal agencies, evaluating workforce demands and education needs, identifying and proposing solutions to current and future workforce challenges, and supporting novel programs to improve upon health care professions education. The Commission's goal is to present recommendations to Congress and the President regarding the synchronization of healthcare workforce priorities and the nation's needs. The law specifies that special topics to be reviewed include: "the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations." Such sums as necessary are authorized to be appropriated for this section.

Implementation Status and Progress

On September 30, 2010, the Comptroller General of the Government Accounting Office announced Commission nominations. To date, Congress has not appropriated funding for this provision, so while the 15 Commission members have been announced, they have not been able to

meet or conduct business due to lack of funding. The appointments of the first 15 members are staggered at one, two, and three years (Table 11).

Table 11: Members of the National Healthcare Workforce Commission

Term Expiring in 2013	
Peter Buerhaus, PhD, RN (CHAIR)	Professor of Nursing and Director, Center for Interdisciplinary Health Workforce Studies, Institute for Medicine and Public Health, Vanderbilt University Medical Center
Sheldon Retchin, MD, MSPH (VICE CHAIR)	Vice President for Health Sciences, Virginia Commonwealth University and Chief Executive Officer, VCU Health System.
Brian J. Isetts, PhD	Professor, Department of Pharmaceutical Care and Health Systems, University of Minnesota College of Pharmacy
Harold M. Maurer, MD	Chancellor, University of Nebraska Medical Center
Thomas Ricketts, PhD	Professor, Department of Health Policy and Management, University of North Carolina Gillings School of Global Public Health, and Deputy Director for Policy Analysis, Cecil G. Sheps Center for Health Services Research.
Term Expiring in 2012	
Mary Mincer Hansen, RN, PhD	Director, Masters in Public Health Program, College of Health Sciences, Des Moines University
John E. Maupin, Jr., DDS	President, Morehouse School of Medicine
Neil M. Meltzer, MPH	President and Chief Operating Officer, Sinai Hospital, Baltimore, MD
Fitzhugh Mullan, MD	Professor of Public Health and Pediatrics, George Washington University
Steven Zatzkin, JD	consultant to health plans
Term Expiring in 2011	
Katherine A. Flores, MD	Director of the University of California (UCSF) Fresno Latino Center for Medical Education and Research
Kim Gillan	Workforce Development and Training Coordinator, Montana State University's Billings (MSUB) College of Professional Studies and Lifelong Learning
Lisa Renee Holderby	Director of Health Equity, Community Catalyst
Deborah King	Executive Director, 1199SEIU Training and Employment Funds
Richard Krugman, MD	Vice Chancellor for Health Affairs, University of Colorado Denver and Dean, University of Colorado School of Medicine

Source: Press release: GAO announces appointments to new National Health Care Workforce Commission. September 30, 2010. The U.S. Government Accountability Office. Available at: http://www.gao.gov/press/nhcwc_2010sep30.html

Emerging Programs and Models

In the absence of a current national model for a comprehensive commission addressing workforce planning, development, and advocacy, helpful guidelines and practices can be gleaned from state-level initiatives. California is among states leading in workforce planning and development. Several entities collaborate as part of the Healthcare Workforce Development Division (HWDD) under the Office of Statewide Health Planning and Development. HWDD promotes diversity in California's health care workforce by supporting underrepresented demographic groups in their

pursuit of careers in health care as well as advocating for more primary care practitioners in California's health professional shortage areas.¹³⁸ Its 15-member California Healthcare Workforce Policy Commission (CHWPC), authorized under the Health Care Workforce Training Act, is charged with, among other duties, evaluating and identifying geographic areas in California where healthcare resources are poorly distributed and have high unmet healthcare needs.¹³⁹ It also houses the California Healthcare Workforce Clearinghouse, authorized by Senate Bill 139, which collects and stores publically available health workforce data.

In addition to the state's previously established planning efforts, in 2010 California's Health Workforce Development Council was formed to conduct workforce planning as a special committee of the California Workforce Investment Board. After convening 11 regional focus groups throughout the state, the Council developed a series of recommendations in 10 topic areas, many of which explicitly address the elimination of health disparities including:¹⁴⁰

- Incentivize the education/training admissions process for applicants from diverse populations;
- Provide incentives to attract diverse students to primary care roles;
- Mandate cultural sensitivity training for health professionals (e.g. Culturally and Linguistically Appropriate Service Standards);
- Increase engagement in cross-cultural opportunities for health care organizations and education/training institutions.

The Council has since developed action plans and ad hoc committees to implement the report's recommendations which are currently in progress.

Challenges and Next Steps

The National Healthcare Workforce Commission's lack of budget to conduct operations has dismal implications for workforce planning and policy development that is currently needed at a national level. The current issue of disjointed workforce data and research is likely to persist, challenging workforce policy development under new health care delivery models. Furthermore, questions related to the presence and extent of health care disparities across different regions may remain unanswered. Current groups, such as the Medicare Payment Advisory Commission and the Centers for Medicare and Medicaid Services have the authority to make narrow recommendations related to payment policies and changes to regulations, but there is no group that can provide the broad and comprehensive guidance necessary for national workforce planning and development.¹⁴¹

State Health Care Workforce Development Grants

Legislative Context

Section 5102 of the ACA establishes a competitive, HRSA-administered grant program, referred to as State Health Care Workforce Development Grants. The program is to award 1-year planning grants of up to \$150,000 with a 15% matching requirement to state workforce investment boards. Grants are to be used for the following types of activities, among others:

- Analysis of state labor markets;

- Identification of high-demand health care sectors;
- Identification of current resources for recruiting, training, and retaining a high quality health care workforce; and
- Identification of state and federal policies and barriers related to developing an all-encompassing workforce strategy.

Competitive 2-year implementation grants are also authorized, and the National Healthcare Workforce Commission, as outlined in Section 5101, is charged with making recommendations on grant recipients and reviewing the implementation progress reports. While the law does not include language that explicitly addresses the needs and priorities of racially and ethnically diverse populations, implications for these populations consistently emerge in developing, planning, and implementing goals to create a healthcare workforce that adequately represents and cares for the entire population.

Implementation Status and Progress

On September 27, 2010, HHS Secretary Sebelius announced that 26 states would receive grants under the ACA to enhance the nation’s primary care workforce through workforce planning and implementation. Twenty-five states were awarded planning grants and one state received an implementation grant. Table 12 outlines the authorized funding amount as specified in the ACA and the actual awarded amount for FYs 2010-2013. In FY 2010, \$6 million from the Prevention and Public Health Fund were awarded to implement the HRSA grants. Such sums as necessary were authorized for the following years and no further funding has been appropriated.

Table 12. Authorized and appropriated funding for State Health Workforce Development Grants, FY 2010-2013

	FY 2010		FY 2011		FY 2012		FY 2013	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual
Planning Grants	\$8 m	\$6 m	SSAN	\$0 m	SSAN	\$0 m	SSAN	\$0 m
Implementation Grants	\$150 m		SSAN	\$0 m	SSAN	\$0 m	SSAN	\$0 m

Note: Auth = Authorized; SSAN = Such Sums as Necessary

Emerging Programs and Models

The overall goal described by grantees is to gather data and information for planning activities to create a comprehensive plan to address health care workforce shortages. A variety of efforts are described to achieve this goal, and some include initiatives not only to increase the primary care workforce but also to shape its development through appropriate composition and education. A review of planning grant program descriptions reveals that all states describe goals to develop action plans that will: (1) improve upon workforce data collection; (2) align career planning and education with current health care occupations needs and priorities; and (3) create specific plans for high-demand occupations. Of the 25 grantees, eight outline explicit goals with a focus on immigrants, diverse, or vulnerable populations, or to reduce health disparities. Virginia, the single implementation grantee, describes goals related to cultural competence in its plan to carry out current workforce planning objectives. The following grantees stand out as examples of states

addressing the needs of an increasingly diverse population in workforce development efforts:

- **Hawaii:** The planning grant is intended to serve the state's entire population with a special focus on ensuring adequate primary care for those residing in isolated areas such as the neighboring islands. The project description identifies the need to plan for the state's diverse populations which include indigenous groups, Native Hawaiians, the medically underserved, immigrants as well as individuals from U.S. territories and Pacific Islander protectorates.
- **Colorado:** The state has used the planning grant to identify current labor market needs in order to develop appropriate health care career pathways and to identify policies and best practices in secondary and postsecondary education and training, among other activities. In planning for expansion of the state's primary care workforce, this grantee highlights its effort to address health disparities by planning for the state's vulnerable populations, including those who are underserved and have been afflicted by poor access to health care services.
- **North Dakota:** In its planning grant, the state recognizes the imperative to fully address infrastructure changes created by the ACA. This includes the need to serve a population that is increasingly racially, ethnically, linguistically, and culturally diverse. The state's program description identifies the need to adequately deliver care that is both efficient and accessible for these populations when creating its plan to build, train, and enhance its health care workforce. The state has involved groups such as state associations, educators, and tribal governments in developing its plan.
- **Virginia:** Implementation funding under the ACA supports collaboration between Virginia's Health Workforce Development Authority and several state entities and bodies such as the Department of Health, the state's Workforce Council, the Area Health Education Center Program, and the Health Workforce Incentive Program. Funding has allowed for increased staffing for the Health Workforce Authority, the creation of an ad hoc committee under the Workforce Council as well as the implementation of regional data pilot projects. In carrying out these workforce programs, the state intends to improve both the distribution and composition of its health care workforce. Culturally and linguistically competent care is being provided in the state's most underserved areas through the development of a health professions pipeline that educates, recruits, and retains diverse healthcare workers.
- **Maryland:** The state's workforce investment board has collaborated with the Hilltop Institute at the University of Maryland to create its action plan under the ACA-funded planning grant. The Institute is nationally-recognized for its efforts in addressing disparities. In November of 2011, Maryland's Workforce Investment Board released its report based on the findings from the HRSA-funded 1-year planning grant.¹⁴² The report is intended for the Governor's Health Care Reform Coordinating Council (HRCC) as well as the numerous organizations, agencies, and stakeholders committed to enhancing the state's workforce goals. The action plan was developed with recognition of the HRCC's goal to guarantee access to health care to all of the state's residents. In an evaluation of the state's health care workforce needs, increased attention was given to special populations. Among these are the newly insured who

will require more intensive support in enrollment and may face barriers such as limited English proficiency, poor health literacy, and low education levels. The board proposed solutions such as a focus on recruiting health providers from underserved areas to provide needed services to residents of these areas. In addition, team approaches to providing health care services, mobile health clinics, and community health workers were other proposed strategies to addressing the needs of vulnerable, diverse, and medically underserved communities.

Maryland's investment board has developed 4 strategic goals based on its needs assessment, and sub-objectives are identified for implementation through 2014. The first strategic goal involves undertaking in-depth workforce planning and analysis including ensuring improved data collection efforts to better understand current workforce capacity and future needs. Among the sub-objectives is a call to report on the diversity of primary care providers and health professions students. Secondly, the action plan identifies the strategic goal of strengthening the capacity of the primary care workforce which includes more specific attention to increasing its racial and ethnic makeup and enhancing cultural competency. The third strategic goal describes improving the distribution of the workforce in service shortage areas and includes reference to developing "creative solutions" to improve the number of health professionals serving in these regions. The final strategic goal addresses compensating providers for high quality care where the board will continue to evaluate strategies to grow Maryland's Patient-Centered Medical Home initiatives, which is a promising practice model for diverse and underserved populations.¹⁴³

Challenges and Next Steps

The workforce planning and implementation grants are a crucial first step in addressing the need to plan for a workforce that adequately represents our nation's population and is inclusive of those who are diverse in race, ethnicity, language, and culture. States receiving the 26 grants funded under the ACA have made progress toward this goal. They have initiated important planning activities, created enhanced collaborations with other state entities, and have produced action plans and next steps to meet workforce goals. There are, however, several challenges that these states face in fully implementing workforce evaluation efforts. For example, the amount of funding awarded under this provision was significantly less than the amount authorized according to the law, especially for the 2-year implementation grants. While \$150 million was authorized in 2010 for such grants, only one state received a grant in the amount of nearly \$2 million. The ACA designated the National Healthcare Workforce Commission to recommend which states receive 2-year implementation grants, however, we found that no such actions have taken place as the Commission has not received any funding to date to conduct business.

States are generally leading the way in assessing and addressing workforce needs. States such as Maryland, California, and Virginia, among others, have recognized the importance of planning for diverse populations, who will represent nearly half of the newly insured once Medicaid expansions and the exchanges take effect. However, in order to fully realize the goals developed in their action plans, states will require support at various levels—federal, philanthropic, business, and other sources. State workforce investment boards will need continued support including future funding to carry out planning and implementation goals as well as guidance from a coordinating body such as the unfunded National HealthCare Workforce Commission.

E. Health Care Workforce Investment in Academic Settings

Background

Initiatives to improve upon minority enrollment implemented at the college and graduate level of education have shown promising results in increasing diversity in the health professions.¹⁴⁴ In particular, investments Historically Black Colleges and Universities (HBCUs) have made meaningful contributions to educate and train a cadre of African Americans in professional fields. As expressed in a 2012 *American Journal of Public Health* report on HBCUs and the health care workforce:

The 105 HBCUs in this country are a significant and underused resource in the effort to achieve health equity. HBCUs have played an important role in the education of people of color for more than 150 years. During the last quarter of the 20th century, their role was questioned, and the number of African American students in traditionally White institutions increased dramatically. During the first decade of the 21st century, however, student enrollment in HBCUs increased, along with the number and variety of degrees they pursued.¹⁴⁵

Another program which explicitly focuses on enhancing opportunities for underrepresented minority students and faculty is the Centers of Excellence initiative—a federally funded program administered by HRSA’s Bureau of Health Professions and originally authorized under Title VII of the *Public Health Service Act*. Organizations, such as Hispanics in Health Professions, have recommended that this program should be better supported and expanded in order to meet broad goals in diversity for health professions schools.¹⁴⁶

The ACA includes provisions intended to support and strengthen these and other programs at academic settings to ensure the health care workforce is more reflective of the nation’s patients and population. This section describes the implementation progress, challenges, and next steps for the following three provisions:

- Section 2103. Investment in HBCUs and minority-serving institutions;
- Section 5401. Centers for Excellence initiative; and
- Section 5402. Health care professions training for diversity.

Historically Black Colleges and Universities & Minority-Serving Institutions

Legislative Context

Section 2103 of the accompanying Health Education and Reconciliation Bill amends the Higher Education Act by extending the authority to award funding to HBCUs and other minority-serving institutions through 2019. Mandatory funding for FYs 2008 through 2019 is available in the amount of \$255 million. Of this amount, \$100 million is designated for Hispanic Serving Institutions, \$85 million for HBCUs, \$15 million for Predominantly Black Institutions, \$30 million for Tribal Colleges and Universities, \$15 million for Alaska and Hawaiian Native Institutions, \$5 million for Asian American and Pacific Islander Institutions, and \$5 million for Native American non-tribal serving institutions.

Implementation Status and Progress

The federal government began providing mandatory funding through the ACA to HBCUs and other minority colleges as of FY 2010.

Emerging Programs and Models

While HBCUs comprise only 3% of the nation’s higher education facilities, they graduate approximately 28% of African Americans with bachelor’s degrees.¹⁴⁷ HBCUs are also the top producers of African American physicians.¹⁴⁸ African American students report benefiting from the unique experience of attending an HBCU—small class sizes, personal relationships with faculty members, and fewer experiences with racial tensions, stand out as positive features of these students’ education.¹⁴⁹ Beyond HBCUs are other ethnic and minority-serving institutions such as those which disproportionately train and educate Hispanics (at least 25% of the full-time student body is Hispanic), also known as Hispanic Serving Institutions.

Challenges and Next Steps

In recent years, HBCUs and other minority-serving institutions are increasingly being overlooked as a valuable training resource, with declining or limited support. As a recent study illuminated, overall between 2000 and 2008, HBCU’s progress in training African American health professionals did not change.¹⁵⁰ Tables 13 - 15 illustrate key findings related to the proportion of health professional degrees conferred by HBCUs, the number of health professional degrees awarded to African Americans, and the percentage of African Americans obtaining degrees in health professions.

Table 13. Proportion of All Health Professional Degrees Conferred by HBCUs, 2000 and 2008

Discipline	2000	2008	Percent Change
Medicine	1.40%	1.37%	-.03%
Dentistry	2.83%	2.5%	-.33%
Nursing	2.04%	1.66%	-.38%
Public Health	2.26%	1.57%	-.69%

Source: Noonan, A., Lindong, I., & Jaitley, V. N. (2012). The Role of Historically Black Colleges and Universities in Training the Health Care Workforce. *American Journal of Public Health*, Vol 103, No 3.

Table 14. Number of Health Professions Degrees Awarded to African Americans, 2000 and 2008

Discipline	2000	2008	Percent Change
Medicine	1,013	1,101	+8.69%
Dentistry	186	203	+9.14%
Nursing	7,760	13,993	+80.32%
Pharmacy	557	775	+39.14%
Public Health	820	1,859	+126.71%

Source: Noonan, A., Lindong, I., & Jaitley, V. N. (2012). The Role of Historically Black Colleges and Universities in Training the Health Care Workforce. *American Journal of Public Health*, Vol 103, No 3.

While the total number of degrees conferred to African Americans rose in all professions, the proportion of African Americans among total recipients of these degrees did not rise substantially. For example, in medicine, African Americans made up 6.8% of all recipients of these degrees in 2000 and 6.9% in 2008. Similar results were found for nursing. Between the two time periods, the percentage of nursing degrees among African Americans was stable at 9.6%.

Table 15. Percentage of African Americans Obtaining Degrees in Health Professions, 2000 and 2008

Discipline	2000	2008	Percent Change
Medicine	13.7%	14.6%	+0.9%
Dentistry	44.1%	38.4%	-5.7%
Nursing	11.2%	9.1%	-2.1%
Pharmacy	48.7%	46.2%	-2.5%
Public Health	17.4%	8.2%	-9.2%

Source: Noonan, A., Lindong, I., & Jaitley, V. N. (2012). The Role of Historically Black Colleges and Universities in Training the Health Care Workforce. *American Journal of Public Health*, Vol 103, No 3.

HBCUs are particularly vulnerable during times of economic downturn due to serving students who are frequently from poorer families, and highly dependent on financial aid: estimates indicate that 90% of students enrolled in HBCUs receive financial assistance. These schools are also more likely to have lower tuition rates than other non-minority serving institutions in order to ensure adequate enrollment rates of low-income and diverse students. HBCUs further suffer financially due to receiving smaller endowments than other institutions.¹⁵¹

Questions remain as to whether the increased funding from the ACA is sufficient to alleviate concerns around HBCUs' sustainability. Distributed among more than 100 universities and colleges, the annual funding authorized through the law is relatively modest. Since HBCUs are critical for the educational achievements of many African Americans from college through post-graduate studies, they are an important component of ensuring a diverse healthcare workforce. Despite this promise, however, recent studies suggest that HBCUs are not playing a large enough role in educating African American health professionals. As one study asked, "Why are the enrollments of some critically needed health professionals increasing dramatically in traditionally White institutions while they remain stable or are decreasing in HBCUs? Is there a need to address the number of accredited programs in HBCUs?"¹⁵²

In the fields of medicine and dentistry, whereas the need for diverse practitioners has been recognized for decades, prospective students are able to only apply to three HBCU schools of medicine and two of dentistry. While HBCUs saw a modest increase in the graduation of African American practitioners between 2000 and 2008, this increase did not keep pace with growing need, nor with graduation of African Americans from comparable programs at White institutions. These patterns hold true for nursing and public health as well, and in some cases are even worse.¹⁵³

Centers of Excellence

Legislative Context

Section 5401 of the ACA increases funding for the Centers of Excellence (COEs) and modifies the funding allocation formula. The new methodology disburses funding to designated health professions schools that serve underrepresented minorities. The program’s broad objective is to diversify the health care workforce so that it reflects the current racial and ethnic makeup of the population. The law authorizes \$50 million in funding for COEs for FY 2010 through FY 2015 and authorizes such sums as necessary for each following year.

Among the legislative requirements to be addressed by program applications are:

- To create a competitive applicant pool through partnerships with institutions such as community-based organizations in order to develop pipeline programs;
- To develop or improve upon programs to augment the success of minority students;
- To implement retention strategies for minority faculty members, infuse minority health topics into resources, curricula, clinical opportunities and cultural competence objectives;
- To focus research opportunities for students and faculty on health topics that are applicable to underrepresented groups; and
- To implement training programs for students to provide care to underrepresented populations at community-based clinics.

Implementation Status and Progress

Grants have been awarded to COEs under the ACA for FY 2010 to FY 2013. Overall, each year, the program has received less than half of the funding it was promised through the ACA, with funds declining each year. According to HRSA’s website, in FY 2010, 12 COEs received a total of \$25 million in funding; in FY 2011, 11 received a total of \$24 million in funding, in FY 2012, 18 received a total of \$23 million in funding, and in FY 2013 17 entities received a total of \$21 million in funding. Table 16 shows the amount authorized for the COEs under the ACA and the actual amount appropriated during this period.

Table 16. Authorized Funding in ACA and Actual Funding for Centers of Excellence (COE), FY 2010-2014

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
COEs	\$50 m	\$25 m	\$50 m	\$24 m	\$50 m	\$23 m	\$50 m	\$21 m	\$50 m	\$23 m

Note: Auth = Authorized

Emerging Programs and Models

The COE initiative explicitly focuses on enhancing opportunities for underrepresented minority students and faculty. A review of funded program abstracts between FY 2010 – FY 2012 reveals that they focus on the following racial and ethnic groups:¹⁵⁴

- 18 programs are explicitly focused on Hispanics or Latinos;
- 4 programs explicitly target African Americans;
- 5 programs target Native Americans; and
- 12 programs target minorities in general (i.e., more than one minority group).

A review of these programs revealed that several institutions are adopting common strategies and practices to train and prepare a diverse health care workforce. For example, to recruit, train, and retain students from racially and ethnically diverse heritage, many programs are increasing the pool of qualified applicants through pipeline and outreach programs designed to inspire students early on in their education to pursue health professions careers. Several programs are also offering cultural competency training particularly through diverse clinical experiences in community health settings as well as by increasing diversity among faculty members. For example, the University of Pennsylvania has partnered with a public school in the area to implement pipeline activities and also developed a research coalition with local community-based organizations. The University of California, Los Angeles describes goals to increase the number of Hispanic medical school faculty to promote more research related to minority health in the state. The University is also partnering with community colleges to provide outreach to Hispanic students and assistance in transferring them to four-year universities with the goal of increasing the number of students qualified to apply to medical school.

Challenges and Next Steps

The COEs provide an important step in working to ensure that the health care workforce is both reflective of a diverse population, and that healthcare professionals are well-equipped to serve these populations from a variety of backgrounds. Leaders from the Coalition of Urban Serving Universities report that pipeline programs are effective in reaching goals related to workforce diversity, as half of the collaborative's members reference achieving success in such programs.¹⁵⁵ However, several barriers need to be overcome to meet such goals. COEs face challenges in measurement and evaluation. For example, across COEs, plans for data collection and program evaluation are inconsistent.¹⁵⁶ A streamlined and cohesive effort to evaluate these initiatives will facilitate decision-making and future policy in determining successful programs. For example, California's Office of Statewide Health Planning and Development (OSHPD) initiated efforts to track and analyze educational and employment data by developing a website featuring educational programs in the state.¹⁵⁷

Moreover, barriers still exist in perceptions of the value and efficacy of cultural competency and diversity programs. Objectives in cultural competence may be overlooked in curriculum development and are instead something health professional schools view as additional, and sometimes burdensome, requirements.¹⁵⁸ Furthermore, many promising workforce diversity programs, including COEs, have been declining in support. In 2006, these programs were harshly cut, with support only gradually increasing over the years but not quite reaching the 2005 commitment.¹⁵⁹ Perhaps due to this, academic institutions funnel a considerable amount of funding into their pipeline programs. While almost all of the members of the Coalition of Urban Serving Universities report relying on some amount of federal support for such programs, in the majority of cases funding is primarily generated by the universities and health professions schools themselves.¹⁶⁰

Health Care Professions Training for Diversity

Legislative Context

Section 5402 of the ACA reauthorizes two health care professions training programs for diversity. First, the ACA amends the *Public Health Service Act* by reauthorizing Scholarships for Disadvantaged Students (SDS) program and authorizing an increase in appropriations from \$37 million to \$51 million in FY 2010 and “such sums as necessary” for FY 2011 to FY 2014. Secondly, it amends the *Public Health Service Act* by reauthorizing the Health Careers Opportunity Program (HCOP) and allocating \$60 million in funds for FY 2010 with such sums as necessary for FY 2011 to FY 2014.

The SDS program offers scholarships for disadvantaged students who commit to working in medically underserved areas. The goal of HCOP is to support individuals from disadvantaged backgrounds in entering the health professions. Funds are intended to assist in:

- Recruiting of disadvantaged students for health professions programs;
- Assisting disadvantaged students’ entry into a health professions program;
- Providing counseling and other services to ensure graduation from the school;
- Providing preliminary education and training to disadvantaged individuals before they enroll in a health professions school;
- Publicizing financial aid opportunities for disadvantaged students;
- Implementing training opportunities for primary care in non-profit community-based settings; and
- Enhancing partnerships with higher education institutions, schools and other community-based organizations.

Section 5402 further reauthorizes and expands loan repayments for faculty of health professional institutions.

Implementation Status and Progress

Under this provision, grants have been awarded for the SDS and HCOP programs through HRSA. Both programs aim to enhance diversity among health professionals through their provision of scholarships to financially and disadvantaged students. According to the HRSA website, in 2013 and in 2012 there were 99 active SDS grant programs, in 2011 there were 319 active programs, and in 2010 there were 308 grant programs.

In 2012 there were 20 active HCOP grant programs, and in both 2011 and 2010 there were 33 active programs, each year. HRSA’s website does not list any active HCOP programs for 2013. The following table summarizes funding authorized by the ACA, and actual funding received for both programs for FY 2010 to FY 2014.

Table 17. Authorized Funding in ACA and Actual Funding for Scholarships for Disadvantaged Students and Health Careers Opportunities Program, FY 2010-2014

	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Actual	Auth.	Requested
SDS	\$51 m	\$49 m	SSAN	\$49 m	SSAN	\$47 m	SSAN	\$44 m	SSAN	\$47 m
HCOP	\$60 m	\$22 m	SSAN	\$22 m	SSAN	\$15 m	SSAN	\$14 m	SSAN	\$0

Note: Auth = Authorized; SSAN = Such Sums as Necessary

Emerging Programs and Models

A review of funded programs reveals that all are geared toward disadvantaged students, and the vast majority target students who are racially and ethnically diverse, or provide culturally and linguistically competent care to diverse populations. The vast majority of programs describe goals to ensure that health professions students from disadvantaged backgrounds are successful in pre-entry preparation, retention, graduation, and placement. Before enrollment into a health professions program, many grantees are implementing activities for underrepresented minorities, such as preparation in study skills and enhanced recruitment efforts. Retention strategies described vary from job shadowing to academic support services, and financial support is provided through scholarships earmarked for minority students. The following programs highlight these actions:

- **The University of Alabama at Birmingham:** The University is committed to bridging health disparities and as such is focused on enhancing health professions diversity. Among its efforts are: a program to enhance diversity in physician assistant program; summer educational programs targeted to underrepresented minorities; and recruitment efforts targeted in colleges with large minority populations.
- **Northern Arizona University:** The Nursing Master’s program at the College of Health and Human Services highlights its “commitment to recruiting and retaining educationally disadvantaged students and those from diverse cultural and ethnic backgrounds to serve underserved populations.”¹⁶¹ The grantee describes a specific focus on outreach and retention of Native American students through its Native Journey to Academic Success Program. The program has a previous history of graduating a significant number of students who go on to practice in medically underserved areas (33% in 2010 to 2011) or who practice in primary care (89 %).
- **Miami Dade College:** The School of Nursing’s student body has historically been made up of a majority of economically disadvantaged students, while enrollment includes a large proportion of Hispanic and African American students. The program summary describes that “developing culturally competent registered nurses by establishing a system that values the importance of culture in the delivery of health care services to all segments of the population is a goal of the School of Nursing at MDC.”¹⁶² The school provides expansive clinical experiences in its diverse region of Miami.

Challenges and Next Steps

Programs such as SDS and HCOP have proven successful in improving ratios of healthcare practitioners in underserved areas, and graduating more minority providers, but they are not without challenges that may inhibit their full potential. While financial support is critical for achieving goals for recruitment, enrollment, and retention of a diverse student body, the majority of funded programs identified do not describe in-depth objectives related to other retention strategies that are also important for students' success. Research shows that after enrollment, diverse students benefit from tailored academic and psychosocial support in addition to financial support.¹⁶³ Promising workforce diversity programs, such as the HCOP and others have seen waning financial support from the federal government over the years beginning in 2006. The ACA showed significant promise in changing this trend by authorizing the highest level of funding since 2005. However HCOP was funded for less than half of the authorized amount in 2010 and 2011.¹⁶⁴

IV. Renewed Opportunities and Remaining Challenges for the Health Care Workforce

Among other equity objectives, the ACA is committed to supporting and expanding the nation's health care workforce, including enhancing efforts to ensure providers are more representative of the populations they serve, are located in underserved areas, and possess skills to provide culturally and linguistically competent care. The ACA reauthorizes and expands a number of programs originally authorized under Titles VII and VIII of the *Public Health Service Act*, giving preference to, in many cases, underrepresented minorities and services provided in traditionally underserved, diverse communities. It also authorizes a series of novel workforce initiatives—such as the National Health Care Workforce Commission, grants for community health workers, and grants to test and support cultural competence education, among others—which offer the potential for further strengthening the health care workforce. Despite this momentum, these efforts may not be sufficient to match increases in demand expected from the growth in newly insured populations following the operation of health insurance exchanges and state expansions in Medicaid. Thus, while over 19 million racially and ethnically diverse enrollees may be eligible to become newly insured through the exchanges and Medicaid, lack of funding may jeopardize, if not prevent, programs from achieving their goals.

In this section, we discuss common themes and concerns which have emerged with the rollout of the ACA's health care workforce provisions. These were reiterated through our review of the literature and emerging programs along with interviews with experts, providers, and community representatives in the field. These concerns and challenges include:

- Continued workforce shortages, especially in highly diverse areas;
- Limited and declining funding for workforce diversity initiatives;
- Reluctance to pursue diversity and cultural competency as a priority; and

Continued Workforce Shortages

Significant shortages are expected across the range of health professions—including doctors, nurses, dentists, and others—potentially posing “one of the biggest threats” to the overall success of health care reform.¹⁶⁵ The implementation of the ACA is projected to increase the number of insured by 30 million, over half of whom will be racially and ethnically diverse individuals. This increase, along with an aging population and general population growth, will boost the demand for medical services. In particular, steep increases in demand for primary care are expected, along with an insufficient supply of providers to match this increase in many regions of the country.¹⁶⁶

Increase in demand, shortage of primary care providers. According to the Association of American Medical Colleges, following the implementation of the ACA's insurance expansions, and by 2020, there will be an estimated shortage of 45,400 primary care physicians. This shortage could have catastrophic effects on health, as it could significantly limit access to health care for the very individuals and families the ACA intends to newly enfranchise. Recent estimates project that states with fewest primary care providers per capita (those in the South and Mountain West) are likely to have the largest increases in Medicaid enrollment, and accompanying health service demand,¹⁶⁷ and that the largest increases in demand are expected in Texas (with an estimated

5.3% increase), Mississippi (4.8%), Nevada (4.5%), Idaho (4.4%) and Oklahoma (4.1%).¹⁶⁸ Increases in demand, in turn, may be greater than average in regions with a large number of currently uninsured or fewer primary care providers—i.e., places which are already stressed and designated as health professional shortage areas or medically underserved areas.¹⁶⁹ These areas, in many cases, are also disproportionately comprised of low-income, racially, and ethnically diverse individuals and families—thus, the potential impact could be greatest among this population.

Geographic mal-distribution of providers. While the focus of recent research and programs has been on increasing the sheer number of providers, perhaps even more critical is the distribution of health care providers within and across states and localities.¹⁷⁰ Physician shortages—found to be already extensive—are expected to continue to be so as ACA implementation rolls out, especially in rural and border regions, in low-income communities, and regions with large proportions of minorities,¹⁷¹ elevating the importance of improving distribution of providers in these areas through and beyond the opportunities put forth by the ACA.

Supply and diversity of specialty providers. The emphasis of the ACA, and recent reports highlighting its impact on the health care workforce, has been on primary care. However, much less attention has been given to specialty care despite an acute imbalance of specialists generally, and by race and ethnicity¹⁷²—a disparity that is only likely to grow as the number of insured individuals expands. In a 2010 report on non-primary care specialty shortages, the Association of American Medical Colleges' Center for Workforce Studies predicted a 33% shortage in surgical specialties, and “an undersupply of 33,100 surgeons and other specialists by 2015, increasing to 46,100 by 2020.”¹⁷³ This shortage is likely to disproportionately affect low-income diverse communities who already struggle to see private specialists, even with public insurance such as Medicaid.¹⁷⁴

Limited and Declining Funding for Workforce Diversity Initiatives

Funding continues to be an overarching challenge for supporting the health care workforce, generally, and particularly to advance diversity and cultural competency. Among the 19 provisions reviewed in this report, the six explicitly focused on enhancing primary care capacity—such as increasing the number of primary care physicians, physician assistants, and the National Health Service Corps—have seen the greatest level of federal support and commitment. The other nearly dozen provisions have either been severely under-funded or have not received any funding to date.

National Healthcare Workforce Commission. Among provisions with no funding was a newly introduced initiative known as the National Healthcare Workforce Commission, a 15-member entity created to investigate the supply and demand of health care professionals. Despite its establishment and appointment of members in 2010, the Commission received no funding. As one member of the Commission stated, “it’s like ‘Waiting for Godot’...we are sitting on a park bench, waiting for Godot. We’ll see if he shows up.”¹⁷⁵ Critical questions that the Commission had sought to address, particularly in advance of 2014, include: “How many doctors are needed? What is the right mix of primary care physicians and specialists? Who will care for the millions of people gaining Medicaid coverage? Should states require their laws to allow nurse practitioners and physician assistants to do more of the work done by doctors?”¹⁷⁶ Given that many of the law’s more innovative actions to enhance the health care workforce have gone unfunded, several key

informants suggested that these efforts “have no teeth” and “have not done enough to move the needle,” particularly from a diversity and health equity perspective.

Health professions pipeline programs. Among provisions that were underfunded were important health professions pipeline programs, including the Centers of Excellence, Scholarships for Disadvantaged Students, and the Health Careers Opportunity Program. While a body of research suggests that such programs are critical for increasing minority entrants into the health professions, federal funding for these programs has been waning over the years beginning in 2006.¹⁷⁷ In 2006, funding for the Health Careers Opportunity Program was cut by 89% and for the Centers of Excellence by 65%.¹⁷⁸ Although the ACA showed significant hope and promise in renewing support for these programs by authorizing the highest level of funding since 2005, many of these programs were funded for less than half of the authorized amount in the early years of ACA implementation.¹⁷⁹ And with the advent of sequestration, funding for workforce initiatives—particularly those addressing diversity and cultural competency—may not be fully realized in the near term. As one key informant forecasted prior to the implementation of sequestration:

Currently-funded programs are already seriously underfunded. Sequestration will only work to make a bad situation worse for programs currently funded and make identifying funding streams for the unfunded discretionary health equity programs nearly impossible outside the [Public Health and] Prevention Fund.

Mandatory and discretionary funding streams under the ACA are affected differently by sequestration. According to a recent report, sequestration of mandatory appropriations for workforce programs such as the National Health Service Corps is capped at 2%, while future funding for discretionary programs is even more adversely affected. Likely outcomes as a result of sequestration of discretionary funds suggest that:

With Congress now operating under enforceable discretionary spending caps imposed by the [Budget Control Act], it may prove difficult to secure funding for new programs and activities. To date, few new discretionary grant programs authorized by ACA have received funding through the annual appropriations process, though a handful of programs have received funding from the [Public Health and Prevention Fund]. Even maintaining current funding levels for existing programs with broad support and an established appropriations history can be a challenge when there is pressure to reduce federal discretionary spending.¹⁸⁰

Minority-serving institutions. While HBCUs comprise only 3% of the nation’s higher education institutions, they graduate nearly 3 in 10 African Americans with bachelor degrees, and a large proportion of African American physicians, with the quality of those trained as measured by performance of graduates with health professional degrees from HBCUs demonstrating no difference compared with graduates from traditionally White institutions.¹⁸¹ Despite this evidence, however, no national strategy or effort has been put forth to enhance the promising role of HBCUs—or other minority-serving institutions—to support training future health professionals from diverse racial and ethnic backgrounds.

Reluctance to Pursue Diversity and Cultural Competency as a Priority

Despite considerable progress in addressing health disparities, promoting a diverse and culturally competent health care workforce largely remains a “tough sell”—politically, institutionally, and

within the health care system. Reasons are varied and range from diversity and cultural competency not being a priority to limited data and evidence linking such efforts to better outcomes, and a narrow mindset on what diversity essentially means or encompasses.

Cultural competency is not a priority. Many of the unfunded provisions have an explicit focus on enhancing cultural competency among health care providers. These provisions would support creating an evidence base for cultural competence as well as coalescing standards and guidance by authorizing the development, evaluation, and centralization of model cultural competence curricula. However, in discussing cultural competency with key individuals in the field, it was clear that this was not a priority. As one key informant noted, “...things that are not a priority, like cultural competency, get put on at the very end...it’s not in the ‘urgent’ category.” In a survey of the Coalition of Urban Serving Universities’ strategic plans, themes referencing or related to diversity and cultural competence are frequently cited as core. However, accompanying pragmatic goals for measurement, responsible parties or other specific actions are often absent.¹⁸²

Other report interviewees cited similar resistance to cultural competency efforts, noting: “There isn’t more uptake. There is someone at the institution that is aware that this exists. That’s not the lever for change. What moves the institutions is reimbursement for quality of care. Schools don’t survey cultural competency currently. They are not asking those questions. It’s buried in the ACA.” Some suggested that the reason cultural competency efforts have not made it to the forefront of priorities is that they are still trying to figure out how to implement broader provisions around delivery and payment reform: “It’s evident that no one understands what is happening broadly. There is no discussion of diversity and cultural competency because they’re still struggling with what broader change means.” The problem many cited is that there simply is insufficient federal support for the cultural competency agenda.

Limited health outcomes data on cultural competency. Despite some progress, meaningful data and research linking cultural competency efforts to improved health outcomes are still largely lacking, thereby encumbering efforts to elevate cultural competency as a health intervention priority. A seminal study by Beach and colleagues in 2005 revealed that while there is “excellent evidence” that cultural competence training improves the knowledge of health professionals and “good evidence” that it impacts patient satisfaction, no studies link it to patient adherence or health status outcomes.¹⁸³ Generally, cultural competency training reviews have focused on the effect of training on provider skills, knowledge, and attitudes, and the rigor of methods for replication.¹⁸⁴ Two recent studies assessing the impact of cultural competency training on health care and mental health services found “limited evidence for effectiveness of training on service delivery and health status.”¹⁸⁵ And more recently, a 2010 randomized control trial found that cultural competency training did not improve disparities in diabetes outcomes between Black and White patients, raising further controversy over the true value of cultural competency in reducing disparities.¹⁸⁶ However, other research by Lieu and colleagues found that cultural competence programs and policies in settings treating Medicaid children with asthma reported higher quality of care.¹⁸⁷

Overall, however, as Lie and colleagues concluded in their efforts to update cultural competence research, there remains a paucity of high quality research” on this topic.¹⁸⁸ Their study explicitly underscores the importance of supporting explicit research on cultural competence curricula and education as an intervention for improving health outcomes—much as the ACA had intended to support under Section 5307, but has been unrealized to date.

Limited political will or support for diversity and cultural competency. Efforts to advance the diversity of the health care workforce may also be limited by perceptions regarding the value of a diverse and culturally competent workforce. In fact, under each Presidential administration in the past decade, diversity programs faced cuts in the federal budget, only to be reinstated by Congress.¹⁸⁹ As has been recently argued by many thought leaders in the field, “a narrow, historically civil rights-focused mindset about why workforce diversity is important persists, and proponents of diversity programs often find themselves in a defensive posture.”¹⁹⁰

V. Moving Forward: Ensuring Diversity and Cultural Competency in the Health Care Workforce

The ACA recognizes—in its goals and objectives—the formidable challenges around current and future workforce shortages, the need for greater workforce diversity, and the importance of promoting cultural and linguistic competence. As such, the ACA focuses considerable attention on reinforcing and expanding the health care workforce to meet new demands in care—particularly primary care—as nearly 30 million newly insured will enter the health care marketplace by 2022. While a range of workforce related provisions were included in the law—from reimbursement rates and incentives to building capacity within safety-net settings—this report focuses mainly on those targeting the supply, diversity, and cultural competence of health care professionals. A review of progress revealed that the majority of provisions which intended to reauthorize well-established programs—such as the National Health Service Corps and other Titles VII and VIII programs in the *Public Health Service Act*—were in fact implemented through various grant programs, which in many cases gave preference for funding to institutions addressing diversity, equity, and cultural competency.

Despite these efforts, many longstanding and promising initiatives were underfunded, and other more novel programs remained unfunded, such as noted, the National Health Care Workforce Commission and initiatives focused on cultural competency education and training of underrepresented minorities. Our review also suggests that despite considerable progress in expanding and enhancing diversity, the health care workforce is likely to continue to face challenges to sufficiently address this priority, particularly to expand supply and capacity to serve a large, and growing diverse patient population. As such, we identify at least six areas of priority in working to ensure the nation’s workforce is adequate in supply and skill to serve a growing insured, racially and ethnically diverse, and aging population. These priority areas build on common themes we identified through a synthesis of research, policy review, grant opportunities, grantee programs, and interviews around the implementation of the ACA, but also reflect longstanding challenges, needs and roles. These priority areas include:

- Expanding of scope of practice;
- Encouraging interdisciplinary team-based care;
- Integrating the Enhanced CLAS Standards into workforce programs;
- Evaluating health care workforce diversity needs, capacity, and outcomes;
- Leveraging the ACA with philanthropic support; and
- Enhancing support for health professions schools and initiatives committed to diversity and equity.

Expanding Scope of Practice

While the expansion of insurance coverage created through the ACA will open doors to care for millions, great concern remains around the capacity of health care settings and systems to meet the demand for services, especially for diverse, low-income, and other vulnerable populations. As health professionals’ capacity is at the center of this concern, provider organizations and policymakers are seeking ways to expand the pool of qualified practitioners. With the uncertainty around support for many of the ACA’s workforce diversity provisions, expanding scope of practice

may offer new opportunities for improving provider capacity and diversity and, in turn improving access for historically underserved populations and geographic areas.

Scope of practice laws establish the legal framework by which medical services are delivered. These laws encompass a full range of medical disciplines—from physicians and nurses to physical therapists and dental hygienists—and govern which services each is allowed to provide and in which settings.¹⁹¹ Generally, these laws are set by state governments, and thus vary from state to state. “Some states allow individual professions broad latitude in the services they may provide, while others employ strict limits. The nature of the limitations can either facilitate or hinder patients’ ability to see a particular type of provider, which in turn influences health care costs, access, and quality.”¹⁹²

As the U.S. population continues to grow, diversify, and age, and as newly insured individuals enter the health care market, many states and advocates are looking to Scope of Practice laws to reassess the role that providers such as Advanced Practice Nurses (APNs) and Physician Assistants (PAs) can play to fill shortages in primary care physicians. An Institute of Medicine panel recommended that states consider expanding APNs’ scope of practice for primary care.¹⁹³ Currently, 22 states and the District of Columbia have expanded the scope of practice for APNs, who are permitted to practice independently, while in other states they require some level of physician oversight.¹⁹⁴ “Two-thirds of states with a shortage of primary care physicians also have restrictive scope of practice laws, which may be a barrier to increasing access to primary care services through APNs.”¹⁹⁵

The Institute of Medicine’s 2010 report, *The Future of Nursing: Leading Change, Advancing Health*,¹⁹⁶ cited a large body of academic studies concluding that primary care provided by APNs “has been as safe and effective as care provided by doctors.”¹⁹⁷ Some studies also estimate that APNs can provide up to 80% of the care that primary care physicians currently provide.¹⁹⁸ Given this experience and the comparable quality of care provided by APNs, coupled with the relatively shorter time-frame required to train new entrants, expanding the supply of APNs is one potential avenue for expanding primary care capacity across the country in a timely manner. This is also especially important for expanding access to care among racially and ethnically diverse communities, which are disproportionately more likely to be located in a health professional shortage area or a medically underserved area. In fact, in certain parts of the country, APNs are becoming more reflective of Non-White racial and ethnic patients than primary care physicians. It is becoming more common to tap into the skills of these health care team members who are often better reflective of local communities to close the communication or cultural gap between physicians and patients. Many nurse practitioner training programs, in particular, are beginning to make a concerted effort to increase racial and ethnic diversity among their students. For example, more than half of the student body in the Women’s Health Care Nurse Practitioner Program in Southern California is racially and ethnically diverse.¹⁹⁹ Finally, the National Committee for Quality Assurance’s 2011 medical home recognition standards permit APNs, and also physician assistants, to lead medical homes where allowed by state law.²⁰⁰ In certain communities, particularly in rural areas, these medical homes or centers often represent the sole provider of primary care.

Despite the promise of expanding scope of practice laws, many states are hesitant, and in some cases, strongly opposed to do so, as reflected in this statement: “Organized physician groups, which hold sway in most legislatures, are reluctant to cede professional turf to nurses. Arguing

that nurse practitioners lack the necessary level of medical training, they insist that it is unsafe for patients to be treated by nurse practitioners without a doctor's supervision."²⁰¹

Encouraging Interdisciplinary Team-Based Care

Many of the ACA's provisions are intended to promote patient-centered care, care coordination, and recognition of health-related circumstances beyond the clinical encounter that may significantly affect treatment adherence and outcomes. Culture and language-specific concerns, community characteristics such as child care, safety, and access to healthy foods, all contribute to the ability to deliver services efficiently and effectively. To integrate these and other priorities into treatment plans, many health care providers are testing and implementing new models of care delivery. One such model is the interdisciplinary team-based approach which involves health professionals beyond physicians—including for example, nurses, social workers, mental health professionals, and others—to coordinate care and other patient services. There are a range of team-based approaches to care, and many of which are part of the Patient-Centered Medical Home model of care. Commonly, health workers are part of a larger group that works under the supervision of a physician to coordinate care, manage cases, and provide a comprehensive approach to quality and safety. These arrangements have been associated with positive impacts on quality of care and patient satisfaction, and are also being seen as an avenue to extend availability of limited primary care providers.²⁰²

Community health workers, in particular, are seen as important players in team-based care. A growing body of research documents that community health workers who are part of a team have contributed to improved access to care, culturally competent chronic disease management, and other care, as well as cost-effectiveness.²⁰³ For example, a Denver-based study found that community health worker-led case management increased the use of primary and specialty care, and reduced the use of urgent and inpatient care among patients.²⁰⁴ Another program in Massachusetts—the Southeast Asian Birthing and Infancy Project—worked with trained, bilingual, and bicultural community health workers to provide tailored prenatal care for culturally and linguistically diverse patients, resulting in a significant increase in enrollment in early prenatal care. And more recently, in Minnesota, the scope of practice of community health workers was enhanced to include a greater role for them in medical care, including facilitating patient-provider communication to clarify cultural practices, assisting with navigation of health and human services, providing direct services to patients (including the provision of culturally and linguistically appropriate health, wellness, disease prevention and management information), assisting with chronic disease self-management and medication adherence, facilitating support groups, and conducting health screenings, among other roles.²⁰⁵ Complementing this action is Minnesota's standardized competency-based training and credentialing program for community health workers.

Team-based approaches which utilize social workers and nurse-practitioners, working alongside primary care physicians have also shown promise particularly in the care of diverse and vulnerable geriatric populations.²⁰⁶ Studies have linked this approach with improvements in measures of general health, reduction in emergency department visits and hospital admissions, along with greater physician and patient satisfaction. As hospitals, health centers, and other settings seek to expand their capacity to provide primary care to vulnerable populations, more widespread adoption of interdisciplinary team-based approaches to care—particularly involving community health workers who offer a bridge to racially, ethnically, and linguistically diverse

communities—may offer significant potential for improving access, quality, and outcomes. In a recent interview, Ardis Dee Hoven, the president of the American Medical Association, highlighted this point. She emphasized that shortages of certain health professionals place an increased need to provide efficient services—primarily through team-based care—in order to adequately serve the newly insured by the ACA.²⁰⁷

Integrating the Enhanced CLAS Standards into Workforce Programs

The release of the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS) in 2013 comes at a pivotal time in efforts to redress longstanding disparities and advance health equity.²⁰⁸ Demographic changes across the country, greater recognition of gaps in access to health services, and increased attention to the influence of race, culture, and language in quality of care have elevated equity in both prominence and importance, leading to efforts that span a spectrum of priorities from cultural competence training and use of interpreters to organizational adaptation and transformation. This legacy of inequality as well as population health and health care system change were among the driving forces that shaped the CLAS blueprint. Building on the original standards issued in 2000, the scope of the new publication expands its application to provide guidance for improving quality and safety, engaging communities, meeting standards and accreditation requirements, and justifying the business case through a set of identified actions around governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

The potential value of related guidance and application of the enhanced CLAS standards extends in many directions and across a broad spectrum of the health care system. However, with the enactment of the ACA, CLAS also comes at a critical “moment in time” with the potential to greatly reduce the numbers of uninsured, transform the nation’s health care system, and improve the lives of diverse and vulnerable populations around the country. In particular, the ACA has made reducing disparities and improving equity a centerpiece of its vision and goals—fundamental tenets that the enhanced CLAS standards share with the law.

CLAS standards are intended to serve as a set of guiding principles for health care organizations in serving diverse populations and were developed to direct cultural and linguistic competency in health care. Since their introduction in 2000, awareness of the CLAS standards has risen consistently each year as the number of publications and citations continue to grow. The standards aim to eliminate health disparities as culturally and linguistically appropriate care has shown promise in helping to improve health care quality for diverse populations, particularly through improved health knowledge, behavior, and patient satisfaction. The enhanced set of standards was developed for several reasons including to ensure coordination and alignment with the ACA. The standards are also now designed to be adopted as a set of 15 equally important guidelines. According to the blueprint, organizations should integrate CLAS standards into their practices and can raise awareness and achieve buy-in by promoting and emphasizing key points around quality improvement, increased competition with other institutions and the avoidance of possible malpractice and liability scenarios through improved culturally and linguistically appropriate care.

CLAS standards align closely with the ACA’s provisions around workforce and systems capacity including developing a culturally competent workforce, enhancing diversity, and integrating equity priorities into leadership and governance (Table 18). Examples of the synergy between the

ACA and CLAS standards include provisions around workforce support and diversity—e.g., tailoring CLAS Standards 1 and 4 to inform and guide primary care providers, nurses, dental and mental health providers, pain care providers and community health workers on providing culturally and linguistically appropriate care. Standard 3 addresses recruitment of a diverse workforce, an essential goal to achieving health equity that is also underlined in the ACA. Standard 13 describes community partnerships to enhance cultural and linguistic appropriateness of care, a collaboration that many ACA grantees are pursuing in training and education programs.

Table 18. CLAS Standards with Direct Implications for Workforce Diversity Provisions in the ACA

Standard	Description
1	Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
3	Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4	Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
13	Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Source: *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. (2013, April). HHS Office of Minority Health. Available at: <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>

These standards offer clear opportunity to incorporate elements of culture and language into workforce evaluation, impact, and assessment of ACA-funded programs. For example states receiving State Health Care Workforce Development grants under the law can benefit from the infusion and application of CLAS to ensure they effectively meet, reach, and incorporate the nation’s diverse populations. Organizations and institutions can learn from previously developed resources related to CLAS when embarking on the journey to implement culturally and linguistically appropriate training, recruiting of diverse individuals, or when evaluating outcomes related to workforce diversity programs. For example, the Massachusetts Department of Health developed *Making CLAS Happen: Six Areas for Action*, a guide consisting of tools, case study examples, and relevant resources to help a variety of entities get started with CLAS.²⁰⁹ Organizations and institutions can also look to states that have passed legislation requiring the incorporation of culturally and linguistically appropriate standards of care for examples and “how to’s” when implementing CLAS. Emerging outcomes from the CLAS-ACA alignment should be monitored closely for opportunities to offer tools, models, experiences, expertise, and promote the development of research; and potentially a clearinghouse of information on programs and strategies that have successfully used CLAS to develop, undertake and integrate CLAS into their business and service goals around the ACA.

Evaluating Health Care Workforce Diversity Needs, Capacity, and Outcomes

With the numbers of insured projected to grow exponentially with the rollout of the ACA marketplaces and state Medicaid expansions, understanding community, state, and national workforce capacity needs—including creating a more diverse health care workforce—will be especially critical for meeting new demands for services, for reaching historically underserved populations, and ultimately, for eliminating disparities in access to and quality of care. To this end, evaluating national, state and local strategies to improve workforce diversity across the country as well as those within various disciplines offers the opportunity to determine progress in advancing related goals around: meeting service needs and capacity; recruitment and retention of a diverse workforce; and the effectiveness of cultural competency training and education.

Developing related designs, tools, and methodology will initially require key players in states and localities to ensure that health care workforce diversity is part of any evaluation to assess health professional shortages and needs. This may be especially important in communities experiencing significant gaps in access to and quality of care. To this end, an evaluation of workforce diversity needs and capacity may involve an understanding of:

- Racial and ethnic composition of health professionals in comparison to racial and ethnic makeup of a geographic location—e.g., state, county, city, zip code, or census tract;
- Workforce shortages by health professions (including both specialty and primary care providers), and by race and ethnicity;
- Federal, state, and local programs, including current funding or lack thereof, to address workforce diversity;
- Challenges professionals may face in delivering care to a diverse patient population; and
- Barriers that diverse patients report in receiving care.

While a single entity could take responsibility for undertaking such an assessment—such as an academic institution or a public health organization in a state, county, or city—this may be more efficiently and effectively addressed through a collaboration or coalition of partners representing public health, hospitals, health centers, philanthropy, and even partners outside the health care sector. Such an evaluation may also be part of the Community Health Needs Assessment that non-profit hospitals are required to undertake as authorized by the ACA, in collaboration with the community they serve, to maintain their tax-exempt status.

Secondly, vested agencies and health care organizations should assess the effectiveness of existing and new programs in recruiting and retaining underrepresented minorities. While many diversity recruitment programs have emerged over the years for various health care professions, little is known about which interventions work and why, along with outcomes they are associated with most directly. As such hospitals, community health centers, academic institutions, and others should consider collecting, analyzing, and reporting data on recruitment, retention, and promotion opportunities by race and ethnicity. This analysis should occur in the context of specific programs and funding streams that are most closely associated with increased diversity to understand program scope, reach, and impact. For example, how effective are pipeline and recruitment programs or innovative admissions policies in enlisting diverse individuals? How long are racially and ethnically diverse students retained in such programs as compared to their White counterparts? And are opportunities for growth and achievement comparable between underrepresented minorities and others? What barriers or challenges remain for underrepresented minorities?

Thirdly, advancing evaluation of cultural competency education and training is critical to understanding its impact on quality of care and outcomes and in expanding its acceptance more broadly (Section 5307 in the ACA authorized such support but that provision has not received funding to date). While modest research shows that cultural competency courses (ranging from undergraduate level to medical residency can increase knowledge about common diseases among ethnic populations and can increase cultural awareness, there is little evidence on its impact at the clinical level.²¹⁰ Rigorous comparative evaluations of cultural competency curricula is important to understanding what works, why, and in what circumstances, and thus could shed light on best practices and impact at the clinical level. Such evaluations should not be confined to physicians—as has commonly been the case—but should extend to other health professions such as nursing, dentistry, mental health, and allied health.

Finally, as part of the effort to evaluate process and outcome measures of workforce diversity, health care providers, academic institutions, and others involved with training need to share their research, best practices and lessons, particularly related to underrepresented minority student outreach. Such actions can work to ensure that the individual and cumulative experiences in assessing and addressing diversity become opportunities for others in developing their training programs and can inform other strategies. In so doing this “collective wisdom” can assist in strengthening the institutional climate for diversity across institutions.²¹¹

Enhancing Support for Health Professions Schools and Initiatives Committed to Diversity and Equity

The enactment of the ACA, with the anticipated increase in racially and ethnically insured individuals, and growing diversity in the U.S. population overall, elevate the importance of training a diverse and culturally competent health care workforce. A trained, diverse workforce can benefit health care settings, their patients, and communities in many ways.²¹² It can work to assure that care recognizes and addresses language and cultural distinctions that may affect processes and outcomes of care. It can add important experience and perspective to executive, managerial, and other leadership positions, and their related responsibilities.

Furthermore, research has demonstrated that racial and ethnic minority providers are more likely to provide care in medically underserved areas than their White counterparts. Studies also suggest that some patients who seek care from a practitioner of their own race or ethnicity are more satisfied with their care, leading to improved understanding of conditions, treatment adherence, and positive health behavior changes. Thus, while a number of factors contribute to persistent health care disparities, “the lack of diversity among health care professions has been shown to have a profound impact on minority communities, leading to poor health outcomes or fragmented care at best.”²¹³

Medical and health professions schools, minority-serving institutions, and health professional societies stand to play an important and central role in attracting and training a diverse health care workforce to meet growing need and demand expected in 2014. Several institutions—such as the Association of American Medical Colleges (AAMC) and urban universities— are beginning to take a leadership role in addressing this priority, while others do not have the support that could reinforce their important role—such as

HBCUs and other minority-serving institutions. In all, there is a need to garner more widespread awareness and support for institutions committed to diversity and equity, especially given federal funding through the ACA and otherwise for many efforts is significantly compromised.

Urban universities across the nation that are anchored in local communities are well-positioned to drive local innovations in health care workforce development and diversity given their unique capacity, resources, and expertise. Urban universities produce nearly half of the nation's physicians and dentists, and 40% of nurses and public health professionals.²¹⁴ These universities are often seen as a “gateway” to higher education for urban students—many of whom are from diverse, underserved, and high-need communities—particularly in transitioning to health professions programs, and thus represent a tangible opportunity for integrating diversity priorities. A range of actions at the university-level are important for advancing diversity and equity, including, for example: a commitment from university leadership to advancing this priority; partnerships with education institutions to establish or strengthen pipeline programs from primary and secondary to graduate school level; and partnerships with community health care settings and safety-net providers to offer community-based health professions training.²¹⁵

A promising initiative, known as *Urban Universities for HEALTH* (Health Equity through Alignment, Leadership, and Transformation of the Health Workforce) is being led by AAMC in partnership with the Coalition of Urban Serving Universities and the Association of Public and Land-grant Universities, with support from the National Institutes of Health.²¹⁶ The goal of this effort is to enhance and expand a culturally sensitive, diverse, and prepared health workforce that can improve health and reduce disparities in urban communities. An initial cohort of five urban institutions (a “learning collaborative”) is working to develop metrics, assess institutional capacity, and test and share innovative approaches to talent development with the aim of improving the health of urban underserved populations. This effort represents a unique opportunity to test, strengthen, and enhance diversity and cultural competency programs at the university level, and could also be a resource for promoting ACA's workforce programs and policies.

Minority-serving institutions have great potential to train a more diverse health care workforce, particularly as these institutions train a large percentage of minority health professionals and evidence demonstrates that the academic performance of graduates from minority-serving institutions is not different from graduates of traditional universities. In fact, a review of academic and professional performance of students from HBCUs and traditional universities found that minorities from HBCUs are just as likely to graduate, pass licensing exams, and enter practice as nonminorities from traditional universities.²¹⁷ However, over the years, there has been little growth in degrees conferred by HBCUs for the health professions. As a recent *American Journal of Public Health* article questioned: “[If] the mission of HBCUs is to serve a major provider of education for African Americans...[w]hy are they not playing a larger role in the education of African American health professionals as we seek health equity?”²¹⁸ A focused national strategy is critically needed to enhance and support the role of HBCUs and other minority-serving institutions to train diverse health professionals, given these institutions already educate and train a cadre of professionals from diverse heritage.

Another avenue for attracting diverse students in the health professions is through recruitment and mentorship programs in community colleges. For example, *The Robert Wood Johnson Foundation Clinical Scholars* program partners with California’s community colleges—comprised of a large proportion of diverse students—to mentor, advise, and offer resources to students to help them transfer to a health professions career pathway and enter medical schools or other universities with health professions programs. These efforts draw on talent that may exist in many underserved communities that are often overlooked.

In all, these initiatives and resources are examples of strategies for assuring that the workforce related goals of the ACA are not lost among the efforts to reduce support, sequestration, or similar broader federal actions. As they reflect many of the provision objectives seen as critical to meeting the needs of newly insured, their success would contribute significantly to assuring more effective individual and community-based as well as informed access to and quality of care.

Leveraging Resources Provided through the ACA with Philanthropic Support

Given the many financial and ideological challenges to advancing health equity across states and communities, advancing workforce diversity and cultural competency will require supplemental support from other funding avenues—both federally and through the private sector. Well-funded programs, particularly those with mandatory funding in the ACA, may offer some opportunity. For example, the Patient-Centered Outcomes Research Institute authorized through 2019, may offer an avenue to test efficacy of cultural competency or other workforce diversity initiatives.

The private sector may also fill gaps in support. In fact, in many communities, national, state, and local philanthropies and foundations are beginning to fill an important void to support the health care workforce, particularly where sufficient support from the ACA and other federal sources has not occurred. Such assistance has included scholarships and loan repayments, mentorship programs, health care workforce capacity assessments, training programs, investments in community health workers, and improving provider capacity.²¹⁹

In addition to providing direct support to health care workers, philanthropic organizations can leverage resources to advance important and broader workforce initiatives under the ACA that may not be realized due to limited or no appropriations, or other actions. In the absence of appropriations, there is a need for stronger actions to encourage the federal government to allow, if not work with, private foundations and philanthropies to address many of the ACA’s unfunded provisions. These may include, for example, the National Health Care Workforce Commission—for which foundation or other non-federal support is currently prohibited²²⁰—as well as others such as support for model cultural competency curricula development and evaluation, and enhancing the community health workforce. As part of this effort, advocacy and other health provider organizations may need to frame the diversity and cultural competence discussions within the broader context of “quality” to ensure continued support at the federal, state, local and philanthropic levels. One key informant particularly highlighted this priority:

We know that the presence of health disparities means a lack of quality in the system. My goal is to tie it all together. By 2014 when we have the newly enfranchised, I hope we recognize how inter-dependent this work is—readmissions [as well as] the educational piece as far as who we choose to engage, such as students with the greatest capacity.

VI. Conclusion

The ACA's numerous provisions reaffirm many existing workforce efforts and intend to advance new initiatives—although not funded or underfunded in some cases—such as creating a national workforce commission, promoting cultural competence education, and supporting underrepresented minorities in health professions. At its core, this emphasis seems to acknowledge the formidable challenges that lie ahead in redressing limitations and disparities of the past affecting access to timely, high quality health care, and assuring that the intent of the new law to truly enfranchise new populations is fulfilled. The related demand for a high quality, diverse workforce will only grow, but will require significant resources and political will. What remains much less clear in moving into the fifth year of ACA implementation is whether the resources and political will to support a broad spectrum of critical programs and actions will be sufficient to meet service goals and people's needs.

Appendix A. Key Informants & Contributors

The Texas Health Institute would like to acknowledge and thank the many individuals who contributed valuable information, feedback, and perspective on various topics covered under the *Affordable Care Act & Racial and Ethnic Health Equity Series*. Nearly 70 individuals were interviewed or consulted. They represented a range of sectors—from federal, state, and local agencies to hospitals, health centers, health plans, professional associations, health policy experts, advocates, and community-based representatives. *Note: Opinions expressed in this report are of the authors only and are not to be attributed to the individuals or organizations listed below unless noted as such in the report.*

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Appendix B. ACA Workforce Diversity Progress At-A-Glance

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
<i>Increasing the Supply and Diversity of Healthcare Professionals</i>				
Health care workforce loan repayment programs § 5203	Establishes a pediatric specialty loan repayment program for professionals working in pediatric medical and surgical specialties or child mental healthcare. Priority is given to applicants that, among other criteria, have familiarity with cultural and linguistic competence.	<p>Pediatric specialists: FY 2010: \$30 m FY 2011: \$30 m FY 2012: \$30 m FY 2013: \$30 m FY 2014: \$30 m</p> <p>Child Mental Health professionals: FY 2010: \$20 m FY 2011: \$20 m FY 2012: \$20 m FY 2013: \$20 m FY 2014: \$20 m</p>	\$0	This provision has received no funding as of this writing.
Training in family medicine, general internal medicine, general pediatrics, and physician assistantship § 5301	Establishes a grant program to support primary care training. Funds are to be used for program operation and development, financial assistance, and capacity building. Among other criteria, priority is given to entities with a record of training individuals from underrepresented minority groups and familiarity in providing cultural competency training.	<p>Training programs: FY 2010: \$125 m FY 2011-2014: SSAN</p> <p>Capacity building grants: FY 2010: \$750,000 FY 2011: \$750,000 FY 2012: \$750,000 FY 2013: \$750,000 FY 2014: \$750,000</p>	<p>FY 2010: \$39 m in annual discretionary appropriation + \$198 m from the Prevention & Public Health Fund. FY 2011: \$39 m FY 2012: \$39 m FY 2013: \$37 m</p>	<p>September 2010: HRSA awarded 82 primary care residency training programs and 28 physician assistant training programs.</p> <p>By 2015, these programs are expected to train 889 new primary care physicians and 700 physician assistants.</p>

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
Training opportunities for direct care workers § 5302	Awards grants to eligible entities that provide training opportunities for direct care workers employed in long-term care settings.	FY 2010 – 2013: \$10 m	\$0	This provision has received no funding as of this writing.
Training in general, pediatric, and public health dentistry § 5303	Awards 5-year grants to fund dental training activities (faculty development, financial assistance, pre and post doctoral training in dental primary care) with an emphasis on programs that train students from disadvantaged backgrounds or whose programs focus on care for the underserved.	FY 2010: \$30 m FY 2011 – 2015: SSAN	FY 2010: \$15 m FY 2011: \$17 m FY 2012: \$20 m FY 2013: \$19 m	Grants have been awarded for Predoctoral Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene for FYs 2010 – 2013. All grantees report some kind of priority for targeting diverse dental students, focusing on cultural competency training, or serving a diverse dental patient population.
Mental and behavioral health education and training grants § 5306	Establishes grants programs for academic institutions to recruit and educate students in mental and behavioral health disciplines. Priority is given to institutions that have high participation of individuals from diverse backgrounds.	FY 2010-2013: \$35 m -\$8 m (social work); -\$12 m (psychology); - \$10 m (professional child mental health); -\$5 m (paraprofessional child mental health)	FY 2010: \$0 m FY 2011: \$0 m FY 2012: \$10 m FY 2013: \$0 m	September 2012: HRSA awarded \$10 m to 24 graduate social work and psychology academic institutions. All funded programs target high-needs and medically underserved communities. Ten explicitly report that their programs address racial and ethnic diversity.
Nurse education, practice, and retention grants § 5309	Establishes grants to expand the nursing workforce by training, retaining and enhancing patient care provided.	FY 2010 – 2014: SSAN	FY 2011: \$40 m FY 2012: \$40 m FY 2013: \$37 m	July 2011: HRSA awarded Nurse Education, Practice, Quality and Retention Grants to 33 entities. In 2012 there were 24 active grants and in 2013 there were 37 active grants.

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
Workforce diversity grants § 5404	Amends Title VIII, Section 821 of the <i>Public Health Service Act</i> , modifying the original Nursing Workforce Diversity Program to include advanced education preparation, stipends for diploma or associate degree nurses to enter a bridge or degree completion program, and student scholarships or stipends for accelerated nursing programs.	No funding specifications provided	FY 2011: \$3.6 m	July 2011: HRSA awarded Nursing Workforce Diversity Grants to 11 entities. As described in the Funding Opportunity Announcement, eligible entities are required to have some kind of commitment and activities related to advancing diversity and cultural competency. In 2011 there were 26 active grants. In 2012 there were 40 active grants and in 2013 there were 41 active grants.
Grants to promote the community health workforce § 5313	Authorizes grants under the CDC to train and supervise community health workers to care for medically underserved communities.	FY 2010 – 2014: SSAN	\$0	While not funded, community health workers have been funded through other sections of the ACA, such as the Community Transformation Grants.
Workforce Support for the Health Care Safety Net				
Funding for National Health Service Corps § 5207	Provides scholarships and student loan repayments for primary care students and clinicians who commit to providing care in federally designated Health Professional Shortage Areas.	FY 2010: \$320 m FY 2011: \$414 m FY 2012: \$535 m FY 2013: \$691 m FY 2014: \$893 m FY 2015: \$1.155 b *subsequent amounts based on previous year's funding	FY 2010: \$142 m FY 2011: \$315 m FY 2012: \$295 m FY 2013: \$285 m	October 2011: HHS announced funding for 5,418 loan repayment programs and \$46 m in funding to scholarship programs. February 2012: HHS announced a pilot program "Student to Service". October 2012: HHS announced \$229.4 m in funding for 4,600 awards in scholarships and loan repayment. February 2013: HHS announced more than \$10 m in funding for loan repayment to 87 medical students specializing in primary care.

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
<p>Interdisciplinary, community-based linkages § 5403</p>	<p>Authorizes grants to plan, develop or operate Area Health Education Centers or to maintain and improve existing Centers that recruit and train disadvantaged students into health professions to work in underserved areas.</p>	<p>FY 2010: \$125 m FY 2011: \$125 m FY 2012: \$125 m FY 2013: \$125 m FY 2014: \$125 m</p>	<p>FY 2010: \$33 m FY 2011: \$33 m FY 2012: \$27 m FY 2013: \$28 m</p>	<p>Grants have been awarded for Area Health Education Centers as follows: FY 2010: 11 infrastructure awardees; 43 point of service awardees. FY 2011: 11 infrastructure awardees; 49 point of service awardees. FY 2012: 11 infrastructure awardees; 48 point of service awardees. FY 2013: No active grants are listed on HRSA website.</p> <p>All grantees target underserved and disadvantaged populations, and at least half explicitly cite targeting diverse populations in their grant descriptions.</p>
<p>Distribution of additional residency positions § 5503</p>	<p>Directs the Secretary of HHS, beginning July 1, 2011, to convert unfilled hospital residency positions under the Graduate Medical Education (GME) program to slots for primary care physicians</p>	<p>N/A</p>	<p>N/A</p>	<p>November 2010: CMS issued final regulations regarding the redistribution of resident cap slots from hospitals that were below their caps to hospitals that applied to CMS for increased slots to expand their residency programs.</p> <p>August 15, 2011: CMS announced teaching hospitals to receive changes to their resident caps. Excess slots from 267 hospitals were re-directed to 58 hospitals. Of these, 24 are located in cities where over 50% of the residents are Non-White.</p>

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
<i>Cultural Competency Education and Training</i>				
Advancing research and treatment for pain care management § 4305	Requires the IOM to hold a Conference on Pain to develop the research agenda for pain as a public health problem. A report must be submitted to Congress. Authorizes HRSA to establish a new grants program for health professions schools to develop and implement programs for training health care professionals in the diagnosis, treatment, or management of pain.	FY 2010 – 2011: SSAN	\$0	The IOM Conference on Pain occurred as 5 meetings between November 22, 2010 and April 19, 2011. On June 29, 2011 the committee publicly released the resulting report titled <i>Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research</i> . The report highlights several aspects of racial and ethnic disparities in pain care. HRSA grants have not been implemented.
Cultural competency, prevention, and public health and individuals with disabilities training § 5307	Authorizes grants for research, demonstration projects and model curricula in cultural competency	FY 2010 – 2015: SSAN	\$0	This provision has received no funding as of this writing.
Demonstration projects to address health professions workforce needs § 5507	Authorizes grants for new demonstration projects to develop core training competencies, including cultural and linguistic competence, and certification programs for personal or home care aides.	FY 2010: \$5 m FY 2011: \$5 m FY 2012: \$5 m	FY 2010: \$4.2 m FY 2011: \$4.4 m FY 2012: \$4.4 m	In September 2010, HRSA awarded grants to six states (Massachusetts, California, Iowa, Michigan, North Carolina, and Maine) under the Personal and Home Care Aide State Training (PHCAST) Grant Program. The PHCAST <i>Report to Congress on Initial Implementation</i> has been released.

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
<i>Health Care Workforce Investment in Academic Settings</i>				
Investment in historically black colleges and universities and minority-serving institutions. § 2103	The accompanying Health Education and Reconciliation Bill amends the Higher Education Act by lengthening the authority to award funding to HBCUs and other minority-serving institutions through 2019	FY 2008-2019: \$255 in mandatory funding. \$100 m for Hispanic Serving Institutions \$85 m for Historically Black Colleges and Universities \$15 million for Predominantly Black Institutions \$30 million to Tribal Colleges and Universities \$15 million to Alaska/Hawaiian Native Institutions \$5 million to Asian American and Pacific Islander Institutions \$5 million to Native American non-tribal serving institutions.	The federal government began providing mandatory funding through the ACA to the HBCUs and other minority colleges as of 2010.	While HBCUs saw a modest increase in the graduation of African American practitioners between 2000 and 2008, this increase did not keep pace with growing need, nor with graduation of African Americans from comparable programs at White institutions.
Centers of excellence § 5401	Provides funding for Centers of Excellence which support programs to recruit, train and retain diverse health professions students.	FY 2010: \$50 m FY 2011: \$50 m FY 2012: \$50 m FY 2013: \$50 m FY 2014: \$50 m FY 2015: \$50 m	FY 2010: \$25 m FY 2011: \$24 m FY 2012: \$23 m FY 2013: \$21 m	Grants were awarded to Centers of Excellence as follows: 12 entities funded in FY 2010; 11 entities funded in FY 2011; 18 entities funded in FY 2012; and 17 entities funded in FY 2013. A review of grantees between FYs 2010–2012 reveals that 18 explicitly target Hispanics or Latinos; 4 target African Americans; 5 target Native Americans; and 12 target minorities in general.

Provision	Summary	Funding Authorized by the ACA	Estimated Funding Received	Summary of Implementation Progress
Health care professionals training for diversity § 5402	Authorizes appropriations to support scholarships and educational assistance for disadvantaged students.	Scholarships for Disadvantaged Students (SDS): FY 2010: \$51 m FY 2011-2014: SSAN Health Careers Opportunity Program (HCOP): FY 2010: \$60 m FY 2011-FY 2014: SSAN	SDS: FY 2010: \$49 m FY 2011: \$49 m FY 2012: \$47 m FY 2013: \$44 m HCOP: FY 2010: \$22 m FY 2011: \$22 m FY 2012: \$15 m FY 2013: \$14 m	Grants were awarded for SDS and HCOP in FYs 2010 to 2013 as follows: FY 2010: 33 HCOP awardees 308 SDS awardees FY 2011: 33 HCOP awardees 319 SDS awardees FY 2012: 20 HCOP awardees 99 SDS awardees FY 2013: no HCOP awardees listed 99 SDS awardees All grantees describe goals for medically underserved populations and disadvantaged students, and the vast majority target students who are racially and ethnically diverse.
Health Workforce Evaluation and Assessment				
National healthcare workforce commission § 5101	Creates a workforce commission to evaluate, recommend, and meet the demand for health care workers through research and data collection.	SSAN (No years specified)	\$0	September 2010: Comptroller General of the Government Accounting Office announced Commission nominations for 15-member body. The Commission has been unable to conduct business due to lack of funding.
State Health Care Workforce Development Grants § 5102	Authorizes planning and implementation grants to state workforce investment boards to plan workforce development activities.	Planning grants: FY 2010: \$8 m Subsequent FYs: SSAN Implementation grants: FY 2010: \$150 m Subsequent FYs: SSAN	FY 2010: \$6 m	September 2010: HHS announced 25 states received 1-year planning grants and 1 state received a 2-year implementation grant.

*Note: SSAN = Such Sums as Necessary

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