

Health Care Workforce Diversity Advisory Committee: Policy Recommendations For Consideration by the Governor's Interagency Council on Health Disparities December 10, 2009

Background and Purpose

The Governor's Interagency Council on Health Disparities is charged with creating a state policy action plan to eliminate health disparities by race/ethnicity and gender. The Council's five priorities for the first version of its action plan, which it anticipates will be completed by December 2010, are education, health insurance coverage, health care workforce diversity, obesity, and diabetes. The Council is convening advisory committees around these topics to review, prioritize, and identify policy recommendations for the Council's state action plan.

The purpose of the Council's health care workforce diversity advisory committee is to identify policy recommendations to increase the diversity of the health care workforce so that it reflects the diversity of the population it serves and to increase the cultural competence of the health care workforce in order to promote equity and reduce health disparities. The committee defines health care workforce broadly to include all levels of direct clinical care providers as well as professionals in the mental health, dental health, and public health fields.

Health Care Workforce Diversity in Washington State

Available data in Washington State describing the health care workforce by race/ethnicity are limited. The last comprehensive data source on the diversity of the health care workforce was the 1999 Washington State professional licensing survey, which has since been discontinued. While those data are now ten years old, they revealed that Washington's communities of color were, for the most part, disproportionately underrepresented in the health professions (see Table 1).

Table 1: Proportion of Select Health Care Professions by Race/Ethnicity, Washington State, 1999

Race/ Ethnicity	State Population (2000)	Physician	Physician Assistant	Dentist	Dental Hygienist	Nurse Practitioner	Registered Nurse	Licensed Practical Nurse
African American	3.2	1.0	2.4	0.9	0.5	1.1	1.0	4.4
American Indian/AK Native	1.6	0.5	1.2	0.7	1.1	0.6	1.0	1.9
Asian/Pacific Islander	5.6	7.5	5.9	8.5	3.4	2.9	4.4	4.3
Hispanic	6.0	2.0	4.5	0.7	1.7	1.6	1.7	2.5
Other or Unknown	-	7.5	3.0	8.6	4.4	4.8	16.8	20.1
White	83.5	81.5	83.0	80.6	88.9	89.0	75.1	66.7

Source: Healthcare Personnel Shortage Task Force (2008), 2007 Progress Report, which cites: 2000 Census and Center for Health Workforce Studies, University of Washington. Data Snapshots derived from 1999 Washington state professional licensing survey.

In 2006, the Legislature passed SB 6193, which authorized the Department of Health (DOH) in collaboration with the Workforce Training and Education Coordinating Board (Workforce Board) to survey the health professionals it licenses in order to collect demographic data,

including race/ethnicity. Each profession was to be surveyed every two years. In 2007, surveys were conducted for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Dental Hygienists. In 2008 surveys were conducted for Dentists, Physicians/Osteopathic Physicians, Physicians/Osteopathic Physicians Assistants, Pharmacists, Chiropractors, and Advanced Registered Nurse Practitioners (ARNPs). Survey datasets are available on the Department of Health's Web site. Unfortunately, original funding was not sufficient to allow for analyses of the data. Further, as a result of budget restraints, the Department of Health has decided not to continue the workforce demographic survey. Department of Health staff is currently working on a report to the Legislature that outlines the effectiveness of the survey, the use of survey information, and the extent to which shortages have been alleviated. Staff anticipates that the report will be submitted by the end of the year. Staff is seeking input on recommendations for improving the survey should the survey be reinstated, such as by linking survey administration to online license renewals once that becomes available.

Researchers from the University of Washington Center for Health Workforce Studies (CHWS) completed analyses of the RN, LPN, and ANRP data (Skillman 2008, Andrilla 2009, Skillman 2009). While the authors state that the estimates by race/ethnicity should be considered with caution because they are based on small numbers, the data reveal that, with few exceptions, Hispanic and non-White individuals remain disproportionately underrepresented among the nursing professions (see Table 2). The CHWS (Patterson 2004) also documented program completion data by race/ethnicity and gender for 36 health professions for the years 1996-2004.

Table 2: Proportion of Select Nursing Professions by Race/Ethnicity and Gender, Washington State, 2007 and 2008

Race/ Ethnicity	State Population (2008)	Advanced Registered Nurse Practitioner (2008)	Registered Nurse (2007)	Licensed Practical Nurse (2008)
African American / Black	3.3	0.6	0.8	5.0
American Indian/AK Native	1.4	0.4	0.4	1.1
Asian	6.9	3.2	4.3	4.7
Native Hawaiian/Pacific Islander	Asian and Pacific Islander combined	0.2	0.4	0.5
Other	--	1.4	1.7	2.5
Multiple Races	2.8	1.0	1.6	3.4
White	76.2	93.2	90.8	82.9
Hispanic				
Hispanic	9.3	2.3	2.0	3.6
Non-Hispanic				
Non-Hispanic	90.7	97.7	98.0	96.4
Male				
Male	49.9	12.8	8.6	11.7
Female				
Female	50.1	87.2	91.4	88.3

Sources: (1) Office of Financial Management (2008a). Executive Summary. Population by Race and Hispanic Ethnicity: 2000 and 2008. (2) University of Washington Center for Health Workforce Studies, Final Reports # 120, #123, and #124. (3) Office of Financial Management (2008b). 2008 Detailed Table of Population Estimates by County, Age, Gender, Race and Hispanic Origin. (4) Center for Health Workforce Studies (2008a,b,c), Washington Data Snapshots for ARNPs, RNs, and LPNs.

In 2008, of the 169 medical school graduates from the University of Washington, 137 were White, 26 were Asian, nine were Hispanic/Latino (five Mexican, one Puerto Rican, and three Other Hispanic/Latino), three were African American, three were Native Hawaiian/Pacific Islander, and two were unknown race/ethnicity. Ninety-five (56%) of the graduates were female (Association of American Medical Colleges, 2008).

Why is Workforce Diversity Important?

In its report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, the Institute of Medicine (2003) reported the following findings:

- Concordance by race/ethnicity among patients and their providers is associated with greater patient participation in health care, patient satisfaction, and adherence to treatment.
- Providers of color are more likely to work in communities of color and medically underserved communities.
- The benefits of health care professional diversity are significant and point to the need for a commitment to affirmative action in medical school admissions, residency recruitment, and professional specialty training.

As a result, the Institute of Medicine made the following recommendation: "Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals. To the extent legally permissible, affirmative action and other efforts are needed to increase the proportion of underrepresented racial and ethnic minorities among health professionals."

In 2004, the Institute of Medicine published *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, which summarized evidence that health professional diversity results in improved access to care for communities of color, greater patient choice, and satisfaction, better communication between patients and providers and better educational experiences for all students in health professions training programs (Institute of Medicine 2004). The report outlined a number of recommendations to reduce institutional and policy-level barriers to increase the diversity of the health professions.

Also in 2004, the Sullivan Commission released *Missing Persons: Minorities in the Health Professions*, which focused its recommendations on leadership and accountability, as well as making education and health professions training more attainable and affordable for students of color. The Sullivan Commission found that increasing diversity in the health workforce would improve the health of the nation, not just racial/ethnic groups. It also found that an increase in diversity would strengthen the cultural competence throughout the health system.

A more recent review from the U.S. Department of Health and Human Services Health Resources and Services Administration (2006) reported the following findings:

- Underrepresented racial/ethnic health professionals, particularly physicians, are more likely to serve underrepresented and medically underserved populations.
- Patients of color tend to receive better interpersonal care from providers of their own race/ethnicity, particularly in primary care and mental health settings.
- Non-English speaking patients receive better interpersonal care, experience greater medical comprehension, and have a greater likelihood of keeping follow-up appointments when they are treated by a provider who speaks their language, particularly in the mental health setting.

The authors conclude that greater workforce diversity may result in improved health through improvements in access to care and interpersonal care for underserved populations.

Barriers to Health Care Workforce Diversity

Research studies have identified a number of barriers for students of color to pursue and succeed in the health care field. One study conducted in Washington, found that barriers to pursuing a medical career among American Indian and Alaska Native (AI/AN) students included balancing the academic rigor of medical school with community and family needs, financial concerns, a lack of role models and mentors and a belief that their perspectives on healing and spirituality would not be included (Hollow 2004). As a result, authors recommended the following strategies for recruitment and retention of AI/AN students into medical school (Hollow 2006):

- Provide role models, advisors, and mentors.
- Involve AI/AN students in research on Native health issues.
- Anticipate students' traditional and spiritual practices.
- Provide professional socialization opportunities
- Create rigorous curricula that include Native perspectives.
- Develop a pro-diversity mission statement.

Barriers identified by African American students in pursuing a career in medicine included financial barriers, lack of knowledge about medicine, little encouragement at home or in school, negative peer pressure regarding succeeding in academics, lack of role models in the community and the media, racism in medicine, and other alternatives to make money (Rao 2007). The authors conclude that exposure at a young age to role models and the medical profession might help to increase the number of African Americans physicians.

Another Washington study looked at barriers to educational success among Hispanic/Latino and American Indian nursing students (Evans 2008). The author found that barriers to success included educational and economic resources; balancing work, school, and family needs; a lack of diverse faculty and students; issues of power and privilege; the heavy and intense academic workload; and a fear of failure.

Efforts to Increase Health Care Workforce Diversity in Washington State

In 1998, Washington voters approved Initiative 200 making affirmative action illegal in Washington State for employment, contracting, and public education considerations. Brown and Hirschman (2006) assessed the impact of I-200 and found a temporary (1-2 year) drop in applications from students of color to the University of Washington but not at other state universities and colleges. This drop in applications translated into a similar short-lived decrease in the proportion of high school seniors who went to college in Washington State. The authors noted that while the impact of I-200 was only temporary, significant racial/ethnic differences in the transition of students from high school to college remain.

In 2001, the State Board of Health published a health disparities report focusing on workforce diversity, which included the following six recommendations:

- Enumerate the composition of the health care workforce.
- Establish guidelines for health career development programs.
- Facilitate training and certification of people with prior health care experience.

- Create a graduate medical education incentive pool.
- Develop a health care workforce diversity report card.
- Coordinate health care workforce diversity efforts.

In 2002, the Health Care Personnel Shortage Task Force (i.e., Task Force) published its strategic plan, *Health Care Personnel Shortages: Crisis or Opportunity?*, which outlined goals and strategies to address current and projected shortages of health care personnel in Washington State. In 2003, the Legislature directed the Task Force to monitor progress of the implementation of the strategic plan. One of the strategic plan goals is to recruit more underrepresented populations into health professions and to promote adequate preparation prior to entry (Health Care Personnel Shortage Task Force 2008). Similarly, one of the Task Force's priorities is to recruit diverse populations into health care professions.

In 2005, the Joint Select Committee on Health Disparities released its final report with ten recommendations, three of which were related to the diversity and cultural competence of the health care workforce. These recommendations were to:

- Develop a workforce that is representative of the diversity of the State's population.
- Identify and collect relevant and accurate data on health care professionals, students in the health care professions, and recipients of health services.
- Develop the knowledge, attitudes, and practice skills of health professionals and those working with diverse populations to achieve a greater understanding of the relationship between culture and health.

In response to the Committee's recommendations, in 2006, the Legislature passed 2SSB 6193 and ESB 6194, which authorized the Department of Health in collaboration with the Workforce Board to survey health care professionals to collect race/ethnicity and other demographic data and to create a multicultural health education program for health professionals, respectively. Due to budget restraints, the health professional demographics survey has since been eliminated (see section on Health Care Workforce Diversity in Washington State on page two for more information). Staff at the Department of Health is finalizing the multicultural health education program and hopes to have it available for external review by September 2009.

For many years a number of organizations and entities through Washington State have been working to increase the diversity of the health care workforce. On their own and in partnership, universities, colleges, schools, state agencies and boards, community based organizations, provider associations, clinics and hospitals, health plans, and other entities have implemented such programs. A list of select programs was gathered and presented to the Council at its February 7, 2008 meeting; the briefing document is available at:

<http://www.healthequity.wa.gov/About/prioritization.htm>.

Governor's Interagency Council on Health Disparities Health Care Workforce Diversity Advisory Committee

The Council's health care workforce diversity advisory committee convened on June 9, 2009 and met a total of four times, with its last meeting on September 9, 2009. The committee's purpose was to identify policy recommendations to increase the diversity of the health care workforce so that it reflects the diversity of the population it serves and to increase the cultural competence of the health care workforce in order to promote equity and reduce health disparities. In an effort to

identify policy recommendations, the committee reviewed workforce data, discussed policies and programs, and assessed numerous policy options. See Appendix A for the list of policy options with related information on the evidence of effectiveness and the level implementation in Washington State, which the committee used in its deliberations.

The workforce diversity advisory committee finds that programs aimed at diversifying the health care workforce in Washington are suffering financially and operating at minimum capacity. The committee also recognizes the tough economic situation that Washington State is faced with. Nonetheless, the committee finds that there is a huge cost for not addressing health disparities and that prioritizing and redistributing resources is necessary and vital. The committee offers suggestions to reduce the cost burden for implementing some of its recommendations.

Policy Recommendations

The health care workforce diversity advisory committee recommends the following statewide actions to increase the diversity and cultural competence of the health care workforce:

- 1. Ensuring all health care providers receive the training and resources they need to provide culturally competent care to all patients regardless of race/ethnicity, culture, socioeconomic status, or language.** At a minimum, this can be accomplished by: (1) requiring all licensed health care providers to receive cultural competence training as a condition for initial licensure, (2) encouraging health care employers to deliver cultural competence training as a part of ongoing staff development, and (3) requiring health professions education institutions to report on the cultural competence training offered and the degree to which the training has integrated existing cultural competency standards.
- 2. Requiring postsecondary institutions to set targets to increase enrollment and completion of diverse students in health care education programs until diversity reflects the population served and to report annually on progress to the Higher Education Coordinating Board (HECB).** Progress can be achieved by encouraging postsecondary institutions to create clear mission statements that recognize the importance of diversity, establish policies regarding the need for culturally competent health care and the role of health professions diversity, ensure diversity on faculty recruitment committees, and recognize the role diverse faculty play in the success of diverse students. The HECB could compile data into a “dashboard” for colleges and universities, which could include metrics on diversity of student body, diversity of faculty, graduation rates for students of color, etc. Diversity criteria could also be included in state administered scholarship, grant, and loan repayment programs, such as the opportunity grant program to increase enrollment in high demand career pathway programs, such as health care. In addition, should the Legislature move forward with establishing Performance Agreements with public higher education institutions, increased diversity in enrollment, and completion of health care education programs could be one deliverable in those agreements.
- 3. Providing stable state funding to expand health care career exploration, preparation, work-based learning opportunities, mentorships, and early certification programs** that have been shown to be effective at increasing the diversity of the health care workforce, including funding for outreach and public awareness efforts to recruit diverse students to take advantage of these opportunities.

4. **Providing funding to ensure the regular collection, analysis, and reporting of data on the diversity of the health care workforce.** This can be done by providing support for the Department of Health to reinstate its demographics survey of health professionals and to include funding to regularly analyze and report on findings. The Department of Health can consider adopting a minimal surcharge on license and facilities fees to support the survey. The Department of Health should consider linking the administration of the survey to online license renewal (when available) and using any savings to fund analysis and dissemination of results.

The committee prioritized the above recommendations as the most essential; however, it also submits the following second-tier recommendations for the Council's consideration:

1. **Providing stable state funding to maintain and expand comprehensive career guidance and counseling in K12** to include funding additional counselors, changing program offerings and curricula to meet student needs; holding student-led conferences with teachers and parents that focus on students' learning and goals; increasing student, parent, teacher, and counselor awareness of financial aid opportunities and other successful programs to help students plan for life after high school.
2. **Requiring state program approval agencies and accreditation agencies to ensure that health care programs include cultural competency standards in curricula and in faculty development and recognize the importance of a culturally diverse student population in order to qualify for approval.** Require institutions to address deficiencies if diversity-related standards are not met and repeated deficiencies should result in sanctions.
3. **Expanding educational delivery options and supports that increase participation and successful completion of credentials among diverse adults.** Examples include workplace learning programs, distance learning programs, programs that combine basic skills with occupational skills, mentorship and retention programs, navigator programs to help students in a variety of ways such as learning about financial aid opportunities, filling out applications, exploring career options and more.
4. **Expanding funding supports for diverse students to pursue health care careers.** For example, provide scholarships that target diverse populations. Also, include programs to help students apply for financial aid and financial assistance. Engage in culturally and linguistically appropriate outreach and public awareness efforts to recruit students to take advantage of these opportunities, including ensuring materials are translated into multiple languages. Request that DSHS attach expectations that a portion of existing Medicaid GME funds be used by hospitals to increase the diversity of the health care workforce (i.e., recruit people of color into residency programs). State Board of Health (2001), Institute of Medicine (2004), and Commonwealth Fund (2004) recommend using GME funds as a pathway for incentivizing workforce diversity efforts.

5. **Developing more career ladders from low-paid jobs to high-paid, high-demand health care occupations.** Create and expand incumbent worker outreach programs in hospitals (e.g., Hospital Employee Education and Training (HEET) program) and health agencies to identify workers, including community health workers, interested in advancing in the health profession. Provide financial incentives for employers who offer tuition reimbursement programs and flexible work schedules for employees pursuing health careers. Create more applied baccalaureates to ensure students in health workforce education programs have expanded options to continue education. Improve workplace mentorship/retention programs for diverse employees just starting out in the health professions. Ensure stable funding for community health workers, such as direct reimbursement through publicly funded health plans.
6. **Creating and expanding bridging programs, equivalencies, recognition of credits, and supports for veterans and immigrants who have previous health care training.** This can be done by having the State work with its licensing commissions and to make recommendations to our Congressional delegations and to national accrediting bodies for specific changes that will allow transfer of education and skills into U.S./civilian careers without creating issues of safety of the public. Provide financial incentives to providers who offer internships and supervised practice opportunities.
7. **Providing funding to develop a statewide health care workforce diversity report card** (such as to the State Board of Health, the Health Care Personnel Shortage Task Force, or the Public Policy Institute), which could include cultural competency measures (e.g., agency policies and procedures, signage in multiple languages, etc.). Community-Based Participatory Research should be used to inform the report card measures.
8. **Supporting research initiatives** to link cultural competency efforts to health outcomes, gain knowledge of best methods for cultural competency trainings, and establish minimum standards for cultural competency trainings and outcomes.
9. **Ensuring state-funded programs include funding for data collection and evaluation in order to track progress.**

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Appendix A: Policy Options Considered by the Health Care Workforce Diversity Advisory Committee

Policy Domain	Specific Policy Ideas	Comments – Evidence of Effectiveness and Implementation in Washington
<p>Policies Targeting Students in Grades K-12</p>	<p>1. Increase opportunities for diverse youth to prepare for and succeed in postsecondary health care programs and health careers by:</p> <ul style="list-style-type: none"> • Providing stable state funding to maintain and expand comprehensive career guidance and counseling in K-12 to include changing program offerings and curricula to meet student needs; funding additional counselors, holding student-led conferences with teachers and parents that focus on students’ learning and goals; increasing student, parent, teacher, and counselor awareness of financial aid opportunities and other successful programs to help students plan for life after high school. • Providing stable state funding to expand health care career exploration, preparation, work-based learning opportunities, mentorships, and early certification programs that have been shown to be effective including funding for outreach and public awareness efforts to recruit students to take advantage of these opportunities. 	<p>State Board of Health (2001), Institute of Medicine (2004), Commonwealth Fund (2004), and Sullivan Commission (2004) recommend creating opportunities for K-12 students to participate in career development programs, particularly at younger ages. The Sullivan Commission (2004) recommends an adequately funded campaign to recruit students. The State Board of Health created guidelines for successful health care career development programs.</p> <p>In Washington, Work-based Learning Coordinators are trained to coordinate career exploration programs. Navigation 101 is comprehensive career guidance and counseling curricula that has been gradually expanding to school districts in Washington through support of the Governor and Legislature. Early results show students elect to take harder math and science courses and receive fewer failing grades among other positive benefits.</p> <p>There are a number of health career development and enrichment programs in Washington, e.g., U-Doc, SMDEP, Health Careers for Youth, Project HOPE, Na-ha-shnee, etc. Programs offering dual enrollment/credit in high school and community colleges (e.g., Bright Future Program) demonstrate that offering advanced training in health care programs and additional career and academic advising helps students of color successfully navigate high school, college, and work. There are also a number of programs aimed at helping underrepresented students succeed (e.g., MESA program and Upward Bound).</p>

Policy Domain	Specific Policy Ideas	Comments – Evidence of Effectiveness and Implementation in Washington
<p>Policies Targeting Post-Secondary Institutions</p>	<p>2. Assure health professions education programs to increase representation of diverse populations into postsecondary health care programs and provide modes of educational delivery that lead to successful completion and transition to work by:</p> <ul style="list-style-type: none"> • Providing incentives for postsecondary institutions to increase enrollment and completion of diverse students in health care education programs and requiring them to report annually on progress to the Higher Education Coordinating (HEC) Board. Progress can be achieved by creating clear mission statements that recognize the importance of diversity, establishing policies regarding the need for culturally competent health care and the role of health professions diversity, ensuring committees to recruit faculty are diverse, and recognizing the role diverse faculty play in the success of diverse students, etc. The HEC Board could compile data into a “dashboard” for colleges and universities, which could include metrics on diversity of student body, diversity of faculty, graduation rates for students of color, etc. In addition, should the Legislature move forward with establishing Performance Agreements with public higher education institutions, increased diversity in enrollment and completion of health care education programs could be one deliverable in those agreements. • Requiring state program approval agencies and accreditation agencies to ensure that health care programs include cultural competency standards in curricula and in faculty development and recognize the importance of a culturally diverse student population in order to qualify for approval. Require institutions to address deficiencies if diversity-related standards are not met and repeated deficiencies should result in sanctions. 	<p>Institute of Medicine (2004) and Sullivan Commission (2004) recommend health professions education institutions establish policies/processes to recognize the value of diversity. The IOM (2004) recommends accreditation bodies develop standards to assess the number and percentage of underrepresented candidates, students admitted and graduated, time to degree, and number and level of diverse faculty. The Sullivan Commission (2004) recommends that accrediting bodies should promote development and adoption of standards for cultural competency for health professions faculty.</p> <p>In Washington, health professions education programs have included diversity language in their mission statements. The State Board for Community and Technical College, the Higher Education Coordinating Board, and the State Nursing Quality Assurance Commission each has roles in approving programs.</p>

Policy Domain	Specific Policy Ideas	Comments – Evidence of Effectiveness and Implementation in Washington
<p>Policies Targeting Adults, Including Incumbent Health Care Workers</p>	<p>3. Create or expand programs to support adults, including incumbent health care workers, succeed and progress in health care careers by:</p> <ul style="list-style-type: none"> ● Expanding educational delivery options and supports that increase participation and successful completion of credentials among diverse adults. Examples include workplace learning programs, distance learning programs, programs that combine basic skills with occupational skills, mentorship and retention programs, navigator programs to help students in a variety of ways such as learning about financial aid opportunities, filling out applications, exploring career options and more. ● Expanding funding supports for diverse students to pursue health care careers. For example, provide scholarships that target diverse populations. Also, include programs to help students apply for financial aid and financial assistance. Engage in culturally and linguistically appropriate outreach and public awareness efforts to recruit students to take advantage of these opportunities, including ensuring materials are translated into multiple languages. Set aside a portion of GME funds to create a GME incentive pool to incentivize workforce diversity efforts. State Board of Health (2001), Institute of Medicine (2004), and Commonwealth Fund (2004) recommend using GME funds as a pathway for incentivizing workforce diversity efforts. ● Developing more career ladders from low-paid jobs to high-paid, high-demand health care occupations. Create and expand incumbent worker outreach programs in hospitals and health agencies to identify workers, including community health workers, interested in advancing in the health profession. Provide financial incentives for employers 	<p>Sullivan Commission (2004) recommends support services such as mentoring, test-taking skills, counseling, and interviewing skills. Washington Center for Nursing (2008) recommends navigator programs. Hollow (2006) recommends providing American Indian/Alaska Native role models, advisors and mentors as a strategy to improve recruitment and retention of Native students into medical school. The Sullivan Commission (2004) recommends financial assistance, particularly shifting from student loans to scholarships. State Board of Health (2001) and Sullivan Commission (2004) recommend helping foreign-trained professionals transfer skills. The Commonwealth Fund (2004) suggests creating fellowships and internships for health professionals to work with underserved populations. Sullivan Commission (2004) recommends accrediting bodies promote the adoption of standards for cultural competency and that continuing education in cultural competency be a condition of licensure.</p> <p>The Rural Outreach Nurse Education (RONE) Program at Lower Columbia College is an online learning program to support working adults. IBEST, which combines basic skills with occupational skills, has expanded to all 34 community and technical colleges. Many IBEST programs are in health care.</p> <p>Early evaluation of the Opportunity Grant Program show a large proportion of students served are students of color and a large proportion go into health care education programs. Eligibility to the State Need Grant was expanded by the Legislature to include part-time students but the amount provided is capped. The HEC Board offers loan repayment and scholarship programs to improve the number of health professionals working in underserved areas. The Employment Security Department is creating a WorkSource Training Academy to provide training for frontline staff. Pierce County</p>

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	<p>who offer tuition reimbursement programs and flexible work schedules for employees pursuing health careers. Create more applied baccalaureates to ensure students in health workforce education programs have expanded options to continue education. Improve workplace mentorship and retention programs for diverse employees just starting out in the health professions. Ensure stable funding for CHWs, such as direct reimbursement through publicly funded health plans.</p> <ul style="list-style-type: none"> • Creating and expanding bridging programs, equivalencies, recognition of credits, and supports for veterans and immigrants who have previous health care training. This can be done by having the State work with its licensing commissions and to make recommendations to our Congressional delegations and to national accrediting bodies for specific changes that will allow transfer of education and skills into U.S./civilian careers without creating issues of safety of the public. Provide financial incentives to providers who offer internships and supervised practice opportunities. • Ensuring all health care providers receive the training and resources they need to provide culturally competent care to all patients, regardless of race/ethnicity, culture, socioeconomic status, or language. Research shows there is a link between the provision of culturally competent care and positive health outcomes. 	<p>Workforce Development Council has created health care career recruitment materials in multiple languages.</p> <p>The Health Employee Education and Training (HEET) program creates alternative education methods to support hospital workers receive training in nursing and high demand careers. Funding was expanded in the 2009-2011 budget.</p> <p>The Welcome Back Center at Highline Community College started enrolling students in October 2008 (they have about 150 students in 2009). The Center provides career coaching and works with health care commissions in the state to assist students receive licenses to work in Washington. The Nursing Quality Assurance Commission (assisted through the Workforce Board and Pacific Mountain Workforce Development) worked with the military to review a military training program and provide input on changes to allow those personnel to become licensed as LPNs and then continue up the career ladder. Eight applied baccalaureate program pilots are underway in Washington – at least two are in health care programs (Nursing at Olympic College and Radiology Technology at Bellevue College).</p> <p>CHWs (outreach workers, health navigators, lay health educators, etc) serve as bridges between the health care systems and communities they serve. The IOM (2003) recommends supporting CHWs as part of multidisciplinary teams to improve care and reduce health disparities. Minnesota currently reimburses CHWs through its Medicaid program. Some states have certification processes.</p> <p>In Washington, the Legislature passed SB 6194 (2006) which authorized the Department of Health to create a multicultural health education training program for health care professionals.</p>

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		The UW Center for Cultural Proficiency in Medical Education provides resources for cultural competency.
Data and Assessment	<p>4. Support data and research efforts to assess the current status of health care provider diversity and cultural competence and evaluate the effectiveness of interventions by:</p> <ul style="list-style-type: none"> • Providing funding to ensure the ongoing collection, analysis, and reporting of data on the diversity of the health care workforce. This can be done by providing support for the Department of Health to reinstate its demographics survey of health professionals and expand to include funding to regularly analyze and report on findings. • Providing funding to develop a statewide health care workforce diversity report card (such as to the State Board of Health, the Health Care Personnel Shortage Task Force or the Public Policy Institute), which could include cultural competency measures (e.g., agency policies and procedures, signage in multiple languages, etc.). Community-Based Participatory Research should be used to inform the report card measures. • Supporting research initiatives to link cultural competency efforts to health outcomes, gain knowledge of best methods for cultural competency trainings, and establish minimum standards for cultural competency trainings and outcomes. • Ensuring state-funded programs include funding for data collection and evaluation in order to track progress 	<p>Commonwealth Fund (2004) suggests data can be used to tailor interventions to areas with shortages of diverse health professionals. State Board of Health (2001) recommendations included guidance on the elements of a diversity report card.</p> <p>In Washington, SB 6193 (2006) authorized the Department of Health to survey the health professionals it licenses – funds did not allow for the analysis and reporting of these data. The Department of Health is no longer administering the survey due to budget cuts. It will be submitting a report to the Legislature by the end of 2009, which will include recommendations for improving the survey.</p>