

From the Mouths of Leaders:

Challenges and Opportunities to Increase Health Professions Workforce Diversity in California



September 2008

From The Mouths of Leaders: Issues, Challenges, and Opportunities to Increase Health Professions Workforce Diversity in California

**The Connecting the Dots Initiative
A Comprehensive Approach to
Increase Health Professions Workforce Diversity in California**

Produced by:
The Public Health Institute
and the UC Berkeley School of Public Health

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ABOUT THE INITIATIVE

The Connecting the Dots Initiative: A Comprehensive Approach to Increase Health Professions Workforce Diversity in California

This is one of seven reports that share findings from a coordinated set of inquiries commissioned by The California Endowment. The purpose is to foster a more comprehensive, evidenced-based understanding of the issues, challenges, and opportunities associated with efforts to increase health professions workforce diversity. Each report includes a set of targeted recommendations to increase health professions workforce diversity in California. The basic theme and title of the initiative is “Connecting the Dots,” reflecting an understanding of the need for a thoughtful, deliberate, and sustained commitment by the full spectrum of educational institutions, health professions employers, businesses, community stakeholders, and other leaders in the public and private sectors. The Public Health Institute and UC Berkeley School of Public Health formed a partnership to conduct the research and take action as part of The Connecting the Dots Initiative, and worked in collaboration with UCSF Center for Health Professions, Gibson and Associates, and The Praxis Project.

Impetus for the Connecting the Dots (CTD) Initiative was provided by earlier reports from the Institute of Medicine, The Sullivan Commission, and The UCSF Center for Health Professions. These reports documented the dramatic under-representation of many racial and ethnic groups in the health professions and provided evidence that a more diverse health workforce can contribute to improved access and quality for health status for all Americans. They also made the case that increased representation is essential to our future health workforce and economy. The Connecting the Dots Initiative builds on those earlier reports by documenting the current state of affairs in California and developing an evidence-based, comprehensive strategy to increase health workforce diversity. The Connecting the Dots Initiative reports include:

- A quantitative assessment of the current level of diversity in CA health professions education institutions and among practicing professionals.
- A qualitative assessment of issues, challenges, and opportunities based on key informant interviews with the leadership of health professions education institutions, health professions employers, and state regulatory agencies.
- Profiles of 33 exemplary practices to enhance health professions diversity
- An analysis of how the issue of diversity is framed in the California media, and strategies to re-frame the public dialogue.
- Qualitative and quantitative research with health professions students, faculty and alumni to explore the benefits of diversity in the educational environment.
- A comprehensive annotated bibliography and literature review of diversity-related research to date.
- A qualitative assessment of K-12 networks of support to pursue health careers in four California communities.

All seven reports can be found at <http://www.calendow.org/Article.aspx?id=2290>. The Connecting the Dots Initiative is in its next phase to support the implementation of the targeted recommendations. For more information, please contact Shelly Skillern at sskillern@phi.org

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In addition to their role as co-directors of the Connecting the Dots Initiative, Kevin Barnett, Dr. P.H., M.C.P; and Jeff Oxendine, MBA, MPH. provided supervision, oversight and guidance of the study design. They also conducted a significant portion of the interviews and served as co-authors and editors of the report.

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Table of Contents

Executive Summary	vii
Introduction.....	1
Study Design and Methodology	4
Part One: Health Professions Education Institutions	11
A. Mission Statement.....	11
B. Commitment of Senior Leadership.....	12
C. Accountability and Senior Leadership.....	15
II. Expanding the Pathway and Pool.....	19
A. General Issues and Themes.....	20
B. HPEI Investment in the K-12 Pipeline.....	23
C. Expanding the Pipeline in Higher Education.....	26
III. Reducing Financial Barriers.....	34
A. Medical and Dental Schools	35
B. Nursing and Public Health Programs.....	36
IV. Recruit, Admit, and Retain UR Students	41
A. Medical and Dental Schools	41
B. Nursing Schools and Programs.....	48
C. Public Health Schools and Programs.....	57
V. Create a Supportive Environment	64
A. Structural Issues – Building a Critical Mass of Diversity.....	64
B. Creating a Support Infrastructure.....	66
C. Programmatic Support	67
D. Culture and Pedagogy	67
VI. Recruit, Hire, and Retain UR Faculty	71
A. Faculty Gatekeepers.....	72
B. Criteria and Qualifications.....	72
C. UR Faculty Burdens.....	74
D. Grow Your Own Faculty	75
E. Competing with the Private Sector	77
F. Practice in Underserved Communities.....	78
G. Faculty Mentoring.....	79
VII. Curriculum	82
A. Curricular Content	82
B. New Modes of Learning	87

Part Two: Health Professions Employers.....	94
I. Relationships with the Community	95
A. Investing and Participating in the K-16 Pipeline	96
B. Reducing Health Disparities	100
C. Advocacy Efforts With Communities.....	102
D. Communities as Business Partners	109
II. Relationships with HPEIs and Training Issues.....	113
A. Teaching Hospitals.....	114
B. Community Health Centers.....	119
C. Public Health Departments	122
D. Institutional Advocacy	124
III. Workforce Issues.....	128
A. Workforce Shortages	128
B. Diversifying Leadership and Management.....	133
C. Recruitment and Retention	136
D. Cultural and Linguistic Competence	137
E. Collaboration/Competition Among Health Professions Employers.....	142
 Part Three: State Health Agencies	 147
A. Programs and Financial Support.....	148
B. Data Collection and Performance Monitoring.....	151
C. Language Access Assurance and Monitoring.....	156
D. Internal Capacity – State Agency Staffing.....	159
E. Workforce Planning and Development.....	160
 Appendix A:	
Sample Pre-Interview Survey	xxiii
Appendix B:	
Sample Interview Guide.....	xxx
Appendix C:	
Schematic Drawings of Interview and Analysis Process	xxxii

Executive Summary

This report is one of seven inquiries conducted as part of The Connecting the Dots Initiative, a statewide effort to establish an evidence base, develop comprehensive strategies, and build momentum to increase diversity in California's health professions workforce. The findings and recommendations in the report are a product of 68 key informant interviews conducted with leaders of health professions education institutions (HPEIs), organizations that employ health professionals, and State health agencies.

The purpose of the key informant interviews was to solicit input from leaders on issues, challenges, and opportunities associated with efforts to increase diversity in the health professions workforce. The interviews were confidential in an effort to encourage optimal candor.

Among HPEIs, the inquiry focused primarily on four disciplines: medicine, dentistry, nursing, and public health. Health professions employers included teaching hospitals, health systems, health plans, independent practice associations, community health centers, local public health agencies, biotechnology companies, and pharmaceutical companies. Interviews with State health agencies focused on those with roles in data collection and monitoring, program support, and health workforce development.

As with the full report, this executive summary is divided into three parts for each of the three categories of institutions, HPEIs, health professions employers, and State health agencies. For HPEIs and health professions employers, findings and recommendations are divided further into sub-sections that focus on different functions relevant to efforts to increase health professions workforce diversity.

Part One: Health Professions Education Institutions

I. Leadership and Commitment

There was broad agreement among interviewees that inclusion of diversity language in an institution's mission or values statements and the implementation of diversity-affirming policies are essential, but not sufficient conditions to create a campus culture that supports diversity. There was also widespread agreement that the commitment and actions of senior leadership are crucial in creating an institutional climate that supports and facilitates shared learning among students and faculty from diverse backgrounds. In both cases, however, informants noted that there is significant variation among institutional language and leadership commitment.

Informants also acknowledged that bringing about meaningful and lasting change in this regard requires sustained focus. Given the complexity of HPEIs, diversity as an issue must compete with many others for the attention of leaders and faculty. In assessing the commitment of HPEI leadership, it is essential to examine what specific steps are taken and resource commitments are made to translate rhetoric into results.

Despite these issues, informants indicated that the job performance of senior administrators is rarely tied to diversity issues or metrics. Given the importance of senior leadership commitment and action to advancing and sustaining diversity, our interviewees thought it important to have mechanisms to hold department chairs, deans, and higher-level administrators accountable for furthering diversity efforts.

Recommendations

- 1. Formalize institutional commitment to diversity in mission and values statements, as well as through sustained resource allocation.**
- 2. Based on a site specific assessment of factors and conditions, develop an adequately funded strategic plan and designate a high-ranking official to ensure the implementation of the plan.**
- 3. Hold leaders directly accountable to fulfill institutional commitments to advance diversity as part of the evaluation of their job performance and compensation.**
- 4. Develop a statewide consensus document to identify public expectations of HPEIs to fulfill their diversity-related responsibilities.**
- 5. Link HPEI recruitment efforts with the goals of statewide and local health professions employers and community-based organizations to eliminate health disparities and increase diversity.**
- 6. Institutionalize current diversity initiatives at UC HPEIs with designated line item budgeting. Reduce reliance on short term discretionary and external philanthropic funding and establish as a percentage of annual instructional budget.**

II. Expanding the Pathway and Pool

Efforts by many HPEIs to expand the pathway and pool through outreach, investment, and engagement at the K-12 and undergraduate level are limited to date. While there are notable exceptions, we found that most HPEIs devote their resources and energy to competing for the current small pool of under-represented (UR) applicants that meet traditional academic criteria, rather than investing in expanding the pool. While few are substantively engaged in long term development, most acknowledged that a better and more sustainable path to increase diversity is to improve the education and social opportunities for UR students long before they ever apply to health professional schools.

There are numerous programs and activities at multiple levels led by committed individuals, but most are funded with discretionary dollars, and lack the scale, stability, and monitoring infrastructure to produce measurable results. There is also a lack of outreach and coordination between HPEIs and undergraduate institutions. Both

community colleges and the California State University system possess the critical mass of diversity needed to build California’s health professions workforce, but most of these students are not making it into our HPEIs in general, and the University of California in particular.

Recommendations

- 1. Partner with other stakeholders to increase the number, scale, effectiveness and sustainability of linked, sequential K-16 educational and health career pipelines and support networks.**
- 2. Develop comprehensive outreach, academic, career and mentoring support strategies tailored to multiple promising target groups.**
- 3. Expand the goals of pipeline programs to improve career opportunities for a greater numbers of students who want to pursue a variety of healthcare careers, not just the “top performers,” who are tracked toward careers in medicine and dentistry.**
- 4. Develop standardized metrics to evaluate pipeline programs and track participating students.**
- 5. In partnership with health professions employers, plan and implement comprehensive health workforce pathways to support multiple target groups and also research and forecast health workforce demand**
- 6. Advocate for funding and become involved in other means of support to enhance the quality of the K-12 education system.**
- 7. Seek funding from foundations to support needs assessments and strategic plans that identify pipeline goals and create networks of support.**
- 8. Promote the development of diversity-related accreditation standards in postgraduate health professions education.**

III. Reducing Financial Barriers

The cost of higher education in general, and in HPEIs in particular has steadily increased in recent years, driven in part by budgetary cuts at the state and federal level. The net effect is that health professions education has become less accessible for lower income, ethnically and culturally diverse California residents. There are a few elite institutions with large endowments that have the means to ease financial barriers for these populations, but there has been a general upward trend in the socio-economic status of health professions students.

Financial considerations also significantly influence the selection of specific health professions disciplines, perhaps most notably in medicine, where the societal need for primary care providers is impeded by comparatively low reimbursement rates.

Recommendations

- 1. Build a framework for shared advocacy to restore and expand the funding of Titles VII and VIII of the Public Health Service Act.**
- 2. Develop new models for need-based financial aid to support the most costly health professions training programs.**
- 3. Increase investment in innovative approaches to financial support for community college, baccalaureate, and graduate-level nursing students.**
- 4. For California HPEIs and undergraduate education institutions, establish line item funding for promising diversity programs and initiatives.**

IV. Recruit, Admit, and Retain UR Students

Recruitment of UR candidates for HPEIs requires administrative leadership, engagement and buy-in among faculty, an infrastructure that will ensure success, and a commitment to facilitate shared learning among students from diverse backgrounds. Insufficient attention to any of these areas limits both effectiveness and sustainability of efforts.

Building an effective HPEI admissions process requires the development of committees with a diversity of expertise and experience. It must also be supported by an ongoing educational process that ensures understanding and awareness of life challenges faced by UR youth, and the importance of building a critical mass of diversity to enhance the quality of higher education for ALL students.

Most HPEIs claim to employ some form of what is referred to as “whole file review,” an approach to admissions that balances an emphasis on test scores and GPA with consideration of both experiences and challenges overcome by students in their pursuit of health professions careers. There are wide variations, however, in the approach of HPEIs

to the implementation of this approach. The use of different criteria, weighting, and use at different junctures in the evaluation process can profoundly impact results.

Recommendations

- 1. Target investment and coordination to strengthen recruitment of UR and disadvantaged students at CSUs and CCCs.**
- 2. Reflect commitment to diversity in admission committee membership.**
- 3. Document the process by which administrative leaders “set the tone” for admissions committee commitment to diversity.**
- 4. Place senior faculty with understanding of UR issues in admissions committee leadership.**
- 5. Conduct further inquiry into alternative strategies to implement “whole file review” approach to admissions.**
- 6. Increase paid practical and research internship opportunities for undergraduate students with leading employers and HPEI faculty.**
- 7. Increase paid post-baccalaureate fellowship programs or jobs to provide UR students with experience, mentoring, and application preparation.**
- 8. Increase outreach to undergraduates and community college students and parents about public health careers, graduate education and how to advance.**
- 9. Increase enrollment in public health schools and programs.**

V. Create a Supportive Environment

At its broadest level, comments from interviewees suggested that creating an institutional climate that is supportive of UR students, faculty and staff, is an ongoing process, rather than a static endpoint. This process requires more than achieving a “critical mass of diversity,” in terms of adequate representation of people from diverse backgrounds; often referred to as structural, or compositional diversity. It also requires the integration of diversity-related material throughout the formal curriculum, and an infrastructure that provides opportunities and encourages cross-cultural dialogue. Attention to all three dimensions provides optimal support for UR students, faculty and staff and of equal importance, enhances the quality of the educational experience for students from all backgrounds.

There are a variety of approaches to build a supportive institutional climate, including, but not limited to the development of pre-matriculation orientation programs, the

establishment of formal entities that coordinate student support systems, and pedagogical innovations that facilitate shared learning within and external to the formal curriculum.

Recommendations

- 1. Create an office of diversity as part of an overarching institutional strategic planning process.**
- 2. Conduct an assessment of the institutional climate.**
- 3. Establish formal funding and structural support for UR student mentoring.**
- 4. Create mechanisms to strengthen links to UR student families and communities.**

VI. Recruit and Retain UR Faculty

All HPEI leaders acknowledge that they have too few UR faculty members. While there is broad consensus on the need an increase, administrators and faculty have disparate explanations for the lack of progress to date. They also hold a range of views about the steps that should be taken to build an ethnically, racially, and culturally diverse faculty.

The first and most obvious reason cited for a lack of UR faculty is the relatively small pool of UR HPEI graduates. Another challenge to UR faculty recruitment, cited most often in dentistry, is competition with higher salaries in the private sector. A key factor to consider in reforming HPEI recruitment practices is the role played by influential faculty who serve as “gatekeepers” on search and tenure and promotion committees. Sometimes the tendency is to focus on narrow criteria such as publications in prestigious, peer-reviewed journals and a track record that maps neatly onto historical prototypes.

Building a diverse faculty is an ongoing endeavor that extends well beyond recruiting UR faculty. For example, some informants describe growing their own faculty as a short-to-midterm strategy to increase faculty diversity. In general, the culture of a school or department must undergo an evolutionary process that not only supports and values diversity in all facets of intellectual and communal life but also demands the benefits contributed by a diverse faculty.

Input from interviewees indicates that UR administrators and faculty carry a disproportionate burden of responsibility for committee service and student mentoring and advising of both UR and non-UR students. The net result is less time for UR faculty to devote to their research. The extent and nature of this burden appears to be poorly understood by non-UR HPEI administrators. Further inquiry, additional support, and realignment of criteria for promotion and tenure are needed to accommodate these practical realities. Attention should also be given to the mentoring of junior UR faculty, to help negotiate and optimally advance in HPEI systems.

Recommendations

- 1. Establish criteria for faculty search committees that address competencies in teaching, community-based research, and student mentoring.**
- 2. Document annual inventories of efforts to recruit, hire, and retain an ethnically and racially diverse faculty.**
- 3. Institutionalize efforts to recruit faculty from UR graduates.**
- 4. Establish criteria for tenure and promotion that document and reward extraordinary administrative and mentoring responsibilities.**

VII. Curriculum

There are perhaps as many definitions of cultural competency as there are HPEIs to teach it. Our informants at all four types of HPEIs recounted numerous examples of how their students learn about cultural differences, cultural sensitivity, cultural humility, cross-cultural healing, and their own cultural identities. The combined approach of weaving cultural competency throughout the curriculum while also offering stand-alone courses is an important approach that appears to be in place in the nursing and medicine HPEIs in our sample, but less integrated in dentistry and public health HPEIs.

Leaders identified students as a vital “resource” for faculty and other students to learn about cultural competency, especially in departments with few or no UR faculty. There is general acknowledgment, however, that both students and faculty need instruction to build cultural competency. Building cultural competency among faculty can be a challenge when there are few UR faculty, and little interest among non-UR faculty.

In general, the structure of health professions education is undergoing substantial change to accommodate the evolving needs, preferences, and demands of students, faculty, healthcare systems and institutions, and society. These changes are informed by close examination of lessons from best practices in health professions pedagogy.

Recommendations

- 1. Commit sufficient resources and personnel to provide a coherent, integrated diversity curriculum.**
- 2. Implement non-didactic methods of instruction and learning.**
- 3. Prioritize instruction and learning modalities to increase awareness and sensitivity to health disparities.**
- 4. Establish affiliations with community-based health professions employers.**

Part Two: Health Professions Employers

Health professions employers (also referred to as “demand-side” organizations in this report) play a major role in increasing health professions diversity. To that end, CTD team members conducted key informant interviews that examined similar issues to those explored with HPEIs.

I. Relationships with Communities

Health professions employers play an important role in their community, and we explored ways they may increase their impact on health professions diversity and the health of our emerging majority populations.

One important community role for health professions employers is investment in expanding the K-16 pipeline. Ongoing, coordinated investment helps to build “networks of support” that strengthen the educational experience and career preparation for under-represented youth in urban and rural public schools.

Given a continuing debate in the field about the age at which mentoring and other career development activities have the greatest impact, we found many demand-side organizations engaging at different levels. While most programs are small in scale, interviewees often cited examples of positive outcomes, particularly those where strong bonds have been established between young people, the health professional role models, and the health profession employers that serve as program hosts or sponsors.

Among the organizations we interviewed, most of these programs were supported with discretionary funds, and the “case” for more sustainable funding had not been made. We also found that many of the diversity champions that often ran the programs felt that they needed more assistance in effectively “making the case” to senior leadership.

Health professions employers also play other roles in the community. For example, assessing and responding to health disparities is one area in which they may make important contributions. Health professions employers are also forming and/or participating in collaborations at the local, state, and national levels to advocate for increased investment in low income, ethnically and culturally diverse communities.

One important area where health employers could increase their advocacy efforts to benefit individuals, community and health workforce and diversity is K-12 reform. Many health employers we interviewed expressed serious concern about the quality of K-12 education in California and in their communities. Given the influence of health organizations and their employees, this form of advocacy could yield significant benefits, and is consistent with the larger social responsibility of all health professions employers.

Recommendations

- 1. Nonprofit hospitals can use community benefit programming and produce measurable impacts in communities that experience health disparities.**
- 2. Engage in partnerships with HPEIs, colleges and universities, K-12 schools, and community-based organizations to build networks of support for UR youth.**
 - 2a. Use school-based health centers as an entry point for exposure and education of elementary and middle school students to health professions career options.**
- 3. Create and participate in regional workforce planning partnerships.**
- 4. Nonprofit hospitals can invest in the pipeline with attention to regional workforce needs based upon community benefit principles.**
- 5. Advance workforce diversity goals by having leaders advocate for relevant public policy reforms.**

II. Relationships with HPEIs and Training Issues

An important part of the decision to include demand-side institutions in the key informant discussions of the CTD initiative was the recognition that teaching hospitals (and increasingly other sites where patient care is delivered) play critically important roles in the training of health professionals.

Our interviews suggest that concerns about diversity varied greatly among teaching hospitals and often (particularly for larger teaching institutions) varied among different residencies within the institution. Even when there is institutional leadership and commitment, we heard that moving forward at the institutional level is problematic, given relative autonomy within specialty areas. More often than not, our interviews seemed to indicate that advancing diversity per se as a key goal was not generally on most hospitals radar screen of priorities. Most leaders expressed support for diversity, but action leading to greater diversity tended to occur as a result of pursuing some other goal than also happens to concomitantly advance racial or ethnic diversity.

Some of the smaller teaching hospitals across the state have greater challenges in recruiting residents, particularly American UR graduates—even when they are located in communities with diverse patient cohorts. Isolation in terms of few UR faculty and peers who are at the smaller programs is one of the barriers. Often, for these smaller or less prestigious programs, they need to recruit international medical graduates—mostly ‘of color’ to meet their house-staff needs. These physicians sometimes have their own cultural competency challenges when dealing with the diverse array of American patients whom they encounter in California’s hospitals.

Community health centers can play an important role, by providing health professions trainees with exposure to experience that will build cultural competency, and at the same time, increase access to care for underserved communities. The desire for residents among community health centers appears to have decreased over the years, however, due to a lack of financial support at the federal level and from academic and teaching hospital affiliates.

California local health departments are well situated to provide teaching opportunities to HPEI students where work force diversity and health disparity issues are often a central concern. Our interviews revealed significant variation in the level and form of relationships with HPEIs. In physician training, health department experiences can sometimes educate and attract young physicians to consider the challenging but invigorating careers that are available in public health practice.

One of the important areas we explored with health professions employers was about the ways in which they communicate to HPEIs in the region the importance of prioritizing diversity goals at their schools. In the midst of other obligations, it appears that most leaders do not consider that simply emphasizing the importance of diversity as an organizational priority might make a difference.

Recommendations

- 1. Emphasize multicultural education, training, and patient care (in particular teaching hospitals and other HPEI-affiliated training sites).**
- 2. Teaching hospitals that lack a critical mass of UR residents can establish partnerships with other teaching hospitals within their geographic area.**
- 3. Encourage HPEI-affiliated staff to participate in HPEI administrative and decision-making structures to educate colleagues about the benefits of diversity.**
- 4. Create emergency loan funds at teaching hospitals to reduce attrition or disruption of educational experiences for students and postgraduate trainees.**
- 5. Support UR faculty through the hiring, retention, tenure, and promotion processes at teaching hospitals as well as at affiliated HPEIs.**
- 6. Develop creative funding mechanisms through public/private partnerships to increase clinical rotations in rural and urban community health centers.¹**
- 7. Teaching hospitals with primary care training programs should seek medical school affiliations for their staff physicians.**

¹ This recommendation was developed in conjunction with the California Health Professions Workforce Diversity Advisory Council (HPWDAC), a body convened by the CA Office of Statewide Health Planning and Development (OSHPD) as part of a project funded by The California Wellness Foundation. The recommendation was one of nine recommendations in a final report published in May 2008.

8. Create, participate in, and financially support partnerships with nursing programs.

III. Workforce Issues

In light of current health professions workforce shortages and geographic mal-distribution, workforce development has become a priority issue for health care delivery organizations. In general, we found that the immediacy of these shortages for some organizations has meant that increasing diversity may be viewed as a second-level priority. Nevertheless, demographic realities in the state will require particular attention to the needs of our emerging majority populations, and building a workforce that understands how to best meet their health needs.

Workforce shortages, the desire to provide career advancement opportunities to existing staff, current K-16 pipeline limits and the increased demand for UR professionals has led an increasing number of health employers to focus on incumbent worker development. Health professions employers also forge partnerships with HPEIs to fill projected needs for nurses, various allied health professionals, medical records staff, and business office personnel. By underwriting the cost of tuition and support services that ensure students' academic and professional success, these institutions invest in both the pipeline and their future workforce.

Workforce shortages for rural safety-net provider organizations and public health departments can present unique challenges. Most of California's medical schools are located in urban areas. Overall, little attention is paid in medical school or residency curricula to rural or public health issues.

One informant suggested that competition between the most selective teaching hospitals to fill residency slots with medical graduates who chose their institution as a top match contributes significantly to the geographic mal-distribution of physicians in general and UR physicians in particular. Some rural interviewees mentioned that an increasing challenge for the California rural health workforce is a growth in prisons and their demand for health professionals. In light of projected rates of population growth and provider retirement, many workforce shortages are expected to worsen unless definitive action is taken.

Physician shortages have encouraged internationally-trained medical graduates (IMGs), who are also referred to as foreign medical graduates, to emigrate to the U.S. in increasingly large numbers. However, some of our informants expressed concern that cultural differences between providers and patients from different countries and cultures sometimes create communication difficulties and conflicts that are not easily overcome.

Leadership development and succession planning are key areas of focus for health professions employers in efforts to increase diversity. There is growing recognition that

the dearth of UR senior administrators and the “graying” of current leaders present both a challenge and an opportunity. Often overlooked is the fact that diversity among senior health administrators and board members is often even less than in clinical health professions. In recognition of its importance, an increasing number of organizations are engaged in programs with a particular focus on increasing diversity in management.

Race and ethnicity is difficult to discuss and identifying—not to mention changing—prejudiced behavior and attitudes, especially when they are institutionalized in a mainstream organization’s culture, can be extremely challenging. Health professions employers with the active involvement of a critical mass of leaders committed to diversity is essential to ensure that this priority does not die with the departure of a particular diversity champion. While the support of leadership is critical, so, too, bottom-up efforts initiated by students, health care workers, and community activists can be an effective way to develop and implement diversity initiatives.

For a health workforce and leadership that better reflects the racial and ethnic makeup of our communities to ultimately result in improved quality care and outcomes, health employers must create the conditions for staff from all backgrounds to become more culturally competent. Cultural and linguistic competency system development and training for clinicians, management, and boards of directors is also needed on an ongoing basis to advance patient-provider relationships and strengthen relationships that may be strained by misunderstandings over cultural and other differences. The rapidly changing racial/ethnic demographics of California’s communities and regions make advancement in this area more urgent.

One out of every six Californians—over six million people—are limited English proficient (LEP) and would benefit from the services of health care interpreters. Yet many health care organizations lack bicultural and bilingual staff and services, thereby constraining their ability to provide high quality, culturally appropriate care to their LEP clients and patients. Many organizations use employees, such as front office staff, to assist with medical interpretation (in addition to performing their primary job responsibilities) but such services are inadequate, unreliable, and inappropriate. Health professions employers report that there is a general lack of funding to hire certified interpreters, despite the fact that certifying and paying for professional interpreter services are essential health care services.

It is widely recognized that some health care delivery organizations hire clinicians away from safety-net providers with offers of extremely attractive salary and benefits packages that incumbent employers cannot match. This kind of competition between health care organizations at a time of severe workforce shortages places an enormous burden on safety-net providers and other community-based organizations that already struggle to fill positions and lose their investment in the training and building cultural competence among clinicians when they leave the organization to accept more remunerative positions elsewhere.

On the other hand, partnerships between safety-net providers and other organizations, particularly hospitals and health systems, can benefit the participating parties and wider community by reducing duplication of efforts, increasing economies of scale through strategies such as bulk purchasing, and building platforms for shared policy advocacy.

In general, the combination of increases in costs, demand for services, and shortages among various disciplines means that safety-net employers have more competition than ever and fewer resources. They recognize and appreciate that other health professions employers seek to build a more ethnically and culturally diverse staff. In doing so, however, it is essential to approach health professions workforce development from a more holistic perspective that takes into consideration the critically important role of safety net institutions in urban and rural communities.

Recommendations

- 1. Develop strategies to increase diversity across all job categories.**
- 2. Health care providers and health plans can share cultural and linguistic competency resources and exemplary practices.**
- 3. Demonstrate commitment and organizational leadership through the ongoing development of a diversity-supportive organizational culture.**
- 4. Create specific diversity objectives under the responsibility of health profession employer managers at all levels**
- 5. Nonprofit hospitals can share employment of clinicians with community health centers and pay salary/benefit differentials as a community benefit.**
- 6. Provide targeted funding for community health centers to support community-based career fairs.**

Part Three: State Health Agencies

State health agencies play many critical roles in efforts to increase health professions workforce diversity. At the core, they administer and finance essential health care and public health functions, and assess performance to ensure service quality and access. They also administer programs intended to ensure an optimal flow of students into our health professions educational institutions and communities. Agencies also collect and report on health professions utilization and workforce data and offer workforce development programs. Finally, the State is also a major health employer, including many employees whose functions directly interface with or are critical to the provision of care, services or coverage to racially and ethnically diverse communities.

Given these roles, our team interviewed State agency leaders to gain insights into how the State can enhance its impact on development of a health professions workforce that effectively and efficiently serves the residents of California. In the course of our dialogue with State agency leaders, we also explored opportunities to expand the scale and effectiveness of the State's impact on health workforce and on important health issues to our increasingly diverse population.

Many State programs are quite small, and while individual program and student successes are important, it is fair to ask whether the impact at the population level is significant. Of equal importance, there should be an evaluation of the relative cost-effectiveness and sustainability of alternative approaches. At a time of constrained resources, it is more than appropriate to take steps that ensure an optimal use of public dollars. It is also appropriate to examine whether better coordination across programs (and associated State agencies) may yield significant benefits unrealized to date. Given the lack of meaningful progress to date in increasing diversity in California's health professions workforce, these are all relevant questions.

Some informants expressed concerns that the impact on health workforce and diversity will be limited in effectiveness unless California HPEIs have the capacity to accommodate the increased pool. Another leader suggested that health professions employers should play a role in encouraging HPEIs to expand capacity in this regard.

One State leader noted that the Executive branch has the potential to facilitate a systematic, regional approach to enhance coordination and actions among schools (i.e., UC with CSU with Community Colleges) to expand training program slots, enhance pre-requisite access and other things that can lead to an increase in the pool of UR students. Of equal importance, the Legislative branch has the means to establish clear-cut requirements through policy development. Some State agency leaders noted the importance of the legislature influencing and holding the University of California System, UC leaders and campuses accountable for meaningful progress on workforce and diversity through the budget process.

A number of State officials acknowledged the importance of data as a starting point for discussions and workforce planning, and noted that there is a need for greater awareness of the current state of affairs. At the same time, a number of State health agency informants cited a lack of California-derived data as impeding evidence-based discussions and planning around diversity. The common practice of using national-level diversity-related data is problematic due to limited quality and applicability to the unique demographics in California. Informants also discussed the need for regional level data by health profession to document current gaps and facilitate more accurate projections of future workforce needs and demographics related to the general population, talent pool.

The recent passage of SB 139 to establish the California Healthcare Workforce Clearinghouse within OSHPD creates an important resource for state and regional health professions workforce planning. Some informants expressed concern, however, that the legislation calls upon state licensing boards and state higher education institutions to

collect key health workforce and diversity data elements, “to the extent available.” The voluntary nature of this language creates significant potential for failure to achieve the intent of the legislation.

In our examination of the issue of cultural and linguistic competency, we found that the State health agency monitoring in this regard is largely limited to language access. It is unclear the degree to which monitoring of language access will contribute to an increased focus on health workforce diversity among provider organizations.

An important factor in State agency efforts to build a more culturally competent and diverse health workforce is their internal capacity. This is reflected both in terms of their ability to build a critical mass of diversity in their own workforce, and whether they have the breadth and depth of expertise to effectively fulfill their stated mission.

Changes in administrations often present challenges to building and retaining staff with much needed expertise, given shifts in priorities and levels of funding. Across the board hiring freezes can also result in the loss of key personnel who are funded through legislative mandate for special projects that may have involved substantial investment of time and resources. In the absence of more “surgical” approaches to budgetary fluctuations that more carefully weigh consequences, there may be substantial missed opportunities for State leadership.

The lack of a comprehensive workforce planning and development for California to date at the state and regional level impedes efforts to expand pathways of opportunity for UR youth through greater coordination, targeting, and enhancement of the patchwork of current programs. There are immensely important contributions that can be made by educational institutions, health professions employers, and community-based organizations, if provided with the knowledge, guidance, coordination, and incentives. State health agencies and political leaders are in a unique position to provide this kind of support.

State health agencies can “set the table” through data collection, planning, and facilitation, but it is critically important to bring stakeholders together at the regional to coordinate efforts. This level of engagement is required in order to accommodate unique characteristics and make optimal use of available assets. Of equal importance, stakeholders disaggregate data collected at the state level and more closely examine regional variations in current and projected needs for different disciplines.

A number of State agency leaders acknowledged the importance of workforce development as part of comprehensive health reform in California. While issues around workforce development and diversity were not included in the Governor’s Healthcare Reform Initiative, there appears to be interest in moving the agenda forward via legislative authority. One mechanism under consideration by legislators and the administration, given current budget constraints is the development of a public/private partnership with health professions employers, foundations, and other key stakeholders.

Considerable momentum has been established through the hard work and passionate commitment of individual leaders in our academic institutions, among our health professions employers, and in our communities. Data collection, comprehensive planning, coordination, and ongoing support from our State agencies will be necessary to translate the current momentum into a positive reality for the people of the state of California.

Recommendations

- 1. Strengthen state level data collection and reporting on workforce and diversity.**
- 2. Require annual reporting from HPEIs on accomplishments and plans to increase diversity in the coming years through state legislation.²**
- 3. Require evidence that nonprofit hospitals and health systems undertake definitive efforts to increase the diversity of their workforce through legislature and enforcement by relevant oversight agencies (e.g. OSHPD).**
- 4. Develop local and regional collaboratives to build common understanding and establish priorities, goals, and strategies to increase health professions diversity through shared investment of resources and expertise.**
- 5. Create a sustainable funding mechanism to create an infrastructure for collaboration that effectively leverages the expertise and experience of diverse stakeholders at the local and regional level.**
- 6. Develop and implement a comprehensive, multi-year health professions master plan for California that addresses both diversity and cultural competency.**
- 7. As part of the master plan process, conduct a gap analysis³ of current government, regional, professional and CA state initiatives to identify major strengths and gaps relative to local and regional needs.**
- 8. Establish an organizational “home” or other mechanism for planning, coordination and implementation of statewide health workforce diversity initiatives.**

² A version of this recommendation was advanced by Governor’s Health Professions Workforce Diversity Advisory Council and included as Higher Recommendation #2, page 14 of the report released in May 2008.

³ A version of this recommendation was also advanced by the Governor’s Health Professions Workforce Diversity Advisory Council as Overarching Recommendation #2, page 10 of the report released in May 2008.

Introduction

The United States is a highly diverse nation—ethnically, racially, linguistically, and culturally. Demographic trends indicate that nonwhite racial/ethnic groups will comprise the majority of the country's population before the end of the 21st century. In California, whose Caucasian population is 44 percent, this “majority/minority” trend has already been realized.¹

The percentage of African-Americans and Latinos in our nation's health professions workforce, however, lags woefully behind their population proportion in the overall US population.² This disjuncture presents us with a number of challenges, including negative health consequences for African Americans, Latinos, Southeast Asians, Pacific Islanders, and Native Americans, due in part to a lack of healthcare providers and related organizations to deliver linguistically and culturally appropriate services. A large and growing body of evidence indicates that the health status of people of color and the quality of educational experiences among health professions students both would be significantly improved by reducing this gap.³ Studies indicate that when given a choice, patients of color are more likely to select healthcare providers who share their racial/ethnic background.^{4,5} Furthermore, patients of color are more satisfied with the care they receive from providers of color.^{6,7}

In recognition of the gravity of this problem, numerous philanthropic institutions have implemented significant funding initiatives at the national and state levels to increase public awareness and encourage strategic action by educators, practitioners, policy makers, and other stakeholders. At the national level, the W.K. Kellogg Foundation took a leadership role in 2003 by funding the Institute of Medicine (IOM) to conduct a major study. The report, “In the Nation's Compelling Interest,” includes a set of findings and

¹ Source: U.S. Census Bureau, California, racial breakdown, 2005, <http://quickfacts.census.gov/qfd/states/06000.html>. Retrieved on 2007-02-11.

² For example, Sullivan Commission reported that racial and ethnic minorities comprise 26% of the population of the United States, but only 6% of the U.S. physician workforce. A 2002 report noted that in California, Latinos and African-Americans, who comprise about 35.3 percent and 6.3 percent respectively of California's population, are significantly underrepresented among dentists. Historically racial and ethnic data for dentists in California has not been tracked adequately, but a recent reporting of dentists in their 20s and 30s who responded to race and ethnicity questions reveals that 5.8 percent are Latino, 1.7 percent are African-American.

³ See, for example, Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*, Washington, D.C.: The National Academies Press, 2004; and Louis W. Sullivan, *Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce*, 2004.

⁴ L. Cooper-Patrick et al., "Race, Gender, and Partnership in the Patient-Physician Relationship," *Jama* 282, no. 6 (1999): 583-89.

⁵ Bender, D. J. "Patient Preference for a Racially or Gender-Concordant Student Dentist." *J Dent Educ* 71, no. 6 (2007): 726-45

⁶ T. A. Laveist and A. Nuru-Jeter, "Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care?," *J Health Soc Behav* 43, no. 3 (2002): 296-306.

⁷ D. J. Bender, "Patient Preference for a Racially or Gender-Concordant Student Dentist," *J Dent Educ* 71, no. 6 (2007): 726-45.

recommendations to advance the field.¹¹ The Kellogg Foundation also funded the establishment of the Sullivan Commission, under the leadership of former Secretary of Health and Human Services, Dr. Louis W. Sullivan. The Sullivan Commission convened a series of public hearings across the country to solicit input and increase public awareness. The Sullivan Commission report, “Missing Persons,” compiles findings and recommendations from the hearings.¹² It was expected that members of disparate communities and leaders in the field alike would use both reports’ findings and recommendations to sound a clarion call to health professions educational institutions (HPEIs) and healthcare institutions to increase workforce diversity.

In the wake of these national studies, members of the IOM committee and the Sullivan Commission from the University of California, Berkeley School of Public Health (UCB SPH) and the Public Health Institute (PHI) in Oakland began discussions with The California Endowment (TCE) to consider implementation of the IOM and Sullivan Commission recommendations and other strategies in California to advance health workforce diversity. TCE proposed that a key first step in considering how to move forward with the IOM and Sullivan recommendations was to conduct a series of California-focused inquiries to provide insights into the current status, issues, challenges, and opportunities in California, and to develop a set of recommendations that make optimal use of available resources in the public and private sector. In response, PHI and UCB SPH partners designed a major study with seven separate, but inter-related inquiries. This report represents one of those seven inquiries, and shares findings and recommendations based upon a series of group and individual key informant interviews with HPEI and health professions employer leaders.

¹¹ See footnote 3.

¹² See footnote 3.

Report Purpose

Increasing diversity in the health professions requires concerted individual and coordinated efforts by health professions education institutions, health professions employers, government agencies and key stakeholders in the communities they serve. The purpose of this study is to solicit input from leaders of these organizations in California on the issues, challenges, and opportunities associated with efforts to increase diversity within their organizations, in the health professions educational pipeline and in the health workforce. Sixty-eight key informant interviews were conducted with organizational leaders to obtain these insights. The results are intended to provide evidence, insights and recommendations that better inform organizations, advocates and funders in their efforts to accelerate and advance health workforce diversity.

Report Objectives

1. To understand key issues and associated successes or failures in the advancement of health professions workforce diversity.
2. To learn about institutional innovations and strategies implemented to advance diversity in HPEIs and health professions employers, accomplishments to date, and lessons learned.
3. To identify and examine key *challenges* that have been encountered in efforts to increase diversity among HPEIs and health professions employers.
4. Based upon the information drawn from the interviews, develop a set of recommendations to increase under-represented (UR) students and faculty in HPEIs, increase UR hiring among health professions employers, and increase the retention of UR students, faculty, and employees.

Organization of Report

The report is divided into three parts, each covering a different class of institutions included in the key informant interviews. Part One covers HPEIs, Part Two covers health professions employers, and Part Three covers State agencies. Each of the three parts is divided into sections that address different functions or roles of the organizations relevant to efforts to increase diversity. In Part One, some sections are divided further into subsections that address distinctive functions, roles, and dynamics within disciplines.

At the end of each section, there is a set of recommendations that outlines strategies to address issues, challenges, or opportunities identified by key informant interviewees. In some cases, recommendations are a direct outgrowth of suggestions by informants; in others, the recommendations were developed by research team members and informed by input from the Connecting the Dots Statewide Advisory Committee. A number of the recommendations have also been refined based upon input provided at the CTD statewide conference held on October 9th and 10th, 2007.

Study Design and Methodology

This report provides findings from 68 interviews with leaders of health professions education institutions, health professions employers, and government agencies. During the ten-month period spanning October 2006 through July 2007, group and individual key informant interviews, ranging in length from one hour to two-and-one-half hours, were conducted in metropolitan centers and rural areas of California. Almost all interviews were conducted in-person; six individual interviews were conducted by telephone.

Based on data and information collected in these interviews, recommendations for statewide, regional, and local strategies to increase health professions workforce diversity in California are proposed. The recommendations are also intended to offer guidance to the philanthropic sector as it sets funding priorities for the coming years.

Sampling Strategy

Selection of Health Professions

Four health professions were selected as the focus of this report: medicine, dentistry, nursing, and public health. Consistent with the reasoning used in the IOM study “In the Nation’s Compelling Interest,” we focus on a limited group of major health professions given the complexities and challenges associated with collecting data on the broader spectrum of health professions; and with the expectation that many of the strategies outlined in this and other CTD reports are readily applicable to other health professions.

Selection of Interview Sites

The selection of interview sites was informed by the following criteria:

- **Geographic representation**

Health needs, populations, cultures and workforce needs are different in each geographic region. Health professions training and healthcare delivery occurs in a myriad of urban and rural settings throughout the state. California’s enormous population and numerous metropolitan and rural areas are widely distributed and its HPEIs and health professions employers are located in a variety of communities. While many of HPEIs and health professions employers are situated in California’s largest cities, others are located in smaller metropolitan areas. Our sample includes institutions and organizations that represent the spectrum of population centers from Los Angeles, San Diego, Sacramento and San Francisco to Long Beach and Riverside. The demographics of these communities are changing, often rapidly. Our sample captures California’s regional diversity in the selection of HPEIs, local health departments, and healthcare employers. Regional characteristics may influence how institutions/organizations interpret and approach diversity.

- **Size of the institution**

HPEIs, health professions employers, and local public health agencies vary significantly in size. For example, while most physician residencies are located at major teaching hospitals, some residents complete their postgraduate training at smaller hospitals. Accordingly, to obtain a variety of perspectives on diversity, our sample includes both larger and smaller HPEIs, training programs, health systems and hospitals, community clinics, medical groups and local public health agencies.

- **Mission and focus**

Across the spectrum HPEIs and health professions employers have different missions and are perceived by the community—and beyond—in vastly different ways. For example, some HPEIs, including major university affiliated school and teaching hospitals, emphasize training researchers, while other health professional schools and hospitals emphasize preparing excellent primary care providers who will practice in community-based settings. We have tried to capture a range of institutions to help include these mission differences and their attendant perspectives in our sample of interviews.

So, too, an HPEI or health professions employer's mission and operational structure can have secondary effects which can affect the racial and ethnic diversity of its student body or workforce. For example, some programs focus on full-time students, while others enable students to work while attending school part time. This can have consequences for students with differing economic resources and lead to effects on racial and ethnic diversity as well. Because of the influence these factors have on diversity, programs with different emphasis were selected to participate in the inquiry.

- **Type of organization/institution**

Because organizations have different functions, structures and roles in the training and in the health delivery system, we attempted to select informants that represented the major categories of HPEI's and health professions employer types in California. Within those organizations, with four exceptions, key informant interviews were conducted at only one school, department, or program. The four exceptions are two universities, where we conducted interviews at two and three health professions schools/programs respectively; and two other universities, where we conducted interviews at a health professions school and an affiliated teaching hospital. Usually interviews were held with the senior leadership team of the organization. In many cases, people with responsibility for workforce or diversity or diversity "champions" also participated. While perspectives on diversity may differ significantly from program to program—indeed, from person to person—we adhered to this limit to include the greatest number and type of institutions in our sample. Sometimes the views of leaders or cultural norms within an HPEI affect how diversity is framed and discussed. Accordingly, we sought to minimize these effects by conducting only one interview at each HPEI with the exceptions noted above.

- **Commitment to diversity**
Some institutions and organizations have reputations for taking definitive steps to increase diversity within their student bodies and workforce. We solicited recommendations from our Statewide Advisory Committee and other sources to ensure the inclusion of these institutions in our sample.
- **Ownership structure**
Ownership structure was another key selection criterion. We chose a sample of HPEIs and health professions employers which includes a broad range of religious, public, not-for-profit, and investor-owned institutions. For instance, we conducted interviews at an investor-owned health plan as well as one that largely finances the care of Medi-Cal enrollees, community clinics, teaching hospitals, and a religiously-affiliated HPEI and health system. Our analysis explores whether and how an organization’s views on diversity are shaped by its formal structure, religiosity, governance, and/or the populations it primarily serves.

In addition to these six criteria, one other consideration shaped the development of our sample of nursing programs:

- **Paths to nursing degrees**
The current route to RN licensure in the U.S. primarily follows two educational paths: associate degree in nursing (ADN) programs that generally require two years of full-time study *after* completion of what generally amounts to two years of prerequisite courses in the sciences, mathematics, social sciences, and English; and baccalaureate (BSN) programs. In California most new nurses take the former path. Accordingly, we conducted interviews with key informants at both ADN and baccalaureate programs of study.

Based on these seven criteria an initial sample of 41 institutions was developed. Due to scheduling conflicts, hospital acquisitions, and other challenges, 12 of these institutions declined to participate. Seventeen additional organizations were subsequently invited to join the study. This increased the sample from 29 to 46 HPEIs, state and local agencies, and health professions employers. Seven of these invitees declined to participate, reducing the sample to 39 organizations.

The study’s Statewide Advisory Committee and other leaders in the field suggested that we add two new classes of institutions (i.e., biotech/pharmaceutical and independent practice associations), expand our existing categories, and interview leaders in the field. These changes resulted in a final sample size of 68, seventeen of which were interviews with individuals.

The institutions/organizations in our sample are divided into three broad categories: health professions educational institutions (HPEIs), health professions employers, and state agencies. We refer to HPEIs as “supply-side” institutions because they prepare—or supply—future generations of healthcare professionals. These institutions are a key component of the pipeline for HPEI faculty, health professions employers in the private

and public sector. HPEI interviewees were senior administrators and faculty at medical and dental schools; nursing schools, programs, and departments; and public health schools and programs. (See Table 1: Distribution of Health Professions Education Institutions)

Interviews with health professions employers (including local public health agencies) were held with the CEO and/or designated members of the senior management team, and individuals with responsibility for workforce or diversity programs. State agency interviews were held with agency directors and/or members of the senior leadership team and people with responsible for workforce or diversity related programs.

Table 1: Distribution of Health Professions Education Institutions

Medical Schools	6
Nursing Schools, Departments, and Programs	6
Dental Schools	3
Public Health Schools and Programs	5
Total: HPEIs	20

The health professions employers in our sample include California-based teaching hospitals, health systems, community clinics and clinic consortia, health plans, biotechnology companies, independent practice associations, and local public health agencies. (See Table 2: Distribution of Health Professions Employers)

Along with county health agencies we also refer to these disparate health professions employers as “demand-side” institutions because they create a significant demand for and employ professionals from the four HPEIs we studied. They also form complex community and regional partnerships with HPEIs, K-12 schools, community groups, and each other to increase the pipeline of diverse workers as we discuss later in this report.

Table 2: Distribution of Health Professions Employers

Teaching Hospitals ¹³	7
Health Systems	3
Clinic Consortia/Associations and Community Clinics	5

¹³ Teaching hospitals are, in fact, both supply- and demand-side institutions. As supply-side institutions they train medical residents and they may also provide clerkships and other clinical opportunities for medical and nursing students. As demand-side institutions they employ healthcare workers, clinicians, and administrators at all levels. While we have grouped teaching hospitals with demand-side employers, both the supply- and demand-side roles of teaching hospitals are equally valued in this study. We have analyzed the data relevant to residency training programs with the supply-side institutions and the data relevant to the employment function of hospitals with the demand-side institutions.

Health Plans	3
Biotechnology Companies	1
Independent Practice Associations (IPAs) and an IPA Trade Association	3
Local Public Health Agencies	4
Total: Health professions employers	26

Demand-side organizations also employ health professionals from fields beyond the scope of this inquiry, e.g., pharmacy, clinical psychology, and the allied health professions. Our decision to focus on four health professions disciplines follows the emphasis of the Institute of Medicine report, while also acknowledging that many of the issues, dynamics, and recommendations are relevant and applicable to other disciplines. Moreover, participants did not always limit their remarks to these four disciplines. In some cases, issues associated with other disciplines were addressed, since they were also considered priorities for the organization. For example, a number of health professions employers addressed allied health needs.

The five state agencies in our sample have responsibility for oversight of certain aspects of the healthcare workforce and diversity; and the regulation, planning and delivery of health services.

The individual interviews with leaders were categorized according to the class of institution with which they were most closely affiliated. (See Table 4: Distribution of Individual Interviews)

Table 4: Distribution of Individual Interviews

HPEI Leaders	10
Demand-side Leaders	5
State Leaders	2
Total Leaders Interviewed	17

Interview Process

The first step in the interview process was the completion of a web-based, multiple-choice, pre-interview survey.¹⁴

Interviews were primarily conducted by two senior members of the project team and followed an organization specific interview guide based on general questions for each

¹⁴ Pre-interview survey instruments were developed for each of the four categories of HPEIs, six categories of healthcare organizations, state agencies, and local departments of health. (For teaching hospitals one instrument sought data about core diversity issues affecting residency programs, while a second instrument focused on workforce and diversity issues on the administrative side.) Pre-interview survey findings are not reported as part of this inquiry. See Appendix A for sample pre-interview survey.

type of entity, overall inquiry research questions, researcher knowledge of the organization and background information garnered from the Internet and informants' responses to the pre-interview survey.¹⁵ It was planned that interviews would include between three to five key informants and two interviewers and that they would be conducted at key informants' workplaces. However, depending on the complications posed by coordinating schedules, the number of participants in a single interview varied from between one and seven. In some instances, follow-up, face-to-face or telephone interviews were conducted with key individuals who were unable to attend the scheduled interview or, for other reasons, did not meet with the project interviewers at the planned time. Interviews were digitally recorded upon obtaining informed consent.

Coding and Data Analysis

Transcripts were produced for each interview. Completed transcripts were reviewed by a project analyst, who listened to each recording while reading the transcript and made corrections as necessary. Transcripts were then uploaded into either the HPEI (supply side) Hermeneutic Unit (HU) or the health professions employer (demand side) HU. The HUs were created using the qualitative analysis software package Atlas.ti (v5.2).¹⁶ The Atlas.ti software package was selected because of its suitability for the organization, coding, and analysis of large quantities of textual material.¹⁷

A code list, informed by the Institute of Medicine recommendations,¹⁸ was developed for each HU. Additional codes were added in an iterative manner to both code lists as needed. When this occurred, previously coded transcripts were re-reviewed and the new codes were applied, as warranted. During this stage of the data analysis, research staff met regularly to discuss analytic strategies and themes and connections and discontinuities within the data.

Following the coding of all transcripts, the codes were analyzed and reports were prepared for each of the HPEIs and demand-side institutions. For example, a report was generated for the code "create supportive environment" for all segments ("quotations") from the nursing program transcripts where it had been applied. Similarly, a report was generated for "create supportive environment" for all quotations from the local public health department transcripts where it had been applied. This process enabled the research team to examine both similarities and differences between the HPEIs and demand-side institutions as well as similarities and differences *within* the HPEIs and demand-side institutions, while also providing the foundation from which the subsequent meta-analysis reports were developed. Schematic representations of the selection, interview process, and analysis for HPEIs, Health Professions Employers, and State Agencies are provided in Appendix C.

¹⁵ See Appendix B for sample interview guides.

¹⁶ An HU is sometimes referred to as an idea container enclosing a project's data, findings, and documents.

¹⁷ See R. Barry Lewis, "NVivo 2.0 and ATLAS.ti 5.0: A Comparative Review of Two Popular Qualitative Data-Analysis Programs," *Field Methods* 2004: 16: 439-64.

¹⁸ See footnote 3. Key codes include: leadership and commitment; pipeline; reducing financial barriers; recruit, admit, and retain UR students; create a supportive environment; recruit, hire, and retain UR faculty; and curriculum.

Part One: Health Professions Education Institutions

I. Leadership and Commitment

“I think that obviously, this goes with saying, we need the leadership at the very top to not only voice support for diversity at every single step of the way, but also to take action to make sure that happens.”

Medical School Senior Faculty Member

Our findings about leadership and commitment to diversity at the twenty HPEIs in our study cluster around three core themes:

- Inclusion of diversity language in mission statements and other key documents that articulate an institution’s identity, values, and aspirations.
- Evidence of demonstrated leader commitment to create an institutional climate and culture that is hospitable to and supportive of UR students, faculty, staff, and other stakeholders.
- Establishment of accountability mechanisms that support diversity as evidenced by their willingness to make structural changes, support programs and champions and make a personal commitment to the overall effort.

A. Mission Statement

There is widespread agreement among our key informants that inclusion of diversity language in an institution’s mission or values statements and the implementation of diversity-affirming policies are necessary but not sufficient conditions for creating a diverse campus culture.

Mission statements are highly variable in the ways they express—or do not express—a commitment to diversity. Organizations also vary in how and whether they use the mission statement to guide policies and decision-making. For example, the following three examples highlight alternative approaches that articulate a commitment to social justice, culture, diversity, and the underserved:

“Our mission is to develop and apply knowledge from multiple disciplines for the promotion and protection of the health of the human population, giving due consideration to principles of human rights and cultural perspectives that abound in our multicultural country and world.”

“The mission of the School is the education of professional nurses from diverse ethnic, cultural, and racial communities who are dedicated to excellence in nursing science and practice.”

“To conduct education and research in the context of community service in order to train physicians and allied health professionals to provide care with excellence and compassion, especially to underserved populations.”

The next three mission statements do not address diversity, and only two make broad references to a role in addressing broader societal and/or community needs:

“To produce, in a humanistic tradition, health care professionals and biomedical knowledge that will enhance and extend the quality of life in our communities.”

“The School strives to advance human health through a fourfold mission of education, research, patient care and public service.”

“The primary mission of the School is to provide students with a high quality professional education in nursing.”

Mission statements that include racial/ethnic diversity language indicate that an HPEI’s faculty and administrative leaders have engaged in discussions about the importance of these issues in their teaching, research, and patient care/practice. Some leaders suggest that those discussions may even be more important than the final language of a revised document. In either case, most interviewees agreed that a mission statement is a critically important tool to affirm an institution’s commitment to diversity.

B. Commitment of Senior Leadership

There is also widespread agreement that the commitment and actions of senior leadership are crucial in creating an institutional climate that is supportive and facilitates shared learning among students and faculty from diverse backgrounds. Indeed, numerous chancellors and deans told us that promoting a diversity-supportive campus culture is among their key responsibilities. “Oh, I think that’s perhaps the primary role of a chancellor,” one chancellor remarked. Leaders’ verbal and written commitments to diversity take myriad forms, such as launching a campus-wide initiative, faculty recruitment and incentives, allocating funding for new scholarships, and approving the appointment of a dean or provost of diversity. As another chancellor explained:

“I would say that the efforts toward diversifying the school that you see on a campus will reflect the position of the chancellor or the president of the university [or college]. If the president or the chancellor thinks it’s important, then you’ll see changes in a positive direction. If it’s not a high

priority, then you'll see changes either not at all or in a negative direction.”

A senior associate dean affirmed the importance of having committed leadership. She noted, however, that the reach of “leadership at the very top” is constrained by departmental autonomy:

“I think that, obviously, this goes without saying, we need the leadership at the very top to not only voice the support for diversity at every single step of the way, but also to take action to make sure that happens. I think we have the leadership at the top saying we are very committed to diversity. We are committed to not only structural diversity but to actually looking at the institutional climate for diversity and changing things. The challenge is that because we are decentralized, much of the activities of the school are located in departments. How do you get an alignment of all the departments towards this common goal of increasing diversity? And how you actually bring policy to bear on action within departments is a huge challenge.”

During the course of the academic year, dozens of opportunities arise for leaders to link diversity to their institutions' other primary goals, such as attracting talented students and faculty, responding to cutting-edge issues in the health professions—the nursing shortage, medical and dental health disparities, for example—or even dedicating a new building. Leaders' everyday as well as ceremonial endorsements of diversity can have a significant impact on policies and practices in unexpected ways:

“Another thing that had a big impact on our UR admissions was when we had an all-school meeting that the dean hosts on an annual basis. He chose, in his State of the School address, to show our numbers in terms of UR students—to show how low the percentages were and to talk about how it is a priority for the school to do better in that area. And what was interesting was, when the admissions process started up about a week after that, some of the faculty members who I wouldn't have thought were big advocates for diversity were all of a sudden saying, “Well, the Dean said this is really important, and he showed those numbers, and this is something that we need to do something about.” And it really changed their way of looking at the process.”

Admissions, however, is not the only arena in which leadership can impact diversity. The quality of students' education and of trainees' clinical preparation is influenced by the degree to which diversity is identified as a priority by HPEI leaders. Leaders can allocate funding and advocate for research and teaching initiatives that address the interests of UR faculty, students, and communities of color, such as the University of

California, Berkeley's Diversity Research Initiative,¹⁹ Bridge to Nursing at East Los Angeles College,²⁰ and the UC Davis Center for Reducing Health Disparities.²¹

A leader's ability to articulate a commitment to diversity in a compelling but non-polarizing manner is essential. At the same time, however, our informants cautioned us that individuals outside the core administration must be engaged in determining how an institution's diversity agenda will move forward. One dean described his strategy of using a light touch to maintain faculty unity, when diversity is not a universally shared priority:

“People can become defensive and all kinds of things. If we do have a faculty person who isn't in agreement, you know what we do? Gentle approach. We move kind of around them, convince them, persuade them. In other words [we don't force faculty to] take a firm position in opposition that causes them to lose face when they back away from it.”

In general, evidence of a commitment to diversity among HPEI leaders remains highly variable. For some leaders this issue does not rank as a priority. For others, while noting that the issue has importance—the reality is that there are often competing priorities that are considered more urgent, important or easy to address. As noted by one Associate Dean:

“Diversity is a priority, but it is one of 120 priorities for our school.”

In some cases leaders may feel it is a high priority but not know how to approach it and are concerned about the risk. Among the challenges are an array of external pressures, ranging from economic factors to established measures of success that don't provide incentives or attribute importance to diversity as a core value. There remains a perception that advancing student and faculty diversity may be incongruent with established measures of success within academia, their university or profession, and thus represents a risk. In many cases, campus-based diversity initiatives are supported primarily by leadership discretionary funds and/or external support. Many acknowledge the need to better document that positive impact of efforts to date as a lever to bring current innovations to scale and secure long-term internal financial commitment. A number of leaders framed this as achieving a “cultural “ change at the institutional level, where the commitment is reflected and reinforced at all levels of HPEI governance, management, and operations.

For the most part, interviewees indicated a strong commitment to diversity. We selected our sample of HPEIs precisely because it includes some of the most creative and committed leaders involved in the education and training of UR health professionals. Thus, the portrait presented in the foregoing pages may not provide a representative

¹⁹ On the Berkeley Diversity Research Initiative, see <http://bdri.berkeley.edu/> and an exemplary practice profile in the CTD report “Profiles in Leadership.”

²⁰ On Bridge to Nursing, see an exemplary practice profile in the CTD report “Profiles in Leadership.”

²¹ On the UC Davis Center for Reducing Health Disparities, see <http://www.ucdmc.ucdavis.edu/crhd/>.

picture of the leadership of all California HPEIs. Instead, we have shown how progressive chancellors and deans approach the challenge of leading their institutions toward greater diversity.

That having been said, it is important to acknowledge that bringing about meaningful and lasting change in this regard requires sustained focus. It is not enough to declare a commitment; definitive and ongoing action is needed on many levels. Given the complexity of these academic institutions, diversity as an issue must compete with many others for the attention of leaders and faculty. In assessing the commitment of HPEI leadership, it is essential to examine what specific steps are taken and what resource commitments are made to translate rhetoric into results. To bring about meaningful change and lasting progress, leadership articulation of a commitment to diversity must have corresponding resource commitments at a sufficient scale and sustainability

C. Accountability and Senior Leadership

Among the HPEI leaders we interviewed, the job performance of senior administrators is rarely tied to diversity issues or metrics. Yet given the importance of senior leadership commitment and action to advancing and sustaining diversity, our interviewees thought it important to have mechanisms to hold department chairs, deans, and higher-level administrators accountable for furthering diversity efforts. This is true whether those efforts are targeted to increasing the admission and graduation rates of their institutions' UR students, increasing faculty diversity or collaborating with regional partners to establish pipeline initiatives. Some informants indicated that at minimum, there should be accountability for having a meaningful plan for advancing diversity with faculty support and appropriate infrastructure and resource allocations. Some of the exemplary health employers interviewed had linked senior leader compensation and performance evaluation to meaningful progress on diversity metrics. This study identified two promising channels for generating accountability at HPEIs. One channel is an internal set of mechanisms and the other is informal and driven by external stakeholders

Internal Accountability Mechanism

The Academic Personnel Manual at a major university in our sample states that among the responsibilities of department chairs, deans, and higher-level administrators is responsibility for “maintain[ing] a climate that is hospitable to ... diversity [and] ... maintaining a departmental affirmative action program.” When deans, chairs, and other senior leaders have their annual reviews, their effort to increase diversity among students and faculty is one of numerous criteria on which they are evaluated. According to our informants, “When a dean is reviewed it’s qualitative. There’s no quantitative [measure for diversity success], so it’s just one of the explicit criteria in addition to how much funds did you raise and all of the other stuff.... And this is despite [Proposition] 209.” Some of our interviewees wondered about how seriously contributions to diversity are viewed and assessed relative to other criteria, when used for purposes of promotion or merit increases. Ironically, some interviewees thought that contributions to diversity and disparity issues could be entirely discounted or they could even be used to discredit an

individual's record.²² Nor were many that we spoke with very sure of whether or not and with what frequency this type of evaluation occurs at other institutions.

External-Based Accountability

Similarly, an academic program and its leadership can be held accountable by external stakeholders with no formal relationship to an HPEI. The recent history of the Thomas Haider Joint Medical Degree program at UC Riverside (UCR) offers an unusual example of a group of community physicians in the Inland Empire—members of the J.W. Vines Medical Society²³—who successfully challenged the design of the program, which had a poor record of admitting, matriculating, and graduating UR students. Not only has the program and associated support programs been re-designed, but the experience has contributed to the proposed establishment of a new UC Medical School at UC Riverside with an explicit emphasis on diversity and serving the Inland Empire region, one of the most diverse regions in the country. A profile of the J.W. Vince Medical Society's role in this process is included in a separate Connecting the Dots report.²⁴

This experience highlights the potential positive impact of establishing a local constituency that monitors, engages, and when appropriate, challenges HPEIs to address regional and statewide concerns as a part of their larger mission. While it is important for HPEIs to maintain their academic freedom, it is equally important to be responsive to emerging regional, state, and societal imperatives as a fundamental part of fulfilling their academic mission. This is particularly relevant for professional schools that produce a workforce that will serve an increasingly diverse set of populations upon their graduation.

Numerous Senior HPEI leaders interviewed also emphasized the importance of external support and accountability from state legislators or agencies. Many mentioned that progress to date was primarily supported by discretionary funding or external foundation or government grant support. Leaders emphasized that permanent “line item” funding is critical to sustaining promising programs at sufficient scale. Several UC Leaders mentioned that having line item funding in the UC System budget that than is allocated to specific campus programs is an opportunity to simultaneously obtain vital sufficient funding for diversity efforts and hold leadership accountable for meaningful plans, programs and results.

These are only three of many possible strategies for hold HPEI leaders' accountable for increasing their institutions' diversity. The high-level intervention that was required to

²² One interviewee told us about an African American faculty member who a few years ago, received a letter from the Chancellor of her university informing her that her employment would be terminated the following June. Though productive in her research in the area of health disparities in the African American and Latino communities, when she asked the Chancellor for an explanation, she was told that the decision was recommended by her dean and that her department chair was not supportive of her because she just “didn't fit.” The interviewee noted her concern that it is commonplace for African American women to be viewed by their white, male colleagues and supervisors as being a poor fit with the organizational culture.

²³ The Vines Society is a component society of the National Medical Society, which “promotes the collective interests of physicians and patients of African descent.”

²⁴ Profile B.2., “Making the Case for Diversity: Community Advocacy and Academic Reform in the Inland Empire,” in the CTD report “Profiles in Leadership: A Review of Exemplary Practices to Increase Health Professions Workforce Diversity,” pp. 71-75, April 2008.

bring about redesign of the Thomas Haider Joint Medical Degree Program underscores the challenge of implementing overarching, structural changes at HPEIs. This report and other CTD inquiries identify many strategies spearheaded by institutional leaders to increase the admission and retention of UR students and to hire and retain UR faculty. Yet some of the leaders we interviewed who are unwavering in their support of diversity policies and programs generally were clear about their institutions' limited responsibilities to necessarily assure that such policies and programs necessarily touch upon geographically proximal communities of color. To that point, we asked the dean of a health professions school whether he feels a degree of responsibility for encouraging the admission, matriculation, and graduation of students from his school's immediate geographic area. He replied,

“I think, being a public institution in the State of California, we have an obligation to all citizens of the State and all students. I wouldn't limit it to just our region. And it may be different for private universities. I'm not saying private schools wouldn't say something of the same but they're certainly compelled to do so by their charter.

We would be remiss if we don't take every advantage of all the outlets we have to get more young men and women who happen to live in this area, go to school in this area, to know about us, right? That would be my response. Now, say we have two students, okay, more or less relatively all other things being equal. One is from [another part of the state] and one is from [the next town over]. Are we going to flip a coin? Do I feel any special—? I would not make that call based on where they live. I would make it on the other things that [we] talked about.”

This dean's comment and those of other interviewees helped to highlight the challenges accompanying diversity efforts and whether or not the beneficiaries of such efforts should be society at large—or whether there needs to be concomitant gain for local communities near the institution. Such questions are especially apt when looking at the burdens—financial and otherwise which can often accompany the presence of nonprofit and governmental HPEIs. At least one public university official we interviewed lamented that, from his perspective, leadership and accountability in the diversity arena means responding to the concerns of local communities in terms of advancing the careers and opportunities of local people. He noted:

“...this was, in my opinion, a failure of our administration to properly understand the concerns of the local community and the legislature (with respect to making diversity gains locally.). They didn't pay attention, and so I mean, our faculty are probably not blameless in this, but if your administration's supposed to do something; it's supposed to figure out what the state legislature and the local community want, right? And then help the faculty deliver it. And that is the job of the administration....”

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other ‘Inquiry areas’ tied to this project, we proposed the following recommendations tied to supply side health care organization efforts tied to leadership and commitment:

- 1. Formalize institutional commitment to diversity in mission and values statements, as well as through sustained resource allocation.** This is an essential element of a comprehensive approach to produce meaningful and sustainable results.
- 2. Based on a site specific assessment of factors and conditions, develop an adequately funded strategic plan, and designate a high-ranking official to insure the implementation of the plan.** The plan should address the integration of elements into job descriptions, performance evaluations, and incentives for faculty and staff.
- 3. Leaders should be held directly accountable, as part of their job performance, to fulfill institutional commitments to advance diversity.**
- 4. Develop a statewide consensus document to identify public expectations of HPEIs to fulfill diversity-related responsibilities.** Give attention to the obligations of land-grant institutions in the 1862 Land-Grant College Act and its successor act of 1890, as well as the community benefit obligations of nonprofit hospitals.
- 5. Link HPEI recruitment efforts with the goals of statewide and local health professions employers and community-based organizations to eliminate health disparities and increase diversity.**
- 6. Institutionalize current diversity initiatives at UC HPEIs with designated line item budgeting. Reduce reliance on short term discretionary and external philanthropic funding, and establish as a percentage of annual instructional budget.** Hold leaders accountable for meaningful plans, programs and results.

II. Expanding the Pathway and Pool

For the public, as well as for most administrators and faculty at health professional educational institutions, the issue of how best to advance the racial and ethnic diversity of entering classes of health professional trainees tends to be viewed as a near term challenge. The main focus for HPEIs is what can be done now to increase the diversity in next year's entering class. We found most HPEIs devote their resources and energy to competing for the current small pool of UR applicants that meet traditional academic criteria, rather than investing in expanding the pool. When efforts are unsuccessful, the most common perspectives expressed in interviews were "they [qualified UR candidates] are just not out there" or "we don't have the resources to compete [e.g., with Ivy League schools]".

As we discussed this issue with our HPEI interviewees, many indicated that a 'better and more sustainable path' to increase racial and ethnic diversity in the health professions is to improve the education and social opportunities for UR students long before they ever apply to health professional schools. Such an effort, many of our interviewees reminded us, would significantly increase the number of qualified UR students who would be part of the applicant pool at HPEIs.

This sentiment is supported by research that shows dropout rates exceeding 50% in urban and rural public schools with high proportions of African American, Latino, and other groups under-represented in the health professions. In order to address the issue of academic achievement in communities with large and growing populations of UR youth, there is a need to create comprehensive and sustained long-term efforts that involve multiple institutions and stakeholders at a regional or community level. The vernacular for these efforts is often referred to as the 'pipeline' for health professions training.

In this section we share what we learned on this topic from our interviewees. Study participants had many uses and definitions of the term pipeline. For purposes of this study, 'pipeline' encompasses a wide range of activities spanning connections between HPEIs, health employers and others (often schools) from kindergarten age through college graduation, participation in health professions schools and employment. For some of our interviewees, the pipeline notion includes post college efforts (e.g. post baccalaureate programs) all the way through affirmative attempts to assure that more UR people are part of the applicant pool for faculty, department heads and deanships.²⁵ Our summary of findings on efforts to expand the pipeline covers kindergarten through college years, including post-baccalaureate programs. For clarity, we break our discussion into a subsection detailing the K-12 years, followed by a findings discussion from our interviews summarizing efforts focused on college students through participation in post-baccalaureate programs. We precede these summaries by a discussion of some general pipeline program issues and themes that affect efforts at almost all levels.^{26,27} For excellent sources of California-based research, see findings of

²⁵ Faculty advancement and related issues are discussed in Section VI.

²⁶ The CTD report, "Increasing the Diversity of the Health Professions: K-12 Networks of Support" provides more detail on the issues tied to HPEI connections with K-12 pipeline efforts.

Carline and Patterson (2004)¹ as well as Grumbach et al (2003)¹ to gain a more detailed review of specific information about the efforts of HPEIs in this regard. The following section includes findings gleaned from our interviews with HPEI faculty and administrators on pipeline issues and programs at their institutions.

A. General Issues and Themes

The first general issue raised by interviewees was the meaning and relative utility of the “pipeline” metaphor as a starting point for discussion. Examples of interviewee comments in this regard include:

“There are a bunch of pipes, but no pipeline. There are a large number of different programs aimed at increasing the number of UR students who may someday become a health professional, but they lack coordination.”

“The pipeline isn’t actually a pipeline, but more like a funnel that is meant to weed people out rather than get people through.”

“The pipeline has ‘clogs’ in it at certain key points. The goal is to determine where the flow is getting clogged up, figure out why the clog is occurring, and resolve the problem so that the people will “flow” in greater numbers.”

A few interviewees questioned the utility of the metaphor, which suggests there is a prescribed route that carries one from whatever background they have to a final ‘collection point’ of matriculation into a HPEI. One respondent suggested that the use of a “river” metaphor might be more appropriate, reflecting a flow that can be diverted, redirected, pooled, drained, infused, etc.:

“...we’ve been talking about this for the last three decades and in medicine, the idea was to get to 3,000 historically underrepresented minorities by the year 2000. Didn’t even get close. And that was with a lot of very well intentioned people. There’s a wonderful book out called “The Shape of the River,” which is much more accurate in the sense there’s so many obstacles or potential obstacles to derail a young person who might succeed and end up in a professional school like medicine, dentistry, pharmacy, nursing. And you really have to be there at the time of the obstacle to help with that. And it means the coaches, after school, parenting and especially we’re a port of entry here so we’ve got a very dynamic population. If we could change the numbers from one to two percent to ten percent, just that much, it would be remarkable.”

²⁷ There are numerous pipeline programs documented in the CTD report “Profiles in Leadership: A review of Exemplary Practices to Increase Health Professions Workforce Diversity in California.”

A key determinant of whether HPEIs invest in expanding the pipeline is whether senior leaders view it as within their purview. While all acknowledged it as a problem, some viewed it as a larger societal challenge to be addressed by others. For many, however, it is viewed as a shared responsibility in which HPEIs can play an important role. As stated by one chancellor:

“I became convinced that I have to do something actively as a leader. You can't just hope something happens, you have to make some inroads from actually working hard to try to bring under-represented minorities into the system, so that's led to a whole myriad of different operations.”

An HPEI dean also spoke to the importance of leadership from HPEIs in opening up doors to efforts that may already be ongoing in the community in this way:

“I'm very interested in looking at why pipeline efforts have failed because I would like to see - and one of my guesses is that you can have the pipeline working very well in the community but if the doors aren't open on the - at the institutional level, you know, that pipeline's going to run up against a wall there.”

Another general theme that emerged in interviews was the importance of collaboration in pipeline efforts. In order to try to influence the factors that will affect whether or not UR students can successfully navigate through to be able to seek training at HPEIs, our interviewees noted that there is a need for far greater joint planning among a range of actors including programs at different educational levels and health organizations. Some collaborative arrangements are vertical within regions, linking schools and students at all levels:

“...we have a vision, and we try to get funding for it, and we work with partners in our local area to create a sequential path of support from the intermediate school, high school, undergraduate, and graduate school, and having exposure, experience, mentoring, academic support, psycho-social support, along the way...The vision of people at involved is to link them so that there is continuity of support from one level [to the next].”

Other HPEI pipeline collaborations can be horizontal--across similar schools from the same health profession. One dental school dean involved in the Dental Pipeline Initiative talked about it this way:

“I think that the trust that has developed, particularly in admissions [among different schools], to say that we're not stealing students, we're really are working together to nurture this individual. And we count success as an individual who enrolls in dental school. They may not come to xxx and they may not come to yyy, but if we have had any work with that individual, we count that as success if they end up in a dental school.”

Some interviewees also identified the need to improve collaboration and coordination within their own campuses:

“These are the five colleges here on campus, and twenty-three of our departments are represented on this [pipeline] effort because frankly they all exactly [are working on] the same issues at hand--a lack of diversity in the student body, a lack of diversity in the faculty, a lack of ability to retain students after their first year or two in any of those disciplines, as well as placing those students after they leave here. . . . So we're trying to really bring everybody to the table, discuss what we have that works, discuss what our limitations and the real challenges are, and try to really overcome them in a coordinated fashion so that frankly the left hand knows what the right hand is doing.”

One interviewee spoke to the role of foundations, and the need to make funding decisions in a way that fosters collaboration:

“I would say that they [foundations] need to have a holistic program, and it does need to include middle school, high school, community college, the CSUs, the UCs, the medical schools. And there really needs to be a partnership, not a ‘I’m greater than you so I get a bigger piece of the money, and then what’s leftover y’all go over there and do that when all we really want from you is your numbers’; no one wants to work in that kind of atmosphere.”

In addition to working across organizations, one general challenge raised by interviewees was the lack of student tracking in pipeline efforts. As stated succinctly by one interviewee:

“...we'd like to have a way to follow people, you know, across the levels, and if they fall off to be able help them and bring them back. We don't really have the funding and the infrastructure to kind of make that happen.”

Some interviewees cited tracking as a way to sustain faculty interest in pipeline efforts:

“...the other study that we’re proposing is taking all students who matriculated to [different] campuses and tracking their progress and, you know, how did they do. Again, we’re trying to drive data back to faculty to say you know what, these students do just as well, or we’ll find out that they don’t, in which case we can feed that back and maybe there is something in how they’re being taught.”

Finally, a few of our interviewees noted that some of the primary beneficiaries of pipeline efforts are current HPEI students. One interviewee cited the cultural competency benefits:

“We have two hundred students in the thing, and many medical students, that are spending a couple of hours a week tutoring kids in the neighborhood. But it’s doing two things: the students, our students of course, think that they’re helping these young people succeed in school, and I think that it is providing role modeling assistance that I think is very powerful. That is happening. But equally important, in my view is it’s also making my students comfortable working cross-culturally and working cross-economically. That’s incredibly important because then as they go out as professionals, then they’re going to be willing to have those kinds of people in their practice, because they’ll feel comfortable with them.”

Another interviewee noted that participation in pipeline activities has contributed to the development of a broader, public health worldview among medical students:

“The most significant contribution of (Program A) is that it has focused the medical school into an area that is critically important in California, and up to now was really not being on the radar screen at all. For instance, we had a group of students wanting to take medical Spanish courses and (that led to) ... a group of students and faculty, saying, “Wait a second, we have other important issues to address [beyond medical care] and if you want to move Healthy People 2010 [forward], you can not leave behind 35 percent of the population.”

B. HPEI Investment in the K-12 Pipeline

Many HPEI interviewees spoke about the importance of outreach and engagement of K-12 school students as part of their pipeline efforts. Many suggest that this is the “true” pipeline and is the place where critical decisions (e.g., to take physics/advanced science and math courses) are made; and thus is where targeted support is needed. One interviewee cited the importance of engaging UR youth in the K-12 years to lay the groundwork for interest in higher education:

“We go the high schools and the middle schools because we understand that by the time someone is ready to come here, especially people of color and people who have lower economic, socio-economic status, and first generations, we’ve lost a big pool of students who had never even reached the community college nor the four-year institutions.”

The CTD report by Gibson and Associates “Increasing the Diversity of the Health Professions: K-12 Networks of Support” gives particular focus to expanding the pipeline through the engagement of HPEIs and other stakeholders in grades K-12. Among the findings of the parallel CTD report is the observation that HPEIs are not substantially engaged in expanding the pipeline in the K-12 arena, and the few efforts in play tend to

be limited to individual-centered investments at the high school level. These efforts target high performing youth, and emphasize grooming them for future careers in the health professions like medicine and dentistry. Earlier and more systemic investments are needed to improve the career opportunities for greater numbers of students who may then pursue a variety of health care careers.

In general, HPEI interviewees acknowledged a need for HPEIs to be part of expanding the pipeline through K -12 engagement. As one interviewee noted:

“One of the things that I’m very, very interested in is that I’m totally convinced that – we need to level the playing field in the health professions in terms of diversity. It starts very young. We need to start planting seeds, you know, as early as possible. You know, especially underserved groups of kids...So just to spark, you know, their interest and to, just to talk with them what, what could happen in ten years or I mean, twenty years or so.”

Another cited both the importance of early outreach and the challenge of building a common understanding among HPEI colleagues:

“And when you talked about working with schools K-12, I thought this is wonderful, because we've got to reach down into the cradle and prepare these students very early on. And I said that many years ago, but I think people thought I was nuts when I talked about things like that.”

Some interviewees emphasized the need to focus on high school science courses and it’s the long term implications for pursuing careers in the health professions. One such example:

“One of the things that we find important in working with high school students, the tenth grade is really, really important because that’s when they decide what their schedule’s going to be for the eleventh grade. And if they don’t take chemistry and physics, they’re not going to be in the science, if they don’t take the science curriculum, all kinds of things happen. So getting them at that point is really important.”

Interviewees from nursing schools were particularly enthusiastic about expanding the K-12 pipeline. Unlike medicine, dentistry and graduate training in public health, nursing is a health profession that can be pursued at the completion of high school education. In their outreach in high schools, feedback from students suggested that their intervention came too late in the process:

“But we’ve actually gone to many a Career Day at many of the high schools and one of the things that we say to them is “this is what you need to do to be successful”. And I’ve had so many senior high school students say, ‘why didn't you see me three years ago?’ ...”You know, here they are

in their last semester and they haven't taken a science course...It is too late. And so you wonder how many of those students would have been successful if we had told them earlier.”

Interviewees from nursing schools also talked about tapping into other relevant skills at the K-12 level, including a focus on steering students with caring and compassion into health professions like nursing:

“I don’t hear enough counselors saying, this is what it takes to be an RN. Where’s the caring and compassion? You know, let’s focus on those students who have that innate ability that they are caring and they are compassionate. Let’s encourage them to go into nursing, not because it makes good money and there’s going to be a career, but because you care, you care about patients, you want to see patients do well.”

Another issue cited by interviewees is that there is little effort to expose K-12 students to health professions outside of medicine and nursing. As stated by one interviewee:

“...another problem that we’ve clearly identified as part of this pipeline, and that’s the students aren’t getting counseled well either at the college level or at the high school level because health counselors think of medicine, medicine, medicine, or if you’re a woman, it’s nursing or hygiene.”

“I think there needs to be a lot more systematically done. And I think we need to start young, because we do need more people considering public health. Most minority individuals that I work with in the community, and I do a lot of community-based work, don't even know what public health is. ... I do believe that we need to recruit and talk about this as an option much more aggressively.”

Another interviewee spoke of the bias towards medicine:

“ I think that we're missing a great opportunity (in our pipeline program efforts) when we are talking about medicine and not talking about other types of health sciences careers to applicants because there are a lot of them that we know that will not be able to get into medical school. I mean, the numbers are there, that does not mean that they would not be outstanding nurse practitioners, nurses, and so on. But right now, nobody is talking about that.”

At the same time, some interviewees expressed a concern that K-12 schools not set horizons too low. For example, one interviewee noted that some high school academies and medical assistant training programs don’t encourage students to think long term and reach higher in terms of career aspirations:

“But, the medical assistant programs, I think, are not in the pipeline mentality. Their mentality is: we're gonna' get you a job, we're going to get you money quick, it's pretty big money, isn't this great, you can take care of your people. That's their orientation. Rather than thinking of themselves as a stepping stone to something else, and so my thought was that at one point some years ago, is that if we could create one ourselves, that is the bottom rung of a ladder, and that you, right in the medical assistant training, you're thinking, now what do I take, to do, to become an RN, and move on up through this thing.”

In summary, there appears to be a growing recognition of the importance of HPEI investment in the K-12 pipeline. There is also increased awareness of the need for more systemic, early interventions that emphasize the importance of higher education, science and math as a focus, and the scope of potential careers in the health professions.

C. Expanding the Pipeline in Higher Education

Some educators and funders hold the view that health professions pipeline programs are most successful when focused in certain school age years. Foundations are usually interested in supporting activities that target one age group or academic cohort—for instance, middle-school *or* college students—and lean towards programs that provide short-term, easily measurable returns. Yet strong evidence suggests that pipeline programs that begin at multiple points in the educational spectrum can offer students a wide range of benefits. Clearly, an uninterrupted pipeline for UR students extending from preschool through college—and even into professional school and beyond—would be an ideal, universal model. Unfortunately, a more comprehensive approach is difficult to implement given current levels of education funding.

Despite scarce public dollars for undergraduate and health professions education, a plethora of small, but innovative pipeline programs are being implemented by a variety of higher education institutions. Several of these are profiled in the CTD report “Profiles in Leadership.”²⁸ Our informants described numerous approaches and constellations of support services that appear to enhance students’ academic success. Yet the general lack or inadequacy of tracking systems to identify program outcomes *and* student outcomes makes it difficult to draw conclusions about what works for specific student populations and why.

Among our findings is that it is never too late in the educational process to introduce a pipeline program. This view may run antithetical to the belief that once students—notably many UR youth at underperforming schools—begin to lose ground in reading and mathematics in their early elementary-school years, their ability to catch up is highly

²⁸ See the profiles in CTD report “Profiles in Leadership” of UC Riverside’s FastStart and Medical Scholars Program, UC Berkeley’s Biology Scholars Program, the UC Post-Baccalaureate Collaborative Partnership, the Dental Pipeline Program Collaborative Partnership, and Fresno City College’s Future Nurse’s Program.

improbable. While initiatives that begin in the elementary grades and middle school are extremely important, college- and HPEI-based pipeline programs can also have a tremendous impact on student success. When support services are well coordinated and given a pre-health professions focus in undergraduate higher education, they give UR and other disadvantaged students the best possible chance to achieve academic success and reach their professional goals.

Community Colleges and HPEIs

Our informants at community colleges—faculty, staff, and administrators affiliated with nursing programs—described a unique set of challenges in expanding the nursing pipeline. As described elsewhere in this chapter, the path to admission at a California community college nursing program begins with completion of a rigorous series of science courses and labs as well as non-science courses. From our interviews, we learned of only one program, “Future Nurses,” located at Fresno City College that serves as a community college pipeline.²⁹ While all the nursing programs we visited offer some of the services that typically comprise pipeline programs—from tutoring to financial assistance, to mentoring and counseling—Future Nurses appears to be unique. The program enrolls a high percentage of UR students and has a low, documented attrition rate (less than 5.5 percent over five years). However, due to limited tracking and the brief period of time that the program has been in existence, inadequate data are available to assess the program’s effectiveness.³⁰

In the broader context of California’s three-tiered system of higher education, community colleges are isolated from the CSU and UC systems. As one UC medical school faculty member observed:

“I’ll tell you one problem that I never really understood. There’s a total disconnect between the community colleges and the state university system and the University of California. You could take Biology 1A at a community college and find it has no equivalent whatsoever at the university. And Biology 1A means that you have to repeat the whole damn thing when you get here because it’s only half the course or something like that. I came from a system [where] it was 1A whether you were at a community college or a state university. The curriculum, the tests were the same. And here we drive these kids nuts.”

Interviewer: Why is that?

“It’s because University of California is elitist. That’s the frank truth.”

²⁹ Actually, the program serves as a pipeline to a lottery, an obstacle that itself must be overcome to gain nursing school admission. The lottery is discussed at length elsewhere in this chapter.

³⁰ The program has been replicated at other community colleges both in California and elsewhere in the US. Of the Fresno program’s 92 participants to date, 84 percent are URs. (This figure includes 33 percent Asian and Asian American students, more than one-third of whom are of Southeast Asian descent.) Fresno City College’s ADN program and CSU Fresno’s BSN program are the only institutions from which admission data for Future Nurses are collected.

Perceptions of “elitism” and general lack of coordination regarding pre-health professions courses among community colleges and the CSU and UC systems put community college students who want to transfer to a four-year college at a disadvantage for completing their pre-requisites for health professions training, baccalaureate degrees and embarking on graduate-level health professions training. Low-income and UR students are disproportionately affected by the fragmentation and disorganization that plague public higher education in California.

Relations Between the CSU and UC Systems

We learned from informants at both UC and CSU campuses that communication is often poor between the two systems, and that there is a perception that UC faculty and administrators “look down” on CSU, and feel little responsibility to engage, support, and consider the admission of CSU graduates. According to one UC faculty member:

“I think we’ve ineffectually partnered with the Cal State schools and that’s where a lot of lower-income kids end up going, as opposed to the UC schools. And when I say “we,” I don’t mean only this campus. The UC system has not had a strong rapport, a strong a relationship with the Cal State schools. Many of these kids are starting at the community colleges. I think we’ve done an incredibly poor job helping those students transition.”

A CSU interviewee expressed her frustration with UC colleagues with whom she has unsuccessfully tried to build partnerships over the years:

“If UCX medical school comes and says they want to talk to us again, I am not going to go to that meeting. I am through until they can say, “We’re coming, and we have this to offer, and we want to work with you, and this is how we are going to do it, and here’s the money.” That’s what they would have to bring for me to come to another meeting where they say, “We really want to work with you.”

Some CSU faculty believe the deck is stacked against their students when they apply to UC medical schools. One informant recalled a pattern of telephone calls with UC admissions officers:

“We’ll call you up and we’ll say, “Well, how come this person who’s got a 3.8, they may not have done that well on the MCAT, but they have everything else and Vanderbilt is after them—all these other medical schools are after them that are not in California—why is that?” And then we have to argue with them to the point that our students don’t even want to go there anymore. “They don’t want me” [a student will say], “I don’t want them either.” You have that whole thing going on. And then we say [to the admissions officer], “Okay, look at this. Why didn’t they get an interview?” We don’t get that feedback if we even get them to look at the application.”

Her colleague added, “The UCs don’t give any feedback.” The mistrust among this group of faculty runs so deep that an interviewee confided, “We used a test case this year. We actually used a test case. The student had been admitted to a top medical school. But [they said] ‘no’ and they did not even give this child an interview.”

One UC faculty member cited a general pattern of paternalism toward CSU campuses:

“We don’t want to be proscriptive to the Cal State schools. We want them to engage and come up with their own solution. We can put ideas out there, but far too often there’s this big brother/little brother relationship. If I was the little brother I’d be annoyed after a while. So we want to be two siblings that are working together towards the common goal.”

Informants from numerous campuses spoke at length about the importance of linking the three higher education systems through a cohesive, unified pipeline. Recurrent themes that cut across systems include:

- Streamline outreach and support programs in a cost-effective manner to optimize student success.
- Increase recruitment of local students to reduce student flight due to lack of financial support and inaccessibility in California.
- Design health-sciences undergraduate orientation or major (rather than focus on specific health careers).
- Require one-to-one course transferability between systems.
- Permit community college students to take courses at CSUs and UCs.
- Develop compacts between high schools and undergraduate institutions that guarantee student acceptance upon graduation.
- Increase internships for CSU students to do research with UC faculty or obtain practical experience with alumni and leading organizations. These opportunities help strengthen student qualifications, credentials and relationships.

A faculty member at a UC medical school proposed building regionally-based partnerships to enable faculty and staff to be shared between the CSU and UC systems:

“Another deficiency that, I think, the Cal State schools have is the advice that their students are getting—the coaching—and I think we should be partnered to specific CSU campuses.³¹ We should have a staff person who’s a specific premed advisor that doesn’t work at a UC undergrad campus but works maybe Mondays and Tuesdays at CSU A, Wednesdays at CSU B, and Thursdays at CSU C. ...If I were to push it one step further, I’d have some of our faculty that teach on undergrad campuses do an exchange program and teach at the local CSU school and have their faculty teach here. Our dean has already bought off on the idea and, at

³¹ While the broader proposal has merit, the framing of the problem as poor health advising that would be solved by a UC-based pre-health advisor reflects a paternalistic orientation among even the most insightful UC leaders.

some juncture, we'll have to push it so that all the deans at the five medical schools are saying, "This is something that we believe in. This is important."

Post-baccalaureate Programs

California's post-baccalaureate medical and dental programs have demonstrated their effectiveness in improving students' academic preparedness and in increasing UR youth admissions into California HPEIs. Some post-baccalaureate programs students did not complete or do as well on their pre-med requirements as undergraduates and need to complete them prior applying for school while others on students who have applied to school and been unsuccessful. One UC medical faculty member observed, that perhaps instead of waiting to offer programs until "after someone has achieved failure" that the type of support these programs provide could be provided much earlier:

"Then you build them [students] back up and get them to apply. The learning [that goes on] there is not real Aha! learning. We're teaching people how to take tests, etc. Why don't we put that further upstream, so when they're freshmen and sophomores in school they're getting that counseling and guidance, as opposed to waiting until they fail and then we build them back up?"

Like other pipeline programs, post-baccalaureate programs focus on academic readiness by offering prospective health professions students a second chance at admission to medical and dental school. For UR students this can be the chance of a lifetime:

"In the past when kids applied, if they were not ready they were out in the cold and frequently they were not admitted anywhere. Some of the summer programs that are offered by all of our schools now, as a result of the Dental Pipeline Program, again begin to prepare those students with the courses they should take as upper high school students and then as early college students. I think that that helps their readiness because that was an issue."

Our data suggest that different observers variously characterize post-baccalaureate programs. Some faculty and administrators believe they teach new academic content and skills that broaden students' knowledge and strengthen their academic confidence. Others, however, like the individual in the passage quoted above, regard post-baccalaureate programs as strictly remedial.

Medical school faculty we interviewed who were strong supporters of post-baccalaureate programs point to data which demonstrate that medical school graduates who complete a post-baccalaureate programs achieve the same degree of excellence as graduates who began medical school without post-baccalaureate training. Moreover, they suggest that graduates of post-baccalaureate programs have significant contributions to make to UR and other disadvantaged populations:

“We’d like to build that case that they graduate just in the same amount of time [as non-post-baccalaureate students]. If we can demonstrate that more of those students go back and practice in shortage areas, in lower-income communities, we’ve got a huge case to take to the Legislature: “If you believe that we should train physicians to go back and work in low-income communities, here’s a proven way. Put money behind it.”

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other inquiries in the CTD initiative, we proposed the following recommendations to strengthen HPEI investment in expanding the pathway and pool:

- 1. Partner with other stakeholders to increase the number, scale, effectiveness and sustainability of linked, sequential K-16 educational and health career pipelines and support networks.** Because the lack of diversity in the health professions is rooted in educational inequities that begin early in life, a network of support must begin at the earliest point possible and span throughout the educational pipeline. With this end in mind, a network of support should include organizational partners, institutions and stakeholders that interface with each phase of the pipeline. Strategies and formal linkages to enhance the transition between different phases of the pipeline should be identified and prioritized in funding decisions. Increasing and using articulation agreements and mechanisms is critical.
- 2. Develop comprehensive outreach, academic, career and mentoring support strategies tailored to a multiple promising target groups including:**
 - K-12 academic support networks** through collaboration of health organizations, educational institutions and others. See CTD “K-12 Networks of Support” report for detailed recommendations.
 - Undergraduate UR students.** Undergraduates have already overcome the significant hurdle of getting to college and are in a position to become competitive candidates for HPEI’s or the workforce within a short period of time. They often lack academic support, career exposure, opportunities for practical and research experience and mentoring. Research shows that we lose most UR medical student interest in medicine in freshman and sophomore years. Need to target support at that stage for medicine or other health careers and have support through successful admission to health professions schools. Greater support for increased opportunities for more students to get “credentialed” before applying for HPEI’s such as post-bacs, internships, research projects with faculty etc is needed.
 - CSU students** – Both CSUs and California community colleges have the critical mass of diversity that is needed to increase the quality of California HPEIs. It is important for HPEIs to engage, inspire, and support CSU students pursuing a broad range of health careers, not just medicine and nursing.

3. **Expand the goals of pipeline programs to improve career opportunities for greater numbers of students who want to pursue a variety of healthcare careers, not just the “top performers,” who are tracked toward careers in medicine and dentistry.** Resources should be invested in training incumbent workers, career changers, displaced workers, and re-entry students in addition to a broad array of K-16 students for health professions careers.
4. **HPEIs develop standardized metrics to track pipeline programs and participating students.** Create regional databases to analyze outcomes and identify best practices.
5. **HPEIs work with health professions employers to forecast health workforce demand and plan and implement comprehensive health workforce pathways to support multiple target groups.** Pathways need strategies, plans to align and coordinate the following components at the scale and effectiveness needed to support participants and meet organizational workforce needs:
 - Career awareness and exposure
 - Assessment and advising
 - Academic preparation and entry support
 - Training Program financial and logistical feasibility
 - Training Program Access (pre-requisites, enrollment capacity)
 - Training Program retention
 - Internships
 - Hiring and orientation
 - Retention and advancement

These elements of the health professions pathway can be aligned within a local area, region or profession to increase the pool of students and graduates entering the health professions. A key is to include sufficient infrastructure so support the pathway elements and student support as they advance to each stage. The pathway can be used by HPEI’s, K-16 schools, health employers, funders, pipeline programs, government and community based organizations to clarify roles in the pathway and ensuring that key elements are in place, coordinated and are of sufficient scale.

6. **HPEIs prioritize advocacy, funding and other means of involvement or support to enhance the quality of the K-12 education system.** Efforts are needed statewide and particularly in communities with high percentages of underrepresented students who are unevenly prepared due to educational inequities. Without more effective K-12 educational preparation, a high percentage of our workforce talent pool, particularly from emerging majority populations will not be part of the pipeline or will not have the knowledge and skills to enter health professions schools or professions. Efforts to support K-12 should be developed in conjunction with K-12 leaders and advocates.

7. **HPEIs and other stakeholders seek funding from foundations to support needs assessments and strategic plans to identify pipeline goals, create networks of support, and design and implement regional demonstrations in lieu of the current scattershot approach to programming and funding.** This would allow more effective collaboration and planning with stakeholders and optimize transparency, inclusiveness, and assessment.

8. **HPEI leaders advocate to promote the development of diversity-related accreditation standards in postgraduate, health professions education.** These standards should emphasize the need for HPEIs to support pipeline efforts by investing time and resources, as well as creating a supportive academic environment that fosters shared learning among students from different backgrounds

III. Reducing Financial Barriers

The financial cost of education was consistently referenced as one of the most significant barriers to advancing work force diversity goals. At the same time, it is important to acknowledge that a strategy limited to reducing financial barriers may not substantially increase diversity in HPEIs, given the fact that most low income youth are white. This issue and the overall cost challenge facing many UR students are succinctly summarized in the opening chapter of the IOM's "Compelling Interest" report:

"The costs associated with health professions education pose a considerable barrier for many UR students, whose economic resources are, on average, more limited compared to their majority counterparts. UR students, in particular, may be discouraged from entering health professions training programs when faced with the prospect of high debt...while UR students are more likely than non-UR students to come from low-income families, most low-income students are white. Policies that solely target financial support to low-income students may or may not successfully help UR students to access and succeed in health professions training programs. Therefore, it is important for financial strategies to be implemented in conjunction with other "race-conscious" interventions targeting, for example, admissions and accreditation policies."³²

At the national level, HPEIs have responded to a gradually but steady reduction in public sector support by dramatically increasing student tuition. This trend has been exacerbated by a shift from grants to loans for students, with the net result being an overall increase in the socio-economic status of health professions students.

In California, the financial costs to students for health professions training is high, but quite variable, depending on the discipline and whether the program is offered at a public or private college or university. For example, full time dental school tuition and fees—especially at some of the state's private universities are now priced at more than \$60,000 per year.³³ At the other end of the cost spectrum, if one is fortunate enough to be tapped in the lottery for a two-year associate degree leading to RN licensure at a community college, your debt may be limited to a few thousand dollars.³⁴

All interviewees cited a very fiscally tight environment for their schools resulting from a combination of factors, including:

- Budget cuts to higher education from the legislature

³² In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce (2004), Institute of Medicine, Chapter 3, Costs and Financing of Health Professions Education

³³ If you add living expenses the total is closer to \$80,000 per year; see <http://www.usc.edu/dept/publications/cat2006/tuition/>

³⁴ Community college tuition for nursing school often runs around \$20 per credit hour. See William Zumetee and Debbie Frankle's March 2007 Report: California Community Colleges Making Them Stronger and More Affordable, accessed at <http://www.insidehighered.com/news/2007/03/07/calcc>

- Unfunded mandates on schools which thwart their ability to dedicate resources towards needs-based scholarships
- Cuts to the federal government's Title VII and VIII programs
- Cuts in the NIH budget and the resultant loss of overhead monies
- Anti-tax sentiments from various constituencies throughout the state
- Inflation in the capital and operating costs tied to running HPEI programs
- Prop 209 impact in thwarting certain grant opportunities

The net effect of the budget pressures is an acknowledgement that funding “activities” that advance racial and ethnic diversity in class composition often must compete with other priorities. Leadership decision-making becomes the operative difference and the issues here are explored further below.

Across most HPEIs, students often share the challenge of the high costs of education as a result of rising tuition, professional degree fees and cost of living expenses. To some degree, however, high out-of-pocket and opportunity costs for medical and dental students and the (ultimate) prospects for lucrative careers make their issues somewhat different from the other health professional groups. Accordingly, for purposes of sharing interviewee findings in this section, it is useful to separate out medical and dental school financial challenge issues confronting UR students from those facing UR nursing and public health program students.

A. Medical and Dental Schools

For medical and dental students, the four years of professional school followed by graduate training for almost all physicians (and increasingly for dental students going on for specialty training as well) make their education process quite costly in terms of tuition, fees and lost income from time costs tied to the education process. Even though HPEIs receive substantial subsidies for the training costs of these students, tuition fees are still significant from the individual trainee's perspective. Even at public universities, out-of-pocket costs for state residents to attend medical or dental school can run between \$45,000 and \$65,000 per year.³⁵

These significant personal cost expectations, while causing great concern to all students, have been noted by our interviewees as being particularly challenging to UR students who tend to come from less affluent family backgrounds.³⁶ As one public dental school faculty member noted to us in assessing why his particular school sometimes loses UR students to other schools with more scholarship monies available:

“So some of [the UR students] are interested in going elsewhere for a whole variety of reasons. Sometimes there's more scholarship money available elsewhere, particularly in private schools as compared to public ones in California.”

³⁵ At USCF, for example see <http://saawww.ucsf.edu/financial/general/budget.htm>

³⁶ See IOM Report “*In the Nation's Compelling Interest.*”

In addition, a number of our interviewees stated a concern that UR students of more modest socioeconomic backgrounds do not apply to medical or dental school, or may not accept offers of admission, because of debt fears and limited family history of debt repayment at such significant levels resulting from attendance at medical or dental school. They noted that such fears would need to be overcome at the front end of the application/admission process to medical or dental school. Data supports this concern as more UR applicants enter medical school with some form of debt than do their non-UR counterparts (75% vs. 47%).³⁷ UR students may be particularly affected in their school choices by the net costs.

It is worthwhile to note that concern about debt is occurring in an environment where scholarship monies are more difficult to secure and cover a smaller proportion of growing costs. Interviewees expressed considerable concern about the reduction in federal and state support:

“My concern is looking at the California schools in terms of the impact of the loss of Title VII funds. I think it's huge. ... The hit is not going to come this year. You will see the impact in the following year because these programs will not have been in place or they'll be in the process of dismantling or cut way back.”

It is important to acknowledge, however, that the future income of most doctors and dentists will create the space for loan payback for their lengthy and costly educations. As noted by one dental school administrator:

“One of our students going out into private practice right after dental school will earn more or just as much money as our chair of oral and maxillofacial surgery whose got an MD and three years of practice experience within five years.”

Nevertheless, evidence points to fewer students choosing lower paid health professions careers such as primary care or geriatrics in medicine. Debt load pressures are also thought to be steering students away from choosing geographic and/or practice settings where the focus is caring for low income communities with high proportions of uninsured and publicly insured residents. This challenge was described by numerous interviewees, observing that UR students are often caught between their desire to practice in their communities of origin and their quest to professionally and economically succeed in their careers... While students from all backgrounds experience difficult choices and the resultant emotional challenges accompanying them, UR students with whom we spoke more often experience these kinds of career choice dilemmas.³⁸

B. Nursing and Public Health Programs

³⁷ Source: Student National Medical Association

³⁸ See CTD Report “The Benefits of Diversity: An Exploratory Study,” June 2008

Interviewees indicated that financial barriers are less of a core issue among nursing and public health programs. These health professional educational programs generally have much lower tuition costs for attaining a degree than medicine or dentistry. In some cases, some programs also offer part-time or other alternatives to full-time, daytime on campus courses that enable students to work, care for families or complete them over a longer period of time. In many cases both nursing and public health programs are available at local community colleges or CSU campuses that may enable them to be lower cost and more accessible to people who want to live with or near family in the regions they are from. While tuition cost barriers still exist for public health and nursing, the more affordable tuitions and less lengthy training periods make financial pressures in the short term—a bit less acute.

Nursing

For nursing education in particular, a systemic appreciation of the structural nursing shortage has led to more state monies being devoted to efforts to increase the number of nurses being educated throughout the state.³⁹ California also starts from a base where the nurse to population ratio is less than the national average—highlighting the shortage of these professionals for California in particular and making program support more likely to achieve public policy interest.

Increased public sector investment in nursing education and the nursing shortage has also helped to leverage increased support from hospitals and other nursing employers. Interviewees noted a number of collaborations involving nursing schools and hospitals, as well as some other community partners to help finance nursing education. Our conversations revealed that many of these collaborations between nursing schools and hospitals or other community agencies help to advance a number of goals, including:

- Providing students with financial aid for their education and associated expenses.
- Providing academic programs/departments with much-needed resources for teaching and other critical functions.
- Creating career paths for young people and incumbent workers whose work options might be limited to the low-pay service sector.
- Reducing providers' nursing workforce shortages.

These synergistic partnerships have helped to keep tuition costs lower for students considering nursing careers, and enabled many of those in programs to stay in school and focus on academics. As noted by one nursing school dean:

“We're partnered with xxx Medical Center and with yyy... Of course I have [my school] no money. My investment is time and, you know, our

³⁹In April 2005, Governor Schwarzenegger announced the California Nurse Education Initiative, which provides \$90 million in funding for nursing education over a 5 year period through public/private partnerships.

building and all the administrative stuff. But our students apply for scholarships and they can get up to a \$10,000 scholarship. [Drawn from a \$1 million commitment by partner organizations] And we're in our sixth year. I can tell you, the day it started, I remember my first student who said to me, 'Ms. BBB, my life is changed. I paid my bills.' She paid off her credit cards. She said, 'I don't have to work.' Because they get it in their final semester of their senior year, all she did was focus on school... from that moment on, we saw our Board rates go up."

A significant challenge yet to be addressed, however, is the fact that most of the gains in the number of nursing graduates in California over the last five years are a result of short term investments from the public and private sector. As near term needs are met, there is a very real possibility that "soft money" support will decline. In the absence of longer term institutional capacity building, California could be faced with even more dire nursing shortages within the next decade.

Public Health

The cost of tuition, professional degree and other fees in UC public health schools and programs has increased significantly in the past 5 years. The cost of living in the surrounding areas has also risen significantly. Sources of financial support for students have decreased during this same time. As a result, interviewee's indicated that financial support is an increasingly important factor in students' decisions about whether to attend a public health program and which program they attend.

This corresponds with an increasing competition from out of state schools with greater financial resources for the small pool of top under-represented students. These schools are able to offer more lucrative financial packages, often for the full two years of an MPH program (California Schools often have financing mechanisms for only the first year). While some of the top competing schools are private schools, public universities such as Michigan, North Carolina and Washington are also able to offer more competitive financial packages to underrepresented students. In response, California-based schools are constantly seeking funds to offer more competitive packages for under-represented and disadvantaged students.

The California State University based public health programs have by far the greatest proportion of UR students. The significantly lower tuition and fees combined with the ability of many students from their surrounding regions to live and continue to work nearby are key factors.

CSU, private public health programs, and many nursing schools offer the advantage of often being able to offer part time and flexible schedules for students. Some of these programs have evening classes that allow students to work day jobs and earn money that is necessary to both pay for school as well as support their basic living expenses. This scheduling flexibility allows some students to obtain paid internships and research assistant positions; these positions are often accompanied by partial or full tuition

remissions. Taken together these factors often benefit economically challenged students—including those from UR backgrounds.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from other CTD inquiries, we propose the following recommendations for efforts to reduce financial barriers in health professions education:

- 1. Build a framework for shared advocacy to restore and expand the funding of Titles VII and VIII of the Public Health Service Act.** Pursue funding from the State of California, foundations and private sources, such as health employers, to combine with federal funds to create a sufficient pool of funds to support greater numbers of under-represented students attending California HPEI’s.
- 2. Develop new models for need-based financial aid to support the most costly health professions training programs.** For example, a feasibility study could be undertaken to explore creation of an Income Contingent Loan Repayment program (ICLR) for California matriculants at HPEIs. Such a program could help to make HPEI training financially accessible to all admitted students, encourage greater pursuit of health careers and specialties that are less financially remunerative, and/or advance important public service goals.
- 3. Increase investment in innovative approaches to financial support for community college, baccalaureate, and graduate-level nursing students.** For example, Bridge to Nursing,⁴⁰ a collaboration of a community college department of nursing, a community development foundation, a tertiary care medical center, and a healthcare foundation is a replicable and sustainable model that targets Latina/o students in Los Angeles. It is based on a multifaceted approach that combines significant financial, academic, and personal support.
- 4. California HPEIs and undergraduate education institutions establish line item funding of promising diversity programs/initiatives.** The current reliance on discretionary funds and external foundation support for programs perpetuates marginalization, requiring a focus on survival and impeding a focus on quality improvement and integration into the fabric of the academic institution. In order for this to occur, levers must be identified and political support secured. One funding strategy is to devote a percentage of the instructional budget to diversity programs.
- 5. Encourage partnerships between HPEI’s and health employers to provide financial and programmatic support for incumbent workers.** Loan forgiveness programs, release time, on-site courses, coaching, part-time or accelerated programs and readiness support would reduce financial and logistical barriers.

⁴⁰ See profile IV.1 in CTD report “Profiles in Leadership: A Review of Exemplary Practices to Increase Health Professions Workforce Diversity in California,” April 2008

IV. Recruit, Admit, and Retain UR Students

Among the range of strategies to increase diversity in HPEIs, efforts to recruit, admit and successfully graduate a diverse student body tend to capture the most interest and attention. Accordingly, our conversations with HPEI interviewees focused on this topic.

As with section III, commonalities in issues associated with medicine and dentistry, as well as distinctions between these two disciplines and nursing and public health are addressed by separating the discussions into subsections. Within each subsection, we found it most useful to break the findings down into recruitment and retention, and admission process.

The social and cultural factors affecting the environment of students attending HPEIs are addressed in detail in section V, Create a Supportive Environment.

A. Medical and Dental Schools

Recruitment and Retention

In general, interviewees agree that successful UR recruitment requires active and ongoing organizational leadership—an overt decision that activities need to be undertaken to help create a pool of qualified applicants who are racially and ethnically diverse. Interviewees also emphasized that senior leaders must both allocate the necessary resources and demonstrate their personal commitment to ensure that *recruitment* of URs takes place. In this regard, it is not enough to simply have an Admissions Committee that seeks to admit a diverse cohort from the annual pool of applications. As noted by one dean, active recruitment is vitally important:

“I think [at our school] there is a commitment to admit qualified UR students. The problem is getting them in the pool, getting them to apply.”

In addition to the support of the official leadership for taking on recruitment efforts, interviewees told us that there needs to be a cadre of HPEI administrators, faculty, and staff who are committed to diversity and can dedicate time to recruitment efforts. These individuals must possess the qualities that will attract UR students, the willingness to serve as advisors, and the ability to perceive the ‘the promise’ in what UR students can offer their fellow students, and upon their graduation, the world. Interviewees noted that while these qualities exist in many different faculty and administrators, taking the steps to facilitate and support these leadership roles is essential to success. UR faculty and administrators can play particularly important roles in this process. As will be discussed in Section VI., the relative paucity of UR faculty and administrators in HPEIs presents challenges to recruitment efforts, and results in the assumption of considerable burdens by these individuals.

Given the common statement that medical and dental schools value diversity but cannot find qualified UR candidates for medical and dental school, a number of interviewees

noted that an important under-tapped source of UR applicants may be undergraduates at the medical school's sponsoring university. As noted by one medical school interviewee:

“The whole key to this is what we do at the undergraduate level (at our university) because we're trying to engineer something here at the undergraduate level that is going to support the kind of students that we want in our medical program or that are going to serve our mission.”

A number of HPEI interviewees noted that their schools attempt to connect to UR students who participate in established undergraduate pre-health professional clubs, or ones specific to medicine or dentistry. Some HPEI interviewees also make special efforts to connect with well-publicized gatherings where UR students will be in attendance (often special meetings or fairs for career planning, including ones focused on health professions). Some of these gatherings are held regionally and have become part of the regular recruitment schedule for those who take on these specific outreach roles—often an administrative person assigned to the task.

Dentistry has its own particular challenges in this regard. Some dental school interviewees told us there is a need to put dentistry “on the radar screen” as a career option for consideration by UR students. Many, if not most UR students have had limited access to dental care or dentists as role models, and hence may lack an understanding of the profession, its contribution to health, the significant oral health challenge confronting our nation, and the accompanying need for a more diverse dental care workforce.

Interviewees noted that organized programs (such as summer research or other programs) to expose UR college students to HPEIs and their work were particularly effective mechanisms to attract potential UR applicants with little knowledge of careers in medicine or dentistry. The programs also help “credential” participants and provide important relationships with faculty and staff that are valuable in the admissions process. Such programs or special visits are sometimes offered contemporaneously to when a student may be applying to medical or dental school or can occur a bit earlier in the undergraduate college experience. Many interviewees indicated that the earlier the exposure, the better as it provides students more time to enhance their preparation, competitiveness and relationships. From a recruitment standpoint, UR students invited for interviews may experience some focused recruitment attention in addition to the standard interview process; or increasingly, after acceptance into a program, some HPEIs offer ‘second look’ programs, in an effort to recruit students who may have a choice to make among schools they have been accepted to attend.

Some academic leaders noted that because of the small pool of qualified applicants, schools often recruit and compete for the same candidates. From a diversity perspective, this only addresses *where* the existing UR applicants who meet traditional admission requirements will attend, and does not address structural factors that limit the size of the pool. This problem is perhaps most evident in allopathic medical education. One interviewee captured this dynamic with the following comment:

“We last year interviewed about 60 Latino students and admitted about 20. We looked at another UC school, they interviewed about 61 Latino students, admitted about 20. We looked at UC xx, they interviewed about 60 Latino students, admitted about 20, so we’re all interviewing and admitting the same group of students. I’m guessing.”

On the other hand, interviewees in dentistry and osteopathic medicine noted that sometimes the “second look” effort can help a student decide whether he/she is going to enter that profession at all; as a result, such efforts may actually contribute towards increasing overall UR enrollment in these health professions.

Over the past ten years, there has been a growth of post-baccalaureate programs that provides post-undergraduates with the preparatory coursework to apply to medical or dental school. Some enter these programs as a proactive step to strengthen their knowledge of basic sciences and preparation for medical/dental education; others enter after an initial failure to secure admission to medical or dental school in order to enhance the potential success of their re-applications. While the details of some of these efforts are provided in Section III, it is worthy to note, that most post-baccalaureate programs have a special focus on UR students. Given the fact that these students are highly motivated to enter medicine or dentistry as a career, these post-bac programs are viewed as being particularly value-adding in helping to build the critical mass of diversity in medical and dental schools. Recent research has documented the effectiveness of these programs as an important part of any overarching strategy to increase UR and disadvantaged student matriculation.⁴¹

While these kinds of efforts are important, interviewees gave the clear impression that challenges in UR medical and dental school recruitment have limited achievements to date. This reality arises from many causes, including, but not limited to the following:

- A philosophical viewpoint among some leaders and faculty that the “colorblindness” concept behind Proposition 209 is good for society, and affirmative approaches to UR recruitment are deferred.
- Reluctance by leaders to take even limited steps that, while not violating the letter of Proposition 209, may be viewed as challenging the intent.
- The general lack of students in the pipeline that meet traditional admission criteria and standards (Discussed in Section II, Expanding the Pool and Pathway).
- The growing cost of medical or dental education for students (Discussed in Section III, Reducing Financial Barriers).

⁴¹ Grumbach, Kevin, and Eric Chen, 2006, “Effectiveness of University of California Postbaccalaureate Premedical Programs in Increasing Medical School Matriculation for Minority and Disadvantaged Students,” JAMA, Vol. 296, pp. 1079-1085.

- Campus geography or community where the school is located is remote from family or perceived to be unfriendly to students of color (Discussed in Section V, Create A Supportive Environment).
- Lack of value placed on racial/ethnic diversity and its positive contributions to the curriculum and learning environment affecting all students (Discussed in Section VII, Curriculum).
- Faculty perceptions that the recruitment of UR students represents a retreat from, rather than a pursuit of academic excellence for the student body.
- A lack of infrastructure, support systems, and a strategic plan that facilitates retention of UR and disadvantaged students.
- In California, a range of practical barriers and perceived prejudices that limit the HPEI matriculation of CSU graduates, even though CSU has a very large pool of UR students interested in health professions.

Interviewees reminded us that at any medical or dental school, there are faculty and administrators who do not “buy-in” to the notion that having a special focus or initiative tied to racial and ethnic diversity is a good thing. Those who take this point of view may argue that from the school’s perspective:

- Recruitment and admittance of students with lower scores on traditional indicators of success (GPA and MCAT/DAT scores) raise questions about institutional commitment to excellence.
- A focus on race and ethnicity, instead of social class, undermines a focus on “truly disadvantaged” students.
- UR students may have academic, financial, personal and social needs that require disproportionate investment of resources and time.

Interviewees described concerns about excellence in a number of different ways. For example, one noted resistance from faculty to recruiting students with diverse backgrounds:

“Because people [the faculty] think that you know they’ve been doing the science for the longest time, and they know what makes a good scientist. They really want diversity, but when they’re looking at a candidate [for medical school], what comes to them is somebody who looks like themselves. In a non-conscious way, and that’s the area in which we’re working on particularly to teach people about the effects of unconscious bias, and how getting over that might help [them to think differently about who is qualified for admission].”

Another interviewee noted that some faculty worry about how excellence will be affected by a process that results in the recruitment of students who are not at the top of the group with respect to grades or entrance exam scores. One medical school dean noted:

“What we're doing right now, I always say and I know that this may be controversial but I always said that I can make absolutely fantastic physicians with an MCAT average of 8. What I can not do is run a medical school where the average MCAT is twelve and a half, and then I have half-a-dozen kids with six, because expectations of faculty are different.”

Others had concerns that consideration of race or ethnicity in recruitment may work against efforts to recruit people from disadvantaged backgrounds. One interviewee noted:

“We're seeing more middle class minority students who are appearing in these pools. It raises questions about is this the target candidate? I mean, are we doing our job when we enroll a middle- class, upper middle-class black student? The interviewee noted further that it is realities like this that make some want to refocus diversity efforts more toward social class/distance traveled criteria— independent of race or ethnicity.”

Also, concerns about “wear and tear” on faculty and staff to recruit and retain a cohort of students who may need more time and attention than other students was cited as a psychological barrier for some schools to more actively recruit. As noted by one interviewee:

“And what we figured out is we only have a limited capacity for the number of high risk students that we take, academically high risk, and we just had to try and figure out what that was. And then I think the other thing we're aware of is there aren't good strategies to support students who have had nonacademic rigorous backgrounds and then put them in a rigorous program. Tutoring is too late. We've tried pre-teaching, as has been successful in K-12 systems. So we limit the numbers now and I think we do a better job.”

Another interviewee spoke of similar challenges associated with economically disadvantaged students:

“I would say in my program that retention becomes the issue. Of the more socioeconomic [challenged] student who's having to work, we either need to extend the program to a part-time program if we can accommodate that or we just lose them because they don't have enough time to study and, you know, academically we lose them... And the bigger Aha! moment was when we took quite a few more minorities into the program, and we lost way more than their percentage in, you know, of admission coming in,

we lost more going out. And so the aha moment for us was we cannot take more than we can support with additional resources and we had to do a better job.”

Still another interviewee referenced challenges associated with academic culture and the need for support:

“They [UR students] may pass their classes but every student goes through some self-confidence crisis ‘cause all of a sudden now they’re surrounded by brilliant students. They’ve always been told that they were, they’ve been the best in everything they’ve done. Now they’re just someone there. It is possible that this group suffers more self-crisis and self-esteem crisis and confidence crisis without a large community of students, and we don’t have a large community of students that they can identify with or a robust faculty that they can identify with, it’s possible that they tend to isolate themselves. If they don’t have a family that understands graduate school or college or high school, they can have competing [life priorities], “Well, you know, what do you mean you can’t come home? You don’t care about us.” “Yes, but I’m in medical school now.” “No, you need to come home.” So there’s a different set of pressures on this group of students. I have to be honest. I don’t think we adequately support them.”

As discussed in Section II, Expanding the Pool and Pathway, there is a lack of coordination and support between the California State University system and University of California HPEIs. California State University leaders spoke at length about barriers for CSU students to UC medical and dental schools in particular. Most CSU campuses possess a highly diverse student population, and more in-depth engagement should be viewed as a near term strategy to increase diversity among California HPEIs. The failure to date to address this issue represents a significant missed opportunity.

Admissions Process

The starting point for a focus on the admissions process is the observation from interviewees that an over-reliance on quantitative measures (e.g., standardized test scores and grade point average) impedes efforts to increase the racial and ethnic diversity of incoming students. As documented in the IOM report “In the Nation’s Compelling Interest,” test scores for African American and Latino applicants are lower on average than for whites and Asian Americans,⁴² and key factors in these differences are inequities in the quality of K-12 education and family influences.⁴³ Given these dynamics, it is not surprising that an admissions process that gives significant weight to these quantitative measures would fail to produce a racially and ethnically diverse class of students.

⁴² Camara, WJ, Schmidt, AE, 1999, “Group Differences in Standardized Testing and Social Stratification,” **College Board Report # 99-5**, New York: College Board Publications, pp. 1-18.

⁴³ As addressed by Bowen and Bok, 1998, in their landmark report “The Shape of the River,” relevant factors in family influence include, but are not limited to family income, parental education, opportunities to travel, parental involvement in secondary education, and the number of books in the home. These influences are in shaped in part by historical and contemporary social and economic forces and patterns of discrimination.

One interviewee summarized this approach in their description of the typical medical and dental school admissions process:

“I think that you know we have, like at most schools, certain automatic cut-offs [based on grades and test scores], certain numbers that essentially we have a computer program that selects those applicants, and we decide out of those very quickly who deserves an interview or who doesn’t.”

It is important to acknowledge that test scores are fairly effective predictors of academic performance, suggesting that HPEIs that increase student diversity must be prepared to provide additional support to ensure optimal results. This is a near term practical reality that should be addressed in a proactive and deliberate manner by HPEIs, given inequities in the quality of K-12 education.

It is also important to acknowledge, however, that standardized tests are not necessarily a good predictor of quality in the practice of medicine, dentistry, and other health professions disciplines. A growing body of research suggests that, assuming the achievement of a core base of health science knowledge, other qualities are of significant importance in ensuring optimal quality in the practice of medicine.

In the course of our interviews and associated background research, we learned that there is a more generalized effort in California and across the country to move beyond the over-reliance on standardized testing. Called “comprehensive admissions” or “whole file review,” one interviewee summarized it by the following description:

“Well, whole file review—comprehensive admissions, is important because there are life experiences that are devalued by superficial review and those are very, very important... What we'd have to do is have programs sensitive to the life history of applicants, comprehensive admissions is how we look at that now and I think that’s a better term and better way than to go with affirmative action.”

Information gleaned from these interviewees and other sources suggest that these more comprehensive approaches to the admissions process vary significantly. Some institutions have developed a set of criteria which add points to the application for certain accomplishments, experiences, and/or “distance traveled” (e.g., family illness, absence of parental support, economic hardship, first in family to go to college), while others take these factors into consideration in a more generalized review of the overall application. For obvious reasons, variations in the criteria selected, whether or not a numerical rating is used, and the relative weighting of different criteria can all produce profoundly different results. While application of a “whole file review” approach represents a promising direction that will contribute to increased diversity in the admissions process, further review is needed to understand the impact of alternative approaches.

Each institution engaged in such a developmental process is well advised to develop and ensure common understanding of goals, objectives, and processes to be implemented, and to closely monitor progress along the way. At UC Davis School of Medicine, for example, the initial integration of criteria that focused primarily upon community service yielded less diversity and higher socioeconomic status in that year's incoming class. Further adjustments in the comprehensive admissions gave increased attention to "distance traveled" criteria. A good discussion detailing the admissions processes at Stanford University School of Medicine, UC Davis School of Medicine, and UCSF School of Dentistry are included in the CTD report "Profiles in Leadership."

In general, admissions committees operate with a fair amount of discretion, and their processes and outcomes are also influenced by the composition of their membership, the perspectives that members bring to the table, and the relative influence associated with their standing in the institution. Institutional leadership plays an important role in setting the tone for the admissions process, and helping to establish common goals and priorities. One dental school dean described his role in relation to the admission committee in this regard with the comment:

"I insist that I come in and give a sermon to the admissions committee when we start, just telling them what their charge is, and one aspect of that is that we have to make a concerted effort if we want to make a difference. It's not going to be good enough just to sit here and wait for the underrepresented minorities to meet all of the [traditional] qualifications. We have to do something active, and so that's part of the commissioning of the committee before they start their activities each year."

In the formation of admissions committees, a number of HPEIs seek to ensure that the membership includes UR faculty members, and in at least one case, have the committee chaired by a UR faculty member. In doing so, it is important to acknowledge that the relative paucity of UR faculty members and the increasing range of advisory functions where UR representation is desired can contribute to UR faculty members carrying disproportionate administrative burdens (This issue is discussed further in Section VI.). Some HPEIs also make an effort to ensure participation of highly respected senior faculty members on admission committees, in part to communicate the importance of this process to the institution.

B. Nursing Schools and Programs

There are 108 nursing programs located at public and private colleges and universities in California. Seventy of the state's community colleges have programs that offer the Associate Degree in Nursing (ADN).⁴⁴ Fifteen of the California State University campuses offer the Bachelor's Degree in Nursing (BSN) and seven of these have Entry-

⁴⁴ The ADN is usually referred to as a two-year degree. In fact, "the best case scenario is about 4 years, but I know nurses that it has taken 6 -7 years or longer completing pre-reqs as a part time student." Mary Contreras, "A Nurse's View," blogs.medwatchtoday.com, comment posted July 17, 2007.

level Master's (ELM) programs.⁴⁵ Two UC campuses, UCLA and UCSF, have baccalaureate-level programs in nursing as well as master's- and doctoral-level programs. The State's private colleges and universities offer seven ADN programs, 12 BSN programs, and five ELM programs. For our study we conducted interviews at community colleges, CSU campuses, and a private university.

Recruitment and Retention

To interest UR students in careers in nursing, community colleges engage in a range of recruitment activities including pipeline initiatives, that provide support and structure to students taking their nursing prerequisite courses. They also visit K-12 classrooms. One department chair told us,

“I used to go to the schools. I'd do things at career fairs to inform students. This program is now well known. I will go to schools to tell young people how to prepare, what to do in high school. Take science, take math, take chemistry in high school because that's the one class we accept here in the college. “

We spoke with one faculty member, recently retired from a CSU campus, who directed a grant focused on recruiting undergraduate UR students. She explained the scope of activities her program had undertaken:

“Those high schools that had a high population of the targeted groups that we were interested in, we chose them to conduct our recruitment program. We would contact different faculty members and the counselors and they would set up the time when we could come and speak to the children. We would talk with them about the benefits of nursing. And after we'd get them all excited in showing them the good things about nursing, we would tell them what they needed to do to prepare to become competitive candidates for the School of Nursing. In addition to visiting the schools we would have the schools visit the campus. Those students who applied for admission but were not accepted, we would follow up to see if there were things they could do to improve the points [awarded to their applications] so they would be accepted [next time].”

Another director of a diversity-related grant, Pipeline to Registered Nursing (PRN), conducts outreach to high schools with high proportions of UR students and hires undergraduates to make presentations about nursing as a career choice. Her dean emphasized the importance of engaging UR undergraduates as “ambassadors” in the recruitment process:

“I do help with the health academy [nearby]. But I don't think that's going to get to the students like someone who's four years older than they are coming and saying, ‘You know, there's this wonderful career and this

⁴⁵ The entry-level master's degree is the appropriate educational path for students who have a bachelor's degree in a field other than nursing.

is what you can do with this career. These are the options you have and here's how you get down that road.”

Other recruitment activities include advising prospective students about how to prepare their applications, inviting prospective students to visit the campus, holding orientations for the community, and participating in community fairs. Recruitment activities are also conducted by BSN programs at community colleges to encourage students to transfer to four-year programs.

While all public college and university nursing programs are heavily impacted, both at the community college- and CSU-level, this does not prevent programs in either system nor at private institutions from continuing to conduct recruitment activities. One community college informant told us:

“So everything's a potential. We've been sowing seeds out there like crazy and periodically we get a little bit of feedback. Somebody in the class will say, “Could I go with you on this next outreach?” And I said, “Why do you want to go?” She says, “Well, you came to our high school. That's where I made up my mind.” I listened to what she had to say, you know, and it's kind of neat.”

Community colleges, where we conducted the majority of our nursing interviews, have the most critical retention problems. Strategies to increase retention include:

- Mentoring
- Remediation
- Tutoring
- Personal and academic counseling
- Advising
- Tracking academic progress
- Development of flexible modes of curriculum delivery
- Financial assistance
- Peer support
- Study groups

Most programs employ a combination of these strategies, but lack the resources and support to address high rates of attrition. Both faculty and department chairs expressed frustration with what is viewed as untenable demands from the Chancellor of the California Community College system:

“The Chancellor's office is giving us continual enrollment growth dollars, which has helped. But of course now they're tying success and retention to those dollars and we're an institution that is not retaining students. We're having our issues down here. I have an attrition rate of 40 percent and that's just outrageous, when you look at the cost of educating [a nurse]. But some of it is because of the learners, and it's because of the

faculty, and it's because of all of these life issues. It's a challenge to figure out how to do it. It's a lot of frustration."

High attrition rates are often attributed to the admission of inadequately prepared students into ADN programs and, in a certain sense, this does explain high drop out rates. But there are systemic causes of attrition that call for systemic solutions.

Policy makers cite statistics as indicators of programmatic success or failure and a 40 percent attrition rate is significantly higher than average. But in this case the tracking system that records dropout rates may actually inflate the extent of the problem. As stated by one academic leader:

"When you talk about 40 percent attrition [you have to consider that] in some instances, the student has a need to drop and then comes back and does complete [the program]. But that's still considered a drop. Even some of the ways in which we categorize or track [are problematic]. Right now, because the nursing shortage is so severe, the state wants you get them in on day one and they're out in two years, if not sooner."

Despite these problems, tracking can help to identify students who need remediation and other services before their problems become overwhelming and insurmountable. We visited one program with a low attrition rate that was attributed in part to systematic student tracking, which ensures that students don't get lost in the shuffle, especially students with recurrent problems. As a counselor explained,

"When students have difficulty, the instructor writes up a form and tells me what it stands for. Then the student is given the form and the teacher signs it. I spend a big part of my time seeing students, I mean, constantly, because I have to see every student that receives one of these forms. Do they need to go see a tutor? Do they need to have remediation in a skills lab? I connect them to the resources. Math, watching a video, whatever it is. Sometimes it's just studying together [with other students]. And then they take the form up to our skills lab person and she tracks everything. She and I meet about every two weeks and she gives me big printouts of how [the students are progressing]. She tracks to me if the student has followed up. Everybody has [to sign off on the form]. It requires about four signatures. So it's a good strategy."

The dean of this program underscored the system's advantages.

"We found out that if nobody knows what you're doing, then you can just sink in a hole. But if you've got to answer to somebody, like, 'Did you go and talk with so-and-so? Now you've got to go see the director.' [Then] you know that somebody is concerned about you."

Interviewees conveyed a common view that students succeed when they have a variety of supports tailored to specific problems and situations. For one department chair, support begins at home. When the situation calls for tough love, she doesn't hold back, either with her students or their families:

“I tell the students, ‘We’re a family. You spend more time with me than your family. For two years you belong to me.’ I meet with family when I do orientation. I invite family, especially husbands, mothers, and children over five because it’s a commitment on the part of the family and me. So when we buy in, you’re saying [turns to the interviewer], I’m gonna support Ruth. That means when Ruth doesn’t cook—husband, you don’t know how to cook?—you figure out how to feed the family. When Ruth doesn’t clean, forget it. For two years she may say, ‘Honey, the living room is clean and I know where things are in the kitchen but you know what? I’m sorry. I can’t do it.’ I need that kind of commitment. So when my husbands renege, my wives, my students, come to me and say, ‘He changed.’ I get on the phone and I’ll say, ‘Now look, you told me you were going to support her. And she’s saying you’re asking her to cook and she doesn’t have time. If you want her to be successful in this program, you’ve got to let it go.’”

One program has developed a solution that is easily accessed by students who find themselves in unexpected financial straits:

“We’ve developed an emergency fund. Because in looking at why our attrition rates are high, one of the things we found was often it was financial issues that contributed to academic failure. So we created an emergency fund so that students can say, “Hey, my P.G.& E. bill. Here’s the bill. Can you pay this?” And it shows “past due,” so then we go through the process and we pay that for them. This becomes one less worry, hopefully enabling them to apply themselves academically and be successful.”

One educational advisor whose position is funded by the state’s Workforce Investment Act has developed a peer mentoring and tutoring program. He manages the students and creates educational plans and goals, so that students can be successful doing NCLEX-style questions.⁴⁶ “He becomes their support mechanism,” an informant explained.

In another program, clinical competence was identified as an area where students needed remediation in order to succeed. The department chair, a resourceful community leader, developed an effective intervention:

⁴⁶ Becoming familiar with the format and content of NCLEX questions well before it is time to sit for licensure helps students build up confidence and serves as a check on their growing knowledge and competencies.

“The weak students self-select and they do an extra clinical [session] on a Saturday or a Sunday with the instructor that we’ve hired that really focuses on [patient] assessment. It’s a small group, no grade associated. It’s usually about six students, which is much smaller than their [usual] clinical group. And they come back just blossoming. We do it all year round as long as the student is in good standing. A former grad of mine is the instructor. I can’t afford her otherwise but I can afford her on the project. She’s a nurse practitioner.”

Peers can learn together in study groups and one-to-one encounters in ways that are not possible in a formal tutoring session. The intimidation factor is significantly reduced or altogether eliminated when one is studying with a friend or colleague and one can freely ask questions that might otherwise be kept to oneself. One department chair actively encourages study groups:

“I match students with peers. And then when the student tells me, “I have a study group,” I want to know who they’re studying with. Sometimes I say, “Oh no, no, you can’t study with her. That’s the blind leading the blind. I need you to study with someone that can see.” And they look at me like I’m crazy, so then I suggest students that they should study with. The student may say, “But I’m busy.” I say, “You guys work it out.” ...And that’s what my students have learned to do. That’s called survival.”

Admissions Process

Individuals who want to pursue nursing careers face admission challenges quite different from those encountered by prospective medical, dental, and public health students. Community colleges comprise nearly two-thirds of California’s nursing programs and the tuition for California residents is extremely low—\$20 per unit. In-state tuition and fees at CSU campuses are somewhat higher but still comparatively low, ranging from between \$2,500 and \$3,500 per year for in-state students. Tuition at the University of California and at private colleges and universities is higher.

Whereas some prospective undergraduates and applicants to medical, dental, and public health programs may apply to between five and ten or even more professional programs along a spectrum of “safe” schools to “dream” choices, this is not the pattern for most nursing students. Given the 2:1 ratio of public ADN programs to other nursing programs and the cost differential between the various systems, it appears that students generally make their decision of which system or institution they will apply based on consideration of a combination of the following factors:

- Mobility and geographic concerns
- Application criteria
- Tuition costs
- Quality of institution

- The pace at which they can complete their prerequisite and nursing courses, i.e., full time or part time

One informant from a four-year program observed that nurses are increasingly becoming the first members of their families to attend college. The desire to stay close to home may be a salient consideration for prospective students, particularly Latinos, whose families are unaccustomed to the rite of passage of children leaving home at age 17 or 18:

“We need to be aware that our future lies in preparing students who have not had the role models of older siblings or parents that went on to school to bring them in and it can’t help but help the whole country.”

A CSU informant explained that identifying qualified UR applicants poses a challenge:

“We have applicants but not all of them are qualified. We have a very strict point system. You either get the points or you don’t and that’s the only way we can deal with that number [of applications we receive].”

In view of the fact that every public nursing program in the state is impacted, two general approaches are used to determine those candidates to whom acceptance offers will be made after prerequisite coursework is completed. Each program selects the method it will employ, although a movement is afoot, as discussed below, to standardize admission requirements, including prerequisite courses, across the community college and CSU systems.

One approach employs non-selective or random strategies, such as a lottery or a queue with a waiting list, i.e., first come, first served. A total of forty-two, or 60 percent of community college programs use this sort of system.⁴⁷ A second approach relies on merit-based criteria. Programs use different criteria to define merit, such as receiving higher grades in prerequisite courses, previous healthcare experience, or an applicant’s track record of performing community service.⁴⁸ Still other programs use “semi-random methods,” which are neither criteria-driven nor purely random. A fourth approach involves screening applicants using “multi-criteria,” combining merit-based standards and factors such a lottery.

According to Seago and Spetz, California’s community college system operates under the philosophy that all qualified students should have access to the educational resources of the college. Thus, most nursing programs believe selective admissions are in conflict with the open mission of community colleges.⁴⁹

⁴⁷ California Healthline, www.californiahealthline.org, accessed May 15, 2007.

⁴⁸ Jean Ann Seago and Joanne Spetz, *Admission Policies and Attrition Rates in California Community College Nursing Programs*, Sacramento: California Postsecondary Education Commission, n.d.

⁴⁹ *Ibid.*

The lottery system (and other random and “semi-random” methods) were instituted after a 1988 lawsuit by the Mexican American Legal and Educational Defense Fund (MALDEF), which alleged that community college assessment, placement, and prerequisite policies disproportionately excluded Latino students from certain courses and programs, including nursing.⁵⁰ In the intervening decades since program lotteries were established, several trends in and beyond California have led to the current nursing shortage, including the closure or downsizing of numerous nursing schools in the early 1990s, closure of hospitals, and laying off of nurses by hospitals instigated by managed care staffing and reimbursement policies and practices. With fewer nurses being hired to work in acute-care settings, “people [were discouraged] from going into nursing because they were afraid they wouldn’t have a job when they got out [of nursing school].”⁵¹

But the decreased demand was only temporary. Along with demographic shifts in California’s population that have translated into a significant and growing demand for nurses, state-mandated nurse-patient ratios in acute-care settings, and attractive salaries and benefits, nursing—once a field of moderate status and remuneration—has been refigured as a very desirable career. Yet the availability of faculty and facilities to train nurses has not kept pace with either the demand for RN training by prospective students or the demand for nurses by employers. Hence, the state’s nursing programs have become increasingly impacted.⁵²

At the same time that community colleges and CSU programs are deluged with more qualified nursing applicants than they can accept, ADN programs are faced with high attrition rates. According to the Legislative Analyst’s Office, about one-quarter (1,500) of the ADN students enrolled in 2002-2003 never graduated. By contrast, the average attrition rate for BSN and MSN students is less than half that figure.⁵³

This is a formidable statistic whose meaning is contested by various stakeholders. The problem of attrition has caused widespread concern both from the standpoint of the cost

⁵⁰ According to the Legislative Analyst’s Office, MALDEF “agreed to drop the lawsuit in 1991 after the California Community College Chancellor’s Office committed to develop a new set of regulations. Under these regulations, nursing and other programs, are allowed to continue requiring prospective students to achieve a minimum grade point average on science and non-science (such as English composition) prerequisites to be eligible to apply. However, districts must first conduct validation studies showing that students who fail to satisfy these requirements are unlikely to succeed in the district’s nursing program. Districts also must offer programs (such as English-as-a-second-language instruction) to help applicants achieve minimum eligibility requirements. The regulations also require nursing programs to adopt non-evaluative selection methods (such as a lottery system) when there are more eligible applicants than enrollment slots.” Analysis of the 2007-08 Budget Bill: Education, Inter-segmental: Higher Education Nursing Proposals. http://www.lao.ca.gov/analysis_2007/education/ed_18_anl07.aspx.

⁵¹ Andrea Moss, “Industry Insiders Cite Reasons for Nursing shortage,” NCTimes.com, July 14, 2007, P. 2, accessed 2 August 2007.

⁵² During academic year 2005-2006 over 8,000 applicants to nursing programs were placed on waiting lists in ADN, LVN to ADN, BSN, and ELM programs in California. Renae Waneka and Joanne Spetz, California Board of Registered Nursing, 2005-2006 Annual School Report, Pre-Licensure Nursing Programs, Data Summary, 2007, P. 15.

⁵³ Analysis of the 2007-08 Budget Bill: Education, Inter-segmental: Higher Education Nursing Proposals. http://www.lao.ca.gov/analysis_2007/education/ed_18_anl07.aspx.

of training students who are ultimately unable to complete their degrees and the slowed rate of production of new nurses. It has caused many to believe that selection by lottery is a poor strategy for identifying students who will persist in their ADN studies.

In order to decrease the attrition rate of ADN students Assemblymember Berryhill (R. Modesto) proposed AB 1559, which requires a registered nursing program that elects to use a multi-criteria screening process on or after January 1, 2008, to evaluate applicants for admission and that includes specified criteria relating to the academic performance, work or volunteer experience, foreign language skills, life experience, and special circumstances of the applicant.⁵⁴ AB 1559 was signed into law on October 14, 2007.

While organizations such as the American Nurses Association and MALDEF as well as various hospitals and community colleges supported the bill, the legislation was opposed by SEIU, the California Federation of Teachers, and the Latino Coalition for a Healthy California. Among the concerns of opponents is that the combination of academic criteria and high numbers of applicants will impede efforts to increase diversity. Moreover, some groups argue that no conclusive data demonstrates that a higher GPA results in lower attrition rates.^{55,56} In recent years, there has been increased admission of UR applicants to ADN programs. Although the numbers are difficult to sort out due to categories like "other/unknown" and "Asian" (which does not break out specific UR nationalities), according to data for 2005-2006, slightly more than half of newly enrolled nursing students are Native American, African American, Asian and Hispanic.⁵⁷

⁵⁴ Mary A. Hernandez, Government Relations Advocate at the SEIU State Council, one of the few organizations actively opposing the statute, told me that if nursing programs are permitted to "elect" to use a multi-criteria screening process, then it is reasonable to expect that the most extreme screening process could be implemented. (Mary A. Hernandez, pers. com. 8 August 2007) On AB 1559's amendments and status, see www.leginfo.ca.gov.

⁵⁵ A complete discussion of arguments in support of and against the bill is beyond the scope of this report. However, see Latino Coalition for a Healthy California, Rapid Response Network, Policy Update, May 2007, LCHC@lchc.org; letter to The Honorable Tom Torlakson, Chair, Senate Appropriations Committee from SEIU, 24 July 2007 (available from SEIU State Council); and California Healthline, "Overhaul of Nursing School Admissions Draws Opposition," June 05, 2007, <http://www.californiahealthline.org/articles/2007/6/5/Overhaul-of-Nursing-School-Admissions-Draws-Opposition.aspx>. The California Nurses Association also opposed the bill.

⁵⁶ A study conducted under a grant from the Chancellor's Office called *ADN [Associate Degree Nursing] Model Prerequisites Validation Study* demonstrates that applying a merit-based admission system resulted in all ethnic groups experiencing a decrease in the number of students selected for enrollment. However, certain groups particularly African-Americans, Latinos, and Asian-Americans were impacted to a greater degree. (Latino Coalition for a Healthy California, Rapid Response Network, Policy Update, May 2007.)

⁵⁷ Waneka and Spetz, Note 10, p. 5.

C. Public Health Schools and Programs

Recruitment and Retention

Public health as a profession has a complex history surrounding its definition and scope as compared to other health professions. While as one dean we interviewed noted: “the field exists to serve people,” the scope of what constitutes public health, including its broad fields of study as well as its varied career paths for its graduates—make for a profession which is often not well understood as a career option—including by those from UR backgrounds. Despite these challenges, graduate public health training is very much alive in California—and with most of the programs based at public colleges and universities⁵⁸—from a tuition and time perspective, often much more affordable than medical or dentistry training.

As public health is very much connected to improving population health and well being, it is important for California to have a public health workforce that understands and is representative of the culture, language and communities of our increasingly diverse population. For the same reasons, public health is a very attractive profession to UR students, who desire careers that are values and/or service oriented including improving health and access for their communities. From a leadership perspective, all public health school/program leaders that we spoke with stated that racial and ethnic diversity in the work force is important to the teaching, research and practice of public health and that their school/program is working to advance it in one way or another.

Interestingly, while practically all of the leaders we interviewed described their student bodies as being “diverse,” we found significant variation in the degree of intentionality in their approaches. In some cases, UR diversity resulted from very focused thinking and deliberate steps to strengthen UR recruitment, admissions, matriculation, and retention. On the other hand, in at least one school/program, the diversity of the student body came about primarily as a result of local geographic circumstances and low tuition, which yielded an applicant pool with a good number of UR applicants. In at least two programs, while the interviewees cited a critical mass of diversity, they acknowledged that this was primarily a result of the matriculation of a high number of international students. There had been little effort to recruit and support potential UR applicants from the racial and ethnically diverse immediate regions.

Sources for UR student recruitment cited by interviewees included the following:

- The undergraduate program on the same campus
- Church affiliated undergraduate schools
- CSU undergraduate campuses (particularly for Latino applicants)
- Prestigious Eastern colleges and universities (particularly for African American applicants)

⁵⁸ All public institutions, with the exception of Loma Linda and USC.

In most cases, the bulk of the recruitment is carried out by student affairs offices; current students and MPH alumni were also noted as being engaged in the process of UR recruitment for their respective programs.

Undergraduate students groups with a racial/ethnic identity were also noted as places where recruitment of potential UR applicants to MPH schools/programs were sought. For example, UC Berkeley goes beyond just the standard ‘informational’ recruitment effort at its undergraduate campus, as the Office of Graduate Admission Diversity Services provides student coaches who even help with completing graduate school applications. Undergraduate majors, minors, and overall interest in public health is growing on many public and private campuses in California and around the country. For example, within 2 years of launching a new public health undergraduate major UC Berkeley had over 200 students enrolled with over 100 on the waiting list. UCLA’s public health minor has experienced significant growth along with new majors at San Diego State and other CSUs.

Some public health programs are increasing their outreach and support efforts to community college students. CSU San Francisco and San Francisco City College have the “Health Train” program that targets community college students to complete health related programs or course work at City College and then obtain their bachelors and ultimately their masters in public health at CSUSF. Programs are offered in the evening and part-time to accommodate student’s work and family obligations. UCLA School of Public Health offered a public health course at a local community college to stimulate awareness and interest. UC Berkeley and UC Davis Public Health participate in a major conference sponsored by the American Medical Students Associations at American River College, which exposes over 1200 students to medical and public health education and careers. Given the significant numbers of UR students in California Community Colleges, increased emphasis could be placed on public health outreach and recruitment efforts

Increasing the number of paid practical internships and research opportunities for UR undergraduates and community college students are important strategies for increasing interest in and preparation for public health education and careers. These opportunities provide important exposure, experience, mentoring and networking opportunities that enable students to discover the public health path that best suits them and understand how to advance from where they are to pursuit of an advanced public health degree. They also provide experience and relationships that help make them better qualified and competitive applicants.

Unlike medicine, dentistry and nursing, public health graduate programs typically seek students with post-undergraduate work experience, sometimes as much as 3-5 plus years. This creates a challenge for UR and other students as it is difficult to obtain a meaningful job in public health without a Masters degree and career paths and entry level jobs are unclear and hard to find. Internships during school are one way that students obtain post-graduation jobs. In addition to increasing internships, more post-baccalaureate fellowships or specific jobs for undergraduates could be created between public health

programs and employers with the intention that UR students would work in them and be mentored for graduate school, take GRE test preparation courses and build valuable experience to strengthen their MPH retention and qualifications. Absence of specific job opportunities results in bachelors degree students pursuing more tangible jobs and paths in non-health professions or applying to medical school as a more clear, immediate opportunity, whether or not it is the best fit for them. This dynamic may be exacerbated by family or cultural pressures to become doctors, given a lack of understanding of public health as a profession.

Like their medical or dental school counterparts, when resources are available, schools sometimes sponsor visits for prospective students. One interviewee described the approach by their campus:

“We have a spring visit day, when the admitted students, with a focus on diversity, come to campus. It is in conjunction with the campus-wide diversity-visit day. We've actually come up with funds in the last couple of years to pay travel for some of the UR students from out of the area. Here that's not something that happened in the past. So a student of color who lives outside of the area, to pay for them to come here and be part of the campus, we've had them stay with other students of color when they're here. They kind of build some relationships. We try to get faculty to come and participate in those kind of activities.”

These sort of informational opportunities are especially important for fields like public health where undergraduate student understanding about graduate training in public health, as well as careers in the public health field are often incomplete.

There are certain structural attributes in some public health programs that can assist with recruitment and student matriculation as well as program retention of UR students. As stated previously, part-time and/or evening programs allow students who can't afford the tuition or time costs of being a full-time student to earn MPH degrees.⁵⁹

Such part-time flexibility is also useful to students where traditional grade and test score criteria may be lacking and there is some concern about a student's ability to academically handle the curriculum. In such instances, an offer of “conditional matriculation” where a student takes a few courses, and if successful, then offered an unconditional admission to the program.⁶⁰

From a support perspective, a number of public health interviewees told us that when a student is offered full admission to an MPH program with the knowledge that the traditional ‘hard’ criteria are lacking in his/her application; efforts to carefully track student progress and offer additional supports are provided and are viewed as making the difference between successful progress towards graduation or not. Some of these supports may be within the program; others may come from a university-wide office that

⁵⁹ E.g., Loma Linda School of Public Health.

⁶⁰ E.g., SDSU School of Public Health.

can offer such resources to students and even include deferred matriculation in favor of basic supports to those students lacking basic writing and math skills.⁶¹

Finally, as in medical or dental school recruitment and retention, the level of financial support the relative presence of a visible and dedicated cohort of UR faculty members to advise and support students, and evidence of a supportive environment (see section VI) are important issues to prospective UR public health students.

Admissions Process

Some interviewees suggested that the breadth of the field of public health, and the need for practitioners and academics with a wide array of skills, orientations, preferences, and experiences would appear to reinforce the importance of diversity. Hence it should be easier than other health professions to build a common understanding among faculty and administrators that diversity is a priority consideration in the admissions process. In addition, unlike medicine, dentistry or nursing, public health lacks individual licensure and certification programs for individuals⁶²; thus, it can be argued that greater flexibility and experimentation in admissions criteria for graduate training in public health is warranted.

According to some interviewees, this flexibility in approach appears to be more common when the admissions process is decentralized, taking place at the level of departments or concentration areas, rather than in a single school-wide committee. This allows for differential consideration of an applicant's individual characteristics and their implication for successful navigation of a particular curriculum. As noted by one interviewee:

“Some programs are looking for different things and different students. I would say that the social sciences, you know Health Policy and Management, Community Health and Human Development Division, as well as Health and Social Behavior, I would say they are looking at experience, and I would say ‘distance traveled’ is probably more important to those programs that it is to Biostatistics or Infectious Disease. You know, every Biostatistics faculty person will say, give them to me young and smart; so they are primarily going to be looking at GRE and GPA. It also depends on how impacted the program is, Health and Social Behavior is always incredibly impacted, and they get more applicants than any other program in the school by far. And that means they're going to be super selective, and in addition to GPA and GRE they're really looking for experience and they're really looking for alignment with the kind of principles, you know what the community experience, with social justice interest and those kind of things.”

However, in some instances, where a candidate's performance with respect to the “hard,” quantitative criteria for admission is below established minimums, the decision of

⁶¹ E.g., SFSU Public Health Program.

⁶² However, with the recent creation of a national board exam for MPH graduates, it is likely that individual licensure or certification may not be far behind.

whether to offer admission is given to a central group with attendant consequences. As one interviewee noted:

“The central committee is made up of the heads of each division, those people reviewed anybody with GREs scores that are less than 50th percentile, and GPA that is less than 3.0. And now you have a whole group looking at those exceptions, and you also have a culture now where everybody knows that if you recommend someone like that for admission it's got to be reviewed. So, I think it means that people are far less likely to recommend a person who doesn't meet the GRE and GPA requirements.”

Some programs appear to defer to certain individuals on the admission committee to provide leadership in the selection of applicants based on criteria outside of traditional quantitative measures. For example, at one program, UR applicants are pulled out for consideration in the following manner:

“Well, we also institutionalized that we would review the UR [applicants] first, as there's a list of those students that are printed out. And each program is given a directive by February 10th that you will review and decide on your UR students. And that allows us to A) let them know that they've been admitted more quickly, and B) see if we can get some added financial package to them sooner so that they can consider coming here... one person, the head of the Admissions Committee is somebody who has been delegated authority by the overall admissions committee to approve exceptions. Department Faculty Admission Chairs write letters explaining the rationale that supports the admission of students who are strong, qualified applicants in all areas except that they have GRE scores less than 50% or a lower GPA, or something about their application that doesn't work. And they delegate the final decision, unlike before when they used to debate each person in the meeting, to the Admissions Chair. And the person who's been the Admissions Chair does believe in distance traveled. He might not say that in a room or anything like that, but when I submitted many of our under-represented students to him, he went to bat for them. They were below the threshold and this person would go, ‘Oh, this person's from City A. Wow, look at the schools they went to where they had a rough time,’ and they read the statement about their background and he would say, ‘I think we can accept this person, just provide them with support.’ So, it's a kind of an informal thing, and if there was a different chairperson it might be different. But this person, fortunately, has been the chair for the last several years.”

This same school has done studies to evaluate how well UR students admitted by exception perform in the most rigorous core courses. They found that UR students admitted by exception performed just as well or better than students admitted with high traditional quantitative measures. The data was critical to the Admission Committee continuing to have the confidence to admit students by exception.

At another school/program, rather than a single individual, a small group of faculty in a program or concentration is empowered to make judgments based upon a ‘whole file review’ approach:

“... even though we say, in general, this is the minimum GPA for admission to the university, these are the minimum GRE scores that we look for, no application is held back from review, if they don't meet those requirements. So, once a file is complete, whether the person has a 1600 on the GRE and a 4.0, or they're low on the GPA and with the GRE, it goes out to the division for review. And we are able to admit students who are weak on grade point average or other criteria, based on other strengths that they might have. And those are determined by the faculty who are reviewing it, so it might be [in the faculty's judgment] that they've got great experience, or it might be that they speak another language, or some may take ethnic diversity into account. I don't always know what the thinking is.”

Some interviewees indicated that not all MPH programs take “distance traveled” into account. Some schools/programs with large numbers of applicants require that a candidate achieve a certain threshold on the “hard” criteria, as there is concern about accepting students who may not be able to academically get through the program. As is the case in the medical and dental school context, schools/programs and their faculty weigh the financial and time resources that may be required to help students who appear to be academically challenged. This reluctance serves as a practical barrier to the integration of “distance traveled” criteria into the admissions process beyond a few isolated individuals.

Enrollment

The UC Graduate Programs in Public Health have not had an increase in enrollment for over 10 years. UC Berkeley School of Public Health is the smallest of the top 10 schools of public health and admits the lowest percentage of applicants of any accredited public health program in the country. A UC Office of the President report released in January 2007 recommends a 180% increase in enrollment of UC public health schools and programs in order to meet California's projected public health workforce needs. Increasing enrollment would provide graduate public health opportunities for more URM students and all Californians.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other ‘Inquiry areas’ tied to this project, we propose the following recommendations tied to admission, recruitment and retention:

- 1. Target investment and enhance coordination to strengthen recruitment of URM and disadvantaged students at CSU and CCCs.** Increase dedicated funding at

HPEIs to support more focused recruitment and support of UR health science students at California State University and California Community College campuses. On campuses with multiple health professions schools and programs, greater coordination is needed to make optimal use of available resources through interdisciplinary approaches to outreach and recruitment.

2. **Reflect commitment to diversity in admission committee membership.** HPEI admission committees should represent a diverse spectrum across lines of ethnicity/race, gender, and status. They should include faculty, students/trainees, and administrators. Committees should be well informed about the benefits of diversity for the academic community.
3. **Administrative leaders “set the tone” for admissions committee commitment to diversity.** It is critically important for Deans and other leaders to ensure that admissions committees are aware that increasing diversity is a high priority for the institution, and to provide the knowledge and justification for such a focus.
4. **Place senior faculty with understanding of UR issues in admissions committee leadership.** Senior faculty members bring significant experience and influence into the admissions committee process. Provided that their experience has yielded an understanding of the importance of student diversity to quality education, they can play an important role in the application of whole file review approaches to admissions.
5. **Conduct further inquiry into alternative strategies to implement “whole file review” approach to admissions.** Applied research into alternative strategies in the application of whole file review are needed to assess the impact and implications of different approaches, share lessons from efforts to date, and facilitate the promulgation of criteria and processes that yield optimal results.
6. **Increase paid practical and research internship opportunities for undergraduate students with leading employers and HPEI faculty.**
7. **Increase paid post-baccalaureate fellowship programs or jobs to provide UR students with experience, mentoring, and application preparation to enhance graduate program qualifications and competitiveness.**
8. **Increase outreach to undergraduates and community college students and parents about public health careers, graduate education and how to advance.** Support collaboration among public health graduate programs and leading employers to expand these efforts.
9. **Increase enrollment in public health schools and programs.** This would provide more opportunity for UR and other students to pursue public health graduate education and increase the pool of qualified candidates to address the growing public health workforce crisis in California.

V. Create a Supportive Environment

A number of key structural/environmental factors were identified by academic leaders as affecting UR applicant program selection and retention. Leaders also identified factors that have importance for creating a welcoming environment for UR faculty and staff (discussed in Section VI, Recruit, Hire, and Retain UR Faculty).

At its broadest level, comments from interviewees suggested that creating an institutional climate that is supportive of UR students, faculty and staff, is an ongoing process, rather than a static endpoint. This process requires more than achieving a “critical mass of diversity,” in terms of adequate representation of people from diverse backgrounds; often referred to as structural, or compositional diversity. It also requires the integration of diversity-related material throughout the formal curriculum, and an infrastructure that provides opportunities and encourages cross-cultural dialogue. Attention to compositional diversity and interactional diversity at the formal (i.e., curriculum, pedagogy) and informal (i.e., student groups, service learning, mentoring, extra-curricular events) level creates the conditions for an institutional climate that not only provides optimal support for UR students, faculty and staff, but enhances the quality of the educational experience for students from all backgrounds.⁶³

Creating a supportive environment for diversity at the larger campus or university environment is important, but attention must also be given to what happens at level of HPEI schools and programs. Interviewee comments touched on a number of different issues that should be of concern in efforts to create and sustain a supportive environment for UR students and trainees. These issues are discussed under the headings of structural issues – building a critical mass of diversity, creating a support infrastructure, programmatic support, and culture and pedagogy.

A. Structural Issues – Building a Critical Mass of Diversity

A number of interviewees noted that the creation of a supportive environment requires the presence of a ‘critical mass’ of UR students, faculty and trainees. While no one specifically identified a quantitative tipping point, most agreed that in the absence of a sufficient cohort of UR students, creating and sustaining a welcoming and supportive environment is difficult, if not impossible. Many acknowledged the unfortunate reality that when UR students are so few in number so as to be almost ‘invisible’, their particular needs and concerns can simply be “off the radar screen.” One interviewee summarized it this way:

“It is possible that this group suffers more self-crisis and self-esteem crisis and confidence crisis without a large community of students and we don’t have a large community of students that they can identify with or a robust

⁶³ This conceptual framework and an examination of efforts to create such an institutional climate is addressed in the CTD report “The Benefits of Diversity: An Exploratory Study,” released June 2008.

faculty that they can identify with. It's possibly that they tend to isolate themselves.”

Having a cohort of students who share familiar cultural and other experiences is an important factor that contributes to the creation of a more supportive environment for UR students. In the absence of peer support, there is greater risk of isolation, and in some cases, reluctance to share unique experiences and/or challenge “conventional wisdom.” The lack of critical mass can, in turn, impede efforts to recruit other UR students, and make it difficult to build institutional concern about how the school and campus environment can be made welcoming and supportive to UR students. With support, students often find the demanding experience of health professions education can be made manageable:

“When you're all in there together you start becoming friends and understanding. That's our hope; that you become a friend, understand each other. And as we are all trying to get through as a cohort—they're going through as a cohort—as they're trying to all get to graduation.”

Another interviewee emphasized the importance of this cohort-based support system:

“I mean, it's just, there's no doubt a lot of people get through because their colleagues will not let them fail. They're committed to each other.”

These cohort-based support systems can be based upon background (e.g., UR groups)⁶⁴ or programmatic emphasis,⁶⁵ but it is of central importance that HPEIs facilitate the sharing of these groups' experiences and perspectives with students from other backgrounds.

A number of interviewees noted that UR faculty have a critical role in creating a positive campus climate that nurtures HPEI students and supports students in achieving their academic goals. A student's description of the importance of having a diverse faculty is as follows:

“I was [a student at XX and just seeing that as a result [of having UR faculty around in sufficient numbers] it does make a difference to have that welcoming feeling and to see other faculty and staff who look like you and who have the same goals, who've gone through what it is you want to go through, or what it is you want to do eventually. It just gives you a welcoming feeling. You feel more comfortable to go and ask that person a question or ask how it was to go through medical school or graduate school.”

⁶⁴ See example of such a group in profile of UCLA Students of Color in Public Health in CTD report “Profiles of Leadership.”

⁶⁵ See examples of two such groups in profiles of UCR Faststart/Medical Scholars Program and UCI Prime LC Program in CTD report “Profiles of Leadership.”

Beyond the campus environment (and often beyond the control of the sponsoring institution of the HPEI) it is important to note that the reality and perception of the surrounding community (ies) can significantly influence decisions on where to attend as well as the total life experience as an HPEI student or trainee. We heard from at least one residency director and colleagues at a teaching hospital that the residency's ability to attract UR candidates is greatly influenced by whether a spouse and the trainee will feel comfortable living and being welcomed in the surrounding community (ies) where the residency program is primarily based. This reality needs to be incorporated into the thinking about how best to support UR students or trainees when coming to attend education or training at any particular HPEI.

B. Creating a Support Infrastructure

One approach to building broad-based support cited by interviewees is the establishment of an institutionally sponsored office that serves as the nexus for diversity-related activities and planning. The office can both provide logistical support for mentoring UR students, providing specific environmental and other supports, as well as creating a welcoming place in the program for UR students to come to seek a variety of counseling or other supports. An example of this sort of support was captured in the following comment from an interviewee:

“We found out that if nobody knows what you’re doing, then you can just sink in a hole and nobody knows. But if you’ve got to answer to somebody, like, “Did you go and talk with someone?” “Now you’ve got to go see the director,” you know somebody is concerned about you.”

The creation of such an office can send an important signal to UR applicants that the HPEI cares about having a racially and ethnically diverse student body and is committed to creating a supportive environment for UR students and their family members.

It is important to acknowledge, however, that the creation of such an office will not in and of itself ensure the promotion of diversity and the creation of a supportive environment requires a broader cultural change across the entire institution, school, or department. Numerous interviewees emphasized the importance of establishing a framework of shared responsibility throughout the institution to promote diversity on a day to day, week to week, and year to year basis.

The creation of an office of diversity builds on an approach recommended in the IOM report “In the Nation’s Compelling Interest,” which called for the establishment of an “Ombuds Office,”⁶⁶ which serves in a mediation and problem-solving role for all manner of grievances. In this sense, the office of diversity goes beyond addressing barriers to a more proactive role of facilitating an optimal environment for shared learning. The office of diversity also should be distinguished from an office of minority affairs. Such offices

⁶⁶ “In the Nation’s Compelling Interest: Ensuring Diversity in the Health-Care Workforce, 2004, Institute of Medicine, Washington, D.C., Chapter 5, page 165.

served an important function to provide support for racial and ethnic minorities in times when UR students were faced with more explicit forms of hostility and discrimination. In current times, however, a growing number of academic experts⁶⁷ recognize the importance of creating an infrastructure that supports the accrual of the benefits of diversity for students from all backgrounds and experiences.

C. Programmatic Support

A significant number of our interviewees noted the importance of pre-matriculation programs that have a significant focus on the issues affecting UR students. We discuss pipeline programs in Section II of this report, where the focus is primarily on creating longer time interest and ability to study the health professions. In this case, the focus is on programs that take place either just before a student applies to a HPEI or after their acceptance. In the former case, it is a program helps UR prospective applicants become familiar with the resources and faculty at a particular institution in order to encourage their application; the latter is a program that is offered to familiarize students with the academic or environmental aspects (or both) of a particular program.

One example of such a program is the UC Irvine Pre-Entry Program, a month long academic program for students who have been accepted to the UCI College of Medicine. The program is offered in the summer prior to the beginning of the first year of medical school. The Departments of Anatomy and Neurobiology and Biological Chemistry provide comprehensive instruction in anatomy and biochemistry. The course is designed to help jump start a student's knowledge base and develop class leaders in these courses.

The potential value to a UR student was captured in a conversation with one interviewee who described how such pre-matriculation programs could also help UR students become comfortable with faculty and administrators that they will be in contact with during their years of education:

“... students got personally comfortable enough with the Dean that they would come and talk to me personally..... I sense a real need for underrepresented minority students to feel extremely comfortable with their teachers and to be able to interact and be comfortable with their administrators.”

D. Culture and Pedagogy

UR students often come from economically disadvantaged environments, and from families where higher education is not been part of the historic norm. Given the high and rapidly growing costs of higher education in general and health professions training in particular, these students may struggle with the perception that their academic pursuits

⁶⁷ The Institute of Medicine committee discussed this issue at length, with emphasis on moving away from an explicit institutional entity designed to support only one class of students (i.e., UR students).

are a somewhat selfish endeavor. A message sometimes heard from home is that higher education and the attendant financial and other opportunity costs, while benefiting the individual student, can result in great hardship for other family members who lose financial or personal support from the health professions trainee being “occupied with school.” One interviewee captured the essence of this challenge:

“If they don’t have a family that understands graduate school or college or high school, they can have competing. ‘Well, what do you mean you can’t come home? You don’t care about us.’ ‘Yes, but I’m in medical school now.’ ‘No, you need to come home.’ So, there’s this different set of pressures on this group of students. I have to be honest. I don’t think we adequately support them.”

The tensions created by this dynamic can have a negative impact on academic performance and/or psychosocial well-being. It may also reduce graduation rates for students who decide that the opportunity cost of health professions training is too high—even when such students are in good academic standing. A number of interviewees indicated that this dynamic may come into play in particular with Latino students, citing a culture where accruing significant debt is frowned upon. HPEIs try to counter this and related problems with faculty mentoring (often from UR faculty) and other supports. Many interviewees, however, identified this as a core and persistent issue. Among HPEIs that retain the traditional didactic competitive model of education, UR students often experience a tremendous amount of dissonance when attempting to navigate within and between their culture of origin and the culture of the academy. As noted by one interviewee:

“Who sets up the rules, the standards, of what excellence is and what the expectations are? And it tends to be a mono-cultural model that isn’t inclusive of other ways of being excellent. And I think that’s where this level playing field becomes a sham because it’s your level playing field, not my level playing field.”

There was one Latina who was in another school, in the doctoral program, and they were studying for the qualifying exams. And her study cohort said, ‘Oh god, we can’t wait until these exams are over, Cynthia, because then you’ll get back to being yourself.’ Because she was getting very emotional. And she said, she just stopped, she said it was like a cold bucket of water was poured on her. She said, ‘You folks don’t realize this is me. You know how hard it is to act white everyday?’ And she said it was that realization for her, too, that she was living in two worlds and having to negotiate that on a daily basis, what a toll that takes emotionally. And so which level playing field?”

Another approach cited by interviewees to create a more supportive environment is the decision at some schools to eliminate letter grades. While such a decision has implications and potential benefits for all students attending a health professional training

program, interviewees addressed the particular benefits to UR students. At the UCSF School of Dentistry, it was noted that this decision has led to increased teamwork, reduced competitive behavior and enhanced learning for students. Interviewees also indicated that it has resulted in increased classroom and informal interaction among students from diverse backgrounds. These interactions will provide all students with a greater understanding of the increasingly diverse populations they will serve upon graduation. For UR students in particular, creating opportunities for increased interaction and joint problem solving creates a far more welcoming environment, and eases the competitive dynamics fostered by traditional didactic approaches to instruction and grading systems. One administrator (faculty) member summarized it this way: “It takes the pressure off. What it says is if you come here, you’re coming into a family where the other students are gonna’ work with you, not against you.”

Many interviewees cited challenges surrounding “deep-seated value systems and prejudices” among faculty and even current student/post-docs who are not from UR backgrounds. Some of the classroom environmental challenges result when in the area of teaching pedagogy (particularly in teaching to an ethnically diverse student-body) there is often little ability to understand or implement teaching techniques which move away from purely didactic lessons to more interactive learning.

A number of interviewees noted that more participatory, case-study-based, reflective group learning and the like are often more effective than traditional (Western), didactic, classroom-based discussion. However, as well-known in health profession teaching, because of the lack of emphasis on teaching effectiveness as being a valued skill that captures faculty attention and useful for promotion, even when confronted with research evidencing the value of such a different teaching style—especially for UR students—faculty sometimes respond with “What’s in it for me and why should I change?”

Beyond pedagogy, UR students often receive both overt and subtle cues that they are really not equal and welcome members of the HPEI program; often from by faculty who come with their own prejudices. Once interviewee described the responsibilities of the institution and associated challenges in this regard:

“...once the student comes here, [we] make sure that our faculty, and our graduate students, and our post docs understand that there’s promise there, and the student deserves to be here and they’re not just here because they are a minority and the institution needs funding. ...just because they came from a state school does not mean that they’re a less advanced student or they’re not as intelligent and they won’t be as successful. I think that can be a challenge.”

In summary, addressing key impediments and environmental prejudices that are experienced negatively by UR students are often viewed as important to creating a supportive environment as any positive structural or programmatic efforts made by HPEIs.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other inquiries in the Connecting the Dots initiative, we propose the following recommendations to create a supportive environment:

- 1. Create an office of diversity as part of an overarching institutional strategic plan.** The office should function as a locus for the facilitation and monitoring of such a plan, and coordinate efforts to establish an institutional climate that fosters shared learning and accrual of the benefits of diversity for students, faculty, and staff from all backgrounds and experiences.
- 2. Conduct an assessment of the institutional climate.** In order to maximize the educational, professional, and institutional benefits of diversity, institutional leadership should assess the interacting factors and conditions at their site, and identify nodal points where development is lagging, or where an investment of time, personnel and resources will most enhance the benefits of diversity-related factors already in place.
- 3. Establish formal funding and structural support for UR student mentoring.** To optimize student success, resources and structural support should be provided to faculty, staff, and vertical student mentors to enable them to advise and counsel UR students from the outset of their HPEI experience, including pre-entry support programs. Mentors should also be drawn from the alumni community.
- 4. Create mechanism to strengthen links to UR student families and communities.** Bridges of trust and lines of communication should be established between HPEIs and students’ families and communities. Outreach to family and community members could include conducting informational meetings about the school or program in community settings and inviting family and community members to informal dinners. These and other welcoming activities will increase familiarity with the institution and support for students’ educational success.

VI. Recruit, Hire, and Retain UR Faculty

“Our baseline needs to be the diversity of our class and the diversity of our faculty needs to be absolutely identical to the diversity of the population. If we don’t do that, then something is not working correctly because the end line of that is that somebody’s not being taken care of.”

Dean of Health Professions School

“They really want diversity but when we’re looking at a candidate, what comes to them is somebody who looks like themselves.”

Senior Associate Dean at Health Professions School

“The institutions have to give a reason that is substantiated as to why... Black faculty are not recruited, why Black faculty are not retained... There has to be something more than, “It’s just hard to get that group” or “They’re just not making the grade.” I don’t accept that. From my own experiences I know that’s not true. So unless people... come to the root causes, which I think stem in the area of being biased and not accepting blacks as part of the fabric of their institution’s [the status quo] won’t change.”

Associate Professor at Health Professions School

All HPEI leaders acknowledge that they have too few UR faculty members. While there is broad consensus on the need an increase, administrators and faculty have disparate explanations for the lack of progress to date. They also hold a range of views about the steps that should be taken to build an ethnically, racially, and culturally diverse faculty. There are also both commonalities and distinctions among the four health professions examined in this study.

The first and most obvious reason cited for a lack of UR faculty is the relatively small pool of UR HPEI graduates. As a nursing faculty member explained:

“... if you look at the number of undergraduate students from certain minorities and then you look at our master’s, our master’s program has much less diversity than our undergraduate [program]. I think that’s pretty common. And then if you go on from there to doctorate, you figure that there’s only a small percentage of nurses who get doctorates, then the chances of recruiting a tenure track faculty in the minority background are in a similar manner, by pretty small.”

In this way, the pipeline “leaks” UR students at multiple levels, thereby reducing the pool of prospective health professions faculty. This continues well beyond the first stage of HPEI education, as described by one professor and associate dean of admissions:

“When we look at what happens between medical school residency, post-doctoral fellowship, and eventual faculty jobs, the numbers [of URs] go down by half at each step, *by half*. And that’s across the [highly competitive] schools we compare ourselves to.”

Although it is certainly true that the pool of UR candidates in the various disciplines is small, size only partially explains why the number of UR health professions faculty lags so far behind. Other factors are also at play.

A. Faculty Gatekeepers

As one informant explained, in addition to the pipeline, another key factor to consider are influential faculty that serve as “gatekeepers” on search and tenure and promotion committees, ensuring that only the most “qualified” individuals advance to the next stage in academia:

“How do you define “best? Well, they have to be from Hopkins or Harvard or Michigan and they have to have 25 publications. Yeah, but what about other criteria that are also important? And if they’re Black that’s great, but whoever’s the top... it’s like just taking the top tier each and every year. For some people the NIH model [is all that counts]. You’ve got to do the 25 research papers, blah, blah, blah. That’s the only criteria they’re willing to look at. I don’t think that’s the dean’s perspective but I do know that exists on our faculty. Because they say it’s a level playing field—anybody can do that.”

Sometimes that criterion is “somebody who looks like themselves,” who publishes in a narrow band of prestigious, peer-reviewed journals and presents a track record that maps neatly onto the discipline’s prototype faculty member—someone, that is, who is white and male (or in the case of nursing, female). Clearly, basic criteria and the entire concept of a track record merits further examination.

B. Criteria and Qualifications

Our study confirmed what is clear from the literature: traditional criteria for evaluating scholarly productivity may devalue and exclude UR candidates for a number of reasons. A UR candidate’s research may focus on issues of relevance—indeed, urgency—to communities of color or address topics such as health disparities or community violence that may be deemed unimportant or pedestrian by a search committee. Or a candidate may conduct research or teach using non-traditional methods—community-based and other experiential approaches, for example—which provide outstanding learning opportunities for students and trainees and produce knowledge of immediate use to stakeholders. Yet these factors tend to carry little weight as criteria for recruitment. When candidates with extensive experience and scholarship in these areas are reviewed

by search committees, they may be viewed as weak, rather than bringing valued and complementary assets to the overall faculty profile:

“The majority of faculty would say they’re penalized for it [community service] because it takes away from productive—what the institution will call productive work, and now we’re talking about the UC institutions. Now faculty may be out volunteering in the community but they’re not publishing papers. There’s not a relative value that says, you know, a hundred hours of community service equals one paper.”

In this way traditional notions of what a qualified applicant looks like on paper may sabotage efforts to recruit the most excellent candidate.

This dynamic can be particularly acute among HPEIs who view themselves and/or are viewed in the field as second tier, or aspiring first tier institutions. We heard from a number of interviewees from these kinds of institutions that they feel particular pressure to recruit faculty members that rate highly on traditional academic criteria; i.e., high numbers of peer review journal publications.

Evidence suggests that faculty searches often exclude strong candidates due to what one HPEI senior administrator refers to as unconscious bias. Her HPEI has allocated significant resources to increasing faculty diversity. She is tasked with providing training to search committees on how to conduct an inclusive search.

“We start with the search committee and the plans that search committees use, to broaden that, so it becomes more of a systemic approach to dealing with diversity issues. Right now, when a new search is initiated, it comes to my office and I review the search committee composition for diversity. [Then] I follow up with a visit to the search committee to talk about how they might search more broadly and about issues around unconscious bias. That’s a very small focus. What I’d like is [for unconscious bias] to be a school-wide initiative that is talked about prominently, so that it becomes embedded in the culture and the thinking. We’re a long way from that yet.”

Building a diverse faculty is thus a project that extends well beyond recruiting UR faculty. The culture of a school or department must undergo an evolutionary process that not only supports and values diversity in all facets of intellectual and communal life but also demands the benefits contributed by a diverse faculty. Excellence in teaching and research can be achieved only through the integration of a broad range of perspectives and experiences contributed by an ethnically/racially diverse faculty.

In short, the traditional notion of a strong track record is problematic because it is exclusionary—a narrow band of professional activities that may not encompass the strengths and productivity of candidates of color.⁶⁸

C. UR Faculty Burdens

Experience in the field and consistent input from interviewees in this study indicate that UR administrators and faculty carry a disproportionate burden of responsibility for committee service and mentoring and advising both UR and non-UR students. On the administrative side, it's a mathematical reality; a small number of UR faculty and an imperative to ensure UR representation on a broad range of committee functions. In regards to student mentoring, UR faculty not only provide formal and informal guidance to UR students and non-UR students with common interests in their own program, but also serve a similar function for UR students in other programs across the larger campus. The net result is less time for UR faculty to devote to their research. “There was a documentary on the lack of tenured professors of color,” one faculty member explained:

“And the main message was we get spread so thin so fast, that [there are] additional hurdles to go through [besides] the usual process of what we need to do to get tenure. And that's why most of them drop out along the way—because they feel compelled to help the students of color who are trying to get through the program. They're [students] constantly at your door. You know they need the help, you're able to give the help, but then that takes away from your research time.”

Though small, our sample (n=15) shows that with rare exception this disparity is invisible to non-UR administrators.⁶⁹ According to one non-UR professor:

“I think administrators don't know what most faculty do. I mean, they were faculty sometimes once themselves, but if you're a white male or female faculty, white male or female dean, you probably—when you were an assistant professor—you didn't have students coming out of your door. Maybe if you're a female in a discipline that has very few female faculty that would be true. So it wouldn't be part of your consciousness. And this gets back to the fact also of how many administrators are persons of color.

⁶⁸ This situation is similar to that of UR applicants to HPEIs, who often look different on paper from their non-UR peers. They are viewed by search committees as having deficits in certain areas, rather than as having breadth and strengths that traditional, non-UR candidates may lack. This is discussed at length in the section of this chapter entitled, “Recruiting, Admitting, and Matriculating UR Students.”

⁶⁹ We asked the following question on our pre-interview survey: “Is it your observation that your UR faculty colleagues carry a disproportionate burden of administrative duties, such as serving on internal and external committees and mentoring/advising students?” Of the 15 responses we received, 11 replied “no” and four answered “yes.” The 11 “no” responses were from non-UR deans, program directors, and department chairs. Three of the four “yes” responses were given by UR administrators. Two of the administrators who responded “yes” indicated that their departments offer reduced teaching and/or clinical responsibilities as a remedy.

The point being that administrators don't exactly know what faculty are doing, so they're not going to know that their faculty of color are being besieged by students or if they're conscious of it, they may say, "Yeah, I really rely on M. and A. to do these interviews with people who are interested in minority issues because they are involved in it. And, yes, I know it's an extra burden." But they may not realize the professional association committee they're drawn into because of that and the community committees they're drawn into."

The commitment of deans, provosts, and chancellors to hire and champion the contributions of UR faculty is critical to bringing about long-term change. In the intellectual and communal life of an HPEI, misconceptions or ignorance about the responsibilities UR faculty carry have bottom-line consequences. The support of leadership can translate into continued funding of an office of diversity, research initiatives, resources to recruit UR faculty, and dedicated teaching lines that benefit the entire institution. UR faculty members may find themselves in the awkward position of educating the leadership of their institution about their unique responsibilities.

One solution to this problem is to re-conceptualize scholarly activity to include a spectrum of activities that contribute to the academic life of an HPEI (e.g., community-based research, student mentoring). A second strategy is to "grow your own" faculty.

D. Grow Your Own Faculty

Our informants describe growing their own faculty as an effective, short-to-midterm strategy for recruiting UR as well as non-UR faculty. Growing your own faculty may involve a commitment by a department or school to mentor extremely promising students and finance their further education—often, but not always, to underwrite in whole or part the field's terminal degree. Upon completion of their education, recipients of such assistance are expected to return, for various lengths of time, to teach in the departments that provided the financing. While growing faculty one individual at a time can provide important opportunities for prospective faculty members and the departments that hire them, it must not be viewed as a substitute for developing a critical mass of UR faculty:

"The typical scenario here would be that you find a bright, promising individual, they graduate from dental school, we take them on as a faculty member full time, and we try this relationship for a year or two to make sure it's solid. If it is solid, then we retain them on their full-time salary, send them wherever they can get the best advanced education, we pay for that, keep them on salary, and then bring them back here. That's a five hundred thousand dollar commitment. It's unbelievable!

Two of the early [faculty we've grown] happen to both be Black individuals—they're already PhDs—and we're putting them through dental school now. One's in his third year, [another's] a second-year

microbiologist, physiologist, pharmacologist. We also have a third Black individual in one of our own graduate programs and the clear, determined plan is he will become chair of the School of Dentistry, which is our largest, most significant department. And that's with the blessing and support of the department.”

Schools and departments may grow their own UR faculty because of the relatively small size of the current UR faculty pool.⁷⁰ However, in nursing, with a shortage of faculty in general, combined with projected high retirement rates in the next decade,⁷¹ expanding the pool of faculty from all backgrounds is needed. Nursing students, the majority of whom are trained at community colleges, need incentives to stay in school after they graduate and pass their boards. Those with an interest in teaching may need financial support to transfer to four-year nursing programs, complete the BNS, and matriculate in master's-level programs, perhaps working for a few years in a hospital or other clinical setting before starting graduate school.

Baccalaureate-prepared nurses also need incentives to continue training, even after they have joined the workforce and secured positions on nursing faculties. A model of growing your own that relies on soft money is being implemented by a community college with one of California's largest nursing departments:

“We're going to get scholarship monies to support the faculty so they can go back to school and get their master's degree. [Our nursing department] opened up a grant that allowed them to take in 60 more people and we supported that grant because these are the people that are going to get their master's in nursing. That's our [future] faculty. So we supported them on those 60 new people because that would allow 60 more people to become faculty members for us. It's long term, but we decided that we had to invest long term. When we looked at this problem [faculty shortage] we had to look at it all kinds of different ways and that was our long term strategy.”

Still another nursing department with greater than fifty percent UR students has succeeded at growing its own faculty from among its graduates as a result of the sense of community responsibility instilled by its charismatic department chair:

“People that I get that want to come and teach are genuinely wanting to give back to the community that gave to them and that's why many of my instructors are former students. Because I want someone who wants to work with the student like I worked with them, give back. You don't owe me anything but you owe it to this community that has given to you. And

⁷⁰ These arrangements are analogous to the arrangements that some hospitals make with students to finance their nursing education based on a student's agreement to work at the hospital for a given number of years after licensure. See the profiles of East Los Angeles College's Bridge to Nursing Program and CSU Long Beach/Long Beach Memorial Hospital in the CTD report “Profiles in Leadership.”

⁷¹ In dentistry, anticipated retirement rates over the next decade are also a significant concern.

over half the faculty are graduates [of this college who went on to] get their bachelor's and master's degrees.”

Informants at one medical school attributed their relative success in growing their own UR faculty to a long-term investment in student diversity. Like the nursing department just described, this school did not plan or dedicate resources to grow its UR faculty. While the intervening factors are unclear, a surprising number of UR graduates have been hired as faculty following the completion of their graduate medical training. At least one factor could be that a welcoming and supportive environment at the undergraduate and graduate level influenced these candidates' decisions to accept faculty job offers from their alma mater. The dean of the school reflected on the experience:

“Of our twelve minority faculty, we discovered that] ten of them had trained here. And so what emerged from that is a strategy that still needs work on it. It's rich in that it's a grow your own [approach]. We have wonderful programs. Why are we preparing [our medical students] to go all over the country? Why aren't we holding on to them? If you've gone to medical school here, why don't we reach out to you? What are some of the opportunities in our residency programs, our fellowship programs? Or probably most important, how do we send a message to our students that we want you here [for your training]?”

E. Competing with the Private Sector

The salary differential between community-based practitioners and full-time, tenure-track faculty is a daunting barrier to recruiting and retaining URs and non-URs alike in nursing, dentistry, and non-primary care medical specialties. In nursing, a new graduate with an associate's degree can earn more working full-time in a hospital than a senior faculty member. As a department chair at a community college explained:

“The greatest expenditure [in my budget] would be compensating nursing faculty so that I could compete with service. I can't compete with service.

Can you imagine if I hire a master's-prepared or doctorally-prepared nursing faculty, that person's going make less than my students with an ADN degree. I had a student started at \$75,000 a year and I had instructors say, “Where is it [for us]?” Because they weren't going to get that here, even with benefits.”

The salary differential between an academic and community dentist is even greater, particularly if the latter practices in a specialty area such as periodontics or cosmetic dentistry.

“The problem in dentistry is that dentists are earning more money in [community] practice than they ever have. And it might be three or four

or five times as much as they would earn in academic practice. It's related to the subject of UR faculty for an important reason. Number one: if you *don't* have UR faculty, then it's very hard to attract your UR students. And if you *do* have UR students, it's very hard for them [without] role models in academic positions."

The salary barrier was not discussed in our interviews with informants at public health schools and programs, probably because it is not relevant in this field, where teaching and practice salaries may be roughly aligned. Nor was the subject mentioned in our interviews at medical schools. While the academic/community salary divide may have an impact on medicine's most remunerative subspecialties, it is probably not a concern for primary care physicians in academia. However, the trend toward increased sub-specialization in the basic sciences and medicine may well discourage URs from entering these narrowly-focused fields because of the increased costs of training and the years of "lost" salary before one is finally hired in her or his chosen field. As expressed by one interviewee:

"All academic fields are becoming more and more sub-specialized. So you can't just be a geneticist anymore, you have to be a computational geneticist. What does this mean? It means you've got to spend more time in training. And what does that mean? You've got more resources to stay the course because it's now 15 years before you get your first paycheck. So it says the White Protestant[s] are more likely to be in those areas than the African American[s]. I mean, that's the reality of it."

F. Practice in Underserved Communities

Data indicate that a high percentage of UR HPEI graduates ultimately practice in underserved areas with diverse populations. There are a number of state and federal-funded scholarship programs that encourage this choice through scholarships with minimum service requirements in these communities. While UR health professions practice in diverse communities is desired at the societal level for a host of reasons, societal expectations and incentives for UR HPEI students to select this path raises a moral dilemma, reflected in the comment of one interviewee:

"The real challenge for our UR students is the burden we place on them. The burden that they must go to underserved areas and sacrifice, that they must go into teaching and sacrifice. When does their time come?"

The expectation that URs will want to or should return to "their" communities to serve underserved populations is fraught with assumptions about who is responsible for providing care for low-income, communities of color and recalls centuries'-old stereotypes about race and medicine. Like non-UR students, UR students and trainees are entitled to choose their field of specialization and communities they want to serve. The significant salary differential between primary care and (sub)-specialty medicine, as

well as the growing cost of medical education, presents UR students with difficult decisions. The good news is that many UR students enter medical school with a strong inclination to practice in these communities. The problem is that the combination of loan repayment programs with service requirements and societal expectations may cause some to feel trapped into this pathway. In the long term, the clear solution is to build a critical mass of diversity in HPEIs.

Academic medicine also needs UR graduates to train the next generation of UR and non-UR physicians. To discourage UR students with an interest in and talent for research and teaching has a negative impact on the future pool of candidates for faculty positions. As indicated by one interviewee:

“The strategy of admitting people because they’re going to go back to their communities is a terrific strategy but it does hurt faculty, you know. They get that message everywhere: you should go into primary care and go back to your community. So, somehow, we need to get some of those people that are admitted to medical school fired up about [the idea] that giving back to their community includes being on faculty.”

HPEI leaders who have achieved success in the recruitment and retention of UR faculty shared an ability to help students understand the range of options that will enable them to fulfill their career dreams, and create opportunities for those who show an interest and aptitude for research and teaching.

G. Faculty Mentoring

Mentoring UR faculty is crucial to faculty development and retention. It is often a challenge for a new faculty member to become integrated into the life of a department or division. “Once we do get them in we need to support them,” a faculty development leader told us. A mentor, particularly a mentor of color, can make a significant difference in smoothing the transition to a new academic culture, particularly when there is not a critical mass of faculty of color in the department or school.

An effective mentor clarifies departmental and division expectations and procedures related to tenure and promotion and can ease a mentee’s stress and anxiety during this highly competitive process. In research-intensive institutions mentees can benefit from their mentors’ advice and support in developing grant proposals and research collaborations. While having a mentor is especially important for junior faculty, mentorship throughout the span of one’s career is necessary, especially to develop the next generation of UR leaders.

Participating in leadership training or other faculty development activities may not even occur to UR faculty who feel isolated at their institutions. As an informant at a medical school recalled:

“Well, we have a mentorship program for everybody so all of our junior faculty have a mentor and we assist them in how that works. And part of what they can do is find a [mentor of their] gender or race or ethnicity. We have a mid-career development program where, it’s like a year-long thing, [and] they get leadership courses. So people who want to be department leads can take it.

It turns out [that when] you let people just sign up, you get white and Asian men who would like to take this mid-career program. So you have to go out and say to women and minorities, “Don’t you think you’d like to take this?” And then they’ll say, “Oh, yeah!” or even be really grateful. “Gee, I’m so glad you thought of me.” Well, it was an open call. All you had to do was send it back that you were interested. But they don’t—you know—that’s the thing. I think you have to tap people on the shoulder and say, “You could really be a leader. This is an opportunity to make you a better leader. It’s just here for, you know, here for your application.”

In a department that lacks UR leaders, it may be difficult for faculty of color to envision themselves in these roles. Thus, in addition to mentors, UR role models are essential.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other areas of inquiry in the CTD initiative, we offer the following recommendations to recruit, hire and retain a diverse faculty:

- 1. Establish criteria for faculty search committees that address competencies in teaching, community-based research, and student mentoring.** In addition to ranking faculty based on traditional notions of scholarly excellence and “productivity,” search committees, tenure and promotion committees, administrators, and other faculty members should recognize the value of faculty who are exceptionally skilled at and committed to teaching, community service, building relationships with the community, and advising and mentoring students. HPEIs have a responsibility to provide students and trainees with role models whose diverse perspectives and interests will help launch them into careers that span a variety of roles including teaching, research, patient care, population care, and community service.
- 2. Document annual inventory of efforts to recruit, hire, and retain an ethnically/racially diverse faculty.** Transparency of efforts in this area should be of interest to wide-ranging constituencies, from accreditation organizations, the Regents of the University of California, and the Board of Trustees of the California State University to groups dedicated to ending health disparities and healthcare advocacy generally.

- 3. Institutionalize efforts to recruit faculty from UR graduates.** To recruit, hire, and retain UR faculty, “growing your own” is a cost-effective strategy with a proven track record. While UR faculty should be recruited from a broad range of external sources, greater attention, coordination, and targeted investment of institutional resources is needed to achieve greater near term progress in efforts to increase UR faculty representation.

- 4. Establish criteria for tenure and promotion that document and reward extraordinary administrative and mentoring responsibilities.** Course relief or another currency, such as additional teaching or research assistants, are possible forms of compensation that could be offered. Tenure and promotion guidelines could be reformed so that UR faculty members’ additional work is awarded points or credit, just as teaching, publishing, and committee service are recognized and valued. Alternatively, new tenure tracks could be created for faculty whose primary scholarly contribution is the integration and dissemination of ideas. Building pathways to tenure around a broader notion of scholarship is likely to capture and ultimately reward a more diverse cohort of faculty than one that relies solely on the traditional, biomedical model of research.

VII. Curriculum

“Most of the training that the health workforce gets is technical, you know, technical/clinical, while the health system that they’re going to practice in for the rest of their life is a complete basket-case wreck. But they’re not trained to think about that. We in higher education are failing if we’re churning out nurses that hardly have a chance to talk about the fact that we’re thirtieth in the world in life expectancy and twenty-sixth in the world in infant mortality.”

Faculty member of Health Professions Department

“I think the greatest challenge we face is the level of skills at which students come to us. And I would say the greatest achievement is the level of skills that they leave with.”

Chair of Health Professions Department

“It is easier to change the location of a cemetery than to change the school curriculum.”

President Woodrow Wilson

This section will address key educational issues that impact the preparation of health professions students as they prepare to enter the increasingly diverse workforce or the next stage of their training. It is divided into two subsections: curricular content and new modes of learning.

A. Curricular Content

Interviewees discussed two key issues to be addressed in health professions curricular content: cultural competency and health disparities.

Cultural Competency

There are perhaps as many definitions of cultural competency as there are HPEIs to teach it.⁷² Our informants at all four types of HPEIs recounted numerous examples of how their students learn about cultural differences, cultural sensitivity, cultural humility, cross-cultural healing, and their own cultural identities. They also described the different paths their programs followed to incorporate diversity content into the curriculum.

The combined approach of weaving cultural competency throughout the curriculum while also offering stand-alone courses predominates in the nursing programs in our sample. One leader from a nursing department described the transition to an integrated approach to teaching diversity throughout the curriculum:

⁷² See Arthur Kleinman and Peter Benson, “Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It.” *PLoS Medicine* 3, October 2006: 1673-1676.

“...now the emphasis for us is truly to thread it all the way through both the clinical and the didactic. That’s a whole mind changing, culture changing process for the faculty because they truly have to understand it themselves, redirect their instruction. You know, we had a long discussion even in our faculty meeting yesterday about rethinking who our population is and what we are trying to teach. We can’t teach them as we might have 15 years ago or even five years ago. So it’s a retraining.”

“I think for us as a faculty and me as an administrator, there’s a huge need for me to bring in education, outside people who can talk about diversity and how to teach it and even to be sensitive to our learners, our population, not to mention the patients,” a department director noted.

Students are a vital “resource” for faculty and other students to learn about cultural competency, especially in departments with few or no UR faculty:

“Part of our resources actually are our students, our culturally diverse students. I’ll ask a Hispanic student, “Okay, what are some things that we can do?” And we’ve had instances where there’s been the evil eye or there’s been some beads and the student actually picked up the beads and she really wasn’t supposed to. That was put on the child to protect the child.”

Another faculty informant explained that students in her health assessment course, in which students work in pairs, clustered themselves according to their ethnicity. She views this as a missed opportunity for horizontal learning about other racial/ethnic groups. “So now I rotate the students every week so they have a different partner,” a simple enough strategy to ensure that students are able to benefit from interactional diversity.

One dean explained the importance for students, in becoming culturally competent providers, to understand that everyone belongs to at least one culture.

“We try to do more introspective work that first year because a lot of our white Anglo-Saxon background people think that everyone else has a culture but ‘I don’t have a culture.’ We start with individual identity issues first.”

In contrast with the nursing programs in our sample, the course offerings on culture, race, and cultural competency at the public health programs and schools we visited were uneven. One informant stated,

“We couldn’t possibly tell you whether all students really were exposed to cultural competency.”

An administrative leader at another public health school told us that, in the current modification of its religion curriculum, a cultural diversity course has been developed.

“Even though we call it a religion course, it’s cultural diversity.”

The course has three sections, each one taught by a UR faculty member. An associate dean described her school as “challenged” in its courses on culture and diversity with only one regular faculty member offering a dedicated course on race, class, and gender.

“We’re relying on outside lecturers to come in and it’s not systematic exposure. Our capstone course may have more attention to it. It’s one of the competency areas that we need to address. Without having a requirement and strictly offering electives, attendance goes in and out and up and down.”

A faculty member at another public health school described his institution’s course offerings in a similar vein to the nursing programs in our sample:

“A lot of public health is focused on the poor and underserved because we’re focused on those who have the highest risk of poor health and social ills, which tend to be communities of color. I wouldn’t say the entire curriculum is focused on minority health but students get [exposed to] it. So last year I was co-teaching the program evaluation class in our department, which is a requirement class, and each of the students did a project. Every single project dealt with communities of color in one way or another. But it wasn’t a ‘we’re now going to spend a class period in talking about—’ so in that sense it was woven through.”

Still another public health program, the majority of whose students are of color, solicits regular student feedback about diversity and cultural competence through an electronic focus group, which is intended in part to ensure anonymity. Faculty use this mechanism to solicit input, as shared by one interviewee:

“We ask them, ‘How are we doing around issues of diversity?’ And then we ask them that again as they’re going out, to give us feedback on whether they are learning cultural competence. Are we addressing that in the curriculum?”

At one dental school in our sample, with a large proportion of whose students regularly travel abroad, identified “foreign service exposure” as the “best single thing without a doubt” for developing cultural competence. As suggested by one leader:

“It’s true, it doesn’t get them thinking about all the local people automatically but what it does is jars them into the immersion that you need.”

Another school takes a “multi-pronged approach” to provide students with appropriate cultural skills to care for patients from diverse cultures:

“I want to be sure that our students are not just seeing Hispanic patients but they’re seeing a whole variety of Asian patients as well, and the Hispanic patients aren’t just Mexican-Americans but they’re [also] El Salvadorians, and they’re from South America [too]. I must field a call a week or every two weeks saying, “We’d like your students to come”—fill in the blank. And I spend a lot of time determining what that site has to offer and how it could contribute to what we’re trying to do with our students. How is this going to fit in to the whole picture to give them a well rounded education so that we can impact the disparity in California? So how do we teach them to meet the needs of this population?”

Whereas some HPEIs’ infusion of cultural content into the curriculum appears to be scattershot, the medical schools in our sample have designed focused curricular initiatives that incorporate cultural competency. One school developed a Center for Excellence in Diversity as an umbrella for a broad range of activities, including curricular initiatives on cultural competency. “We didn’t just duplicate what was going on here but sought out experiences for students to work with diverse patient populations,” the Center director explained. He underscored the importance of linking compositional diversity with curricular content:

“I currently have a grant from the AAMC [Association of American Medical Colleges] to develop a required cultural curriculum for preclinical and clinical. We’ve established a community that is very much a part of that as well. So we’re not only saying that when you come here that we want diverse students, we also want to have a curriculum that says these things are important, although it’s not designed [only] for those students, it’s designed for everybody because that’s the way we look at it.”

A novel, community-based strategy for teaching cultural competency is being developed by another medical school in partnership with other HPEIs—a homecare initiative that will provide care for very ill elders who are high-volume users of acute-care hospitals and emergency services:

“We believe that if we constructed multidisciplinary teams to see these patients in their homes, we can give them better care and save money. We’re going to start with minority patients because that’s a small group, we can control things, and do the pilot project right there. In doing so, it provides learning opportunities for the students in terms of cultural competency and coordination of care, it provides clinical research opportunities for the faculty, and it provides care for victims of healthcare disparities. It does a lot of good things.”

This initiative is exemplary because it joins two vital issues—developing cultural competency and understanding the consequences of a lifetime of health disparities—in a project whose outcomes will be carefully tracked.

Both students and faculty need instruction to build cultural competency. We learned that one medical school faculty member has been teaching cultural competency to students and faculty. “Very few of our faculty attend,” our informant observed.

Health Disparities

Teaching about health disparities is a critical component of health professions education. “I’m always pointing out both gender and ethnic differences in susceptibility and in outcomes for the different populations,” a nursing faculty member remarked. Our informants in nursing did not mention that their programs offer dedicated courses on health disparities.

The study of health disparities is an integral component of public health training. As one informant explained,

“We have faculty and we have projects going on, so if you want to pursue your interest in addressing all the disparities, which most of the students are interested in these days, here are avenues for you to do that.”

Another public health school began a class last year on policy and health disparities.

“What I see again is students are very interested, in that but the education at the faculty level is really the biggest challenge.”

With so many other pressing demands and time commitments, stimulating or incentivizing faculty interest in a new area can require a significant effort. In such cases, highly motivated students might start a reading group on a specific issue or assume responsibility for leading a seminar on a topic of interest on their own with limited faculty participation.

Students at California’s five dental schools are gaining substantial exposure to health disparities and associated community dynamics through their participation in the California Dental Pipeline Project, a four-year initiative funded by The California Endowment.⁷³ A key component of the program involves placing students in clinical rotations at community health centers located in urban and rural health professions shortage areas. Students provide care for a much larger volume of patients in community health centers than in university-based clinics,⁷⁴ providing them with more intensive clinical exposure and dramatically increasing access to dental care in these communities. Opportunities are created in the formal curriculum to facilitate the sharing of knowledge and cultural sensitivity gained in these experiences. Exposure of students to these

⁷³ A profile of the California Dental Pipeline Project is included in the CTD report “Profiles in Leadership.”

⁷⁴ In this project, students are able to provide care for 7-10 patients per day in community health centers, compared to 1-2 patients per day in university-based clinics.

dynamics in the short period of the project has already contributed to an increase in the number of graduates that choose to practice in these communities.

The medical schools in our sample offer students a broad range of opportunities to study health disparities and, in certain cases, to design interventions to prevent and manage diseases at schools and outreach clinics. Through affiliations with centers for reducing health disparities and a degree program focused on preparing clinician-leaders to become advocates and activists in underserved Latino communities, for instance, the study of health disparities is well integrated into the curricula of the medical schools we visited

B. New Modes of Learning

The structure of health professions education is undergoing substantial change to accommodate the evolving needs, preferences, and demands of students, faculty, healthcare systems and institutions, and society. These changes are informed by close examination of lessons from best practices in health professions pedagogy.

The curricular structure of the nursing programs we visited was relatively uniform. One increasing numbers of students with suitable clinical opportunities. Other scheduling strategies we heard about include weekend clinical instruction and distance learning. program, however, has established a 12 hour hospital training shift to providing rapidly

The statewide scarcity of teaching time on hospital wards has been driven by multiple factors, but the most immediate factors are competition between nursing programs and increased nursing program enrollment. An informant from a public nursing program described the pressure for clinical spots exerted by private schools with more resources. She described further the challenges presented by competition with private programs:

“Some of the private institutions that are coming in are huge. They’re recruiting us [i.e., faculty] all the time for these online programs. Now they want us to do the clinicals.⁷⁵ We’re really trying to discourage it because those are students that have huge resources that can afford those programs. Our programs are much more financially accessible to students than some of these other [private] programs. They charge a huge amount. While it’s putting more nurses out there, they’re getting [out of school] with financial burdens. And I don’t think they’re getting the quality education that we’re giving.”

The proliferation of private nursing schools may then turn out to be a mixed blessing, at least in terms of increasing diversity. How accessible are such programs to UR and low-income students? Does UR students’ reluctance to assume significant debt burden, as we mentioned in our discussion of financing issues, deter URs even from applying to most private institutions? To what degree does the state government encourage the spread of

⁷⁵ In other words private nursing schools are trying to recruit faculty from the CSU and community college systems to teach their clinical courses. Private programs likely offer significantly higher salaries.

private nursing schools by capping funding of the state’s public ADN and BSN programs? On the other hand, such programs do increase the options available for students with the means to pay or borrow tuition and fees to undertake their training in a shorter timeframe than publicly-funded programs because their courses are offered on an as-needed basis without lengthy waiting lists.

While there is competition for clinical spots at hospitals there is also some cooperation among schools. In a southern California region a consortium of programs uses an online planning document to facilitate allocation of clinical placements. As described by one informant:

“We go in at certain times of the year to select where do we want to go, what facility, what floor, what day, what time, all that type of thing. And then the schools get together and work on any kind of conflict.”

An informant from another program explained, “That’s probably one of our biggest, number one issues for expansion—clinical placements.” Her colleague elaborated:

“We’ve shifted our traditional clinical times in that we used to always be in the hospital on Mondays and Tuesdays, usually days, an 8-hour shift. A department at another college was there on Thursdays and Fridays, also for an 8-hour shift. We’ve switched with just our first semester still in that pattern. The other semesters have transitioned to a 12-hour shift so that you can actually end up in a group on Monday and a group on Tuesday asking for days and evenings. Students see the entire shift. You don’t have a person coming in that takes care of the patient and then it’s 2 o’clock—bye-bye, I’m leaving.”

This department also offers an “extended campus program” with classes that meet at night and on weekends to accommodate students with work and/or family responsibilities that prevent them from attending classes on a Monday through Friday schedule.

The structural flexibility that some programs have adopted to take advantage of the greatest number of clinical shifts, improve school-work-family balance, and reduce commuting time for rural students does not appear to adversely affect nursing curricula. In fact, innovations like the 12-hour clinical shift may even strengthen the curriculum by providing students with early exposure to hospital shift structures.

These changes in curricular structure for nursing differ from medicine and dentistry, which have been prompted by pedagogic theories rather than the practical realities of running a health professions department.⁷⁶

⁷⁶Interestingly, the chancellor of an HPEI in our sample told us that his medical school is “running out of clinical rotation spaces” in much the same way as the nursing schools described above. A solution to this problem being considered is sending students off-campus to complete the last two years of medical school—the clinical years—at a teaching hospital elsewhere in the country that is part of the health system with which the medical school is affiliated. “We’re looking at probably starting satellite campuses at some

In public health, we conducted an interview at a program whose curriculum was designed to accommodate the complex lives of working adults. Seventy-five percent of participants in this program are UR students. Instead of the traditional, two-year model of full-time coursework toward an MPH degree, students—most of whom already work in public health—attend school part time over three years. This program’s curriculum takes an integrated approach that seeks to build both core public health competencies and the practical application of those competencies in the real world. As described by one program leader:

“One of the things that we’re doing is identifying the competencies that a person needs to be an advocate for social justice. Students have to address how they have worked on that competency. But we’re also working on how we spell out what we expect of our students if they’re going to be advocates for social justice. What skills and competencies do they need to have? We have said that the competencies of really being able to apply systems thinking to health problems [are important]. Where does that get introduced? How does it get reinforced? How do we measure it? What do students know at the end of your curriculum?”

Students in this department develop electronic portfolios of their work that highlight their accomplishments, an effective way of demonstrating their contributions to the field and building self-assessment into the learning process.

In dentistry and medicine, a shift from didactic instruction to problem-based learning (PBL) and an emphasis on service learning have occurred in a number of programs. The dean of one dental school in our sample noted that since his school adopted PBL, his students’ national board scores have “soared from where they started, so they’re now in the top quintile.” His colleague elaborated on the benefits of PBL:

“Problem-based learning basically organizes the students into a small group. There are eight of them sitting around a round table, unlike before when you had a class of 143 students. So with these small groups, we try to have a mixture of team members who come from diverse backgrounds and also a diverse type of training, so they bring different skill sets, knowledge, attitudes, and most importantly, values. We can get in front of the class and we can tell the student, “When you are talking to your patient, control the tone of your voice. Different cultures perceive it differently.” But it doesn't sink in. But when eight of them get together and they are having debates and they are discussing a case and correcting

other places in the country, which would have distance learning from the junior year on for medical school. [Students] would go back home, if you please; to Portland, to Dayton. We’re at some other places. They go back home to [do] their final two years of medicine out there and then could just stay on. So it plants them back there. It gives us access to more clinical rotations that are not currently saturated. And so it’s a model that we’re going to be exploring pretty hard in the next few years.”

each other and they do self-evaluation and they give feedback and they value each other, it is a much more fascinating experience for them to see that the same tone of voice is perceived in different ways.

As reflected in this statement, a key benefit of PBL is that it facilitates horizontal learning, in which students debate and exchange feedback. If learning groups are configured to optimize diversity and encourage students who don't know each other to work as a team, PBL can create new alliances and break down spoken and unspoken barriers—including ethnic/racial barriers. In this way, PBL can be an excellent catalyst for interactive diversity.

Implementation of the California Dental Pipeline Project mentioned previously has created opportunities for students to develop different kinds of skills, utilize different learning styles, and to practice an engaged form of professionalism.

As in other health professions, dental faculty, like their students, need resources in order to learn about—and about how to teach—cultural competence. One dean identified three things to strengthen his faculty's capacity: conferences, workshops, and seminars, where they can learn about key issues and teaching strategies in the field; financial support to attend such programs; and electronic resources—tapes and DVDs—that would be useful both to faculty themselves and to use as classroom tools.⁷⁷ “Everybody's looking for meaningful resources and when you find great resources, you use them,” our informant noted.

It would be a mistake to assume that most dental faculty and administrators already understand how to teach about the delivery of culturally competent care, overcoming the legacy of racialized health care, and can effectively address the specific learning needs and integrate the unique experiences of UR students. Indeed, even in a field like public health, where one might assume that cultural competency is integral to one's professional expertise, faculty may lack the knowledge and skills to be effective in the classroom. Cultural competency is a critical area for faculty development. An office of diversity or a faculty development initiative can be a vital resource.⁷⁸

Another recent change in the structure of medical education is exposure of students to patients during their first term in medical school. In most programs, patient contact is no longer postponed until clinical rotations begin between years two and three. This shift represents a sea change in the field's understanding of adult learning and the kinds of experiences that nurture the qualities most valued in physicians.

Diversity scholar Roberto Ibarra suggests that there is an important association between a program's emphasis on community-oriented academic activities and its success in

⁷⁷ The tapes that this informant alluded to are J.R. Freed's set of six videotapes designed to teach dental students, faculty, and practitioners how to effectively communicate with a culturally diverse patient population. The tapes were produced in 1994-1995 by staff at UCLA SOD.

⁷⁸ See profile of the Loma Linda Office of Diversity and the UC San Diego School of Medicine EXPORT Center in the CTD report “Profiles in Leadership.”

attracting UR students.⁷⁹ Based on data from faculty surveys collected by the Higher Education Research Institute, majority females and female faculty of color tend to believe more strongly than their male, majority colleagues and their male colleagues of color that it is important to instill a commitment to community service in undergraduate education. Ibarra suggests that a possible explanation for this finding is that students of color, majority women, and other marginalized groups:

“...bring with them a mix of individualized characteristics described as their cultural context that is quite different, and even at odds with the cultural context of academe and college/university life. These learned preferences influence how they interact and associate with others, use living space, perceive concepts of time, process information, respond to various teaching and learning styles, perform academically or in the workplace, and include many other cognitive factors.”⁸⁰

If this finding can be generalized from undergraduate education to health professions education, we might hypothesize that new modes of curricular design and delivery are experienced in different ways by women and men of color and majority women, as distinct from majority men, and that women and men of color and majority women might be more comfortable and learn more successfully in situations that call upon the high-context interpersonal and communication skills used in PBL, service learning, and integrated curricula. As one of our respondents, a medical school dean, explained,

“I think that this new [PBL] curriculum is more amenable to what the new mission [of our school] is and the kind of student that we want. Basically this curriculum is better for everybody.”⁸¹

Institutionalizing integrated, broad-based curricula may thus be a strategy well suited to attracting UR students and creating the conditions in which they will thrive academically because these modes of learning are engaged, flexible, and inclusive of differences.

⁷⁹ See Roberto A. Ibarra, *Beyond Affirmative Action: Reframing the Context of Higher Education*, Madison, WI: U. of Wisconsin Press, 2001 and pers. com., August 1, 2007.

⁸⁰ Roberto A. Ibarra, “Context Diversity: Reframing Higher Education in the 21st Century.”

⁸¹ The new mission emphasizes service and caring for underserved, rural populations.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other CTD areas of inquiry, we propose the following recommendations tied to supply side health care organization efforts tied to develop a curriculum that advances diversity goals:

- 1. HPEIs must commit the resources and personnel necessary to provide a coherent, integrated diversity curriculum.** Diversity content should be integrated into each year, and across classroom and clinical/practical training. Students should have substantive input into the development and evaluation of such curricula.
- 2. HPEIs implement non-didactic methods of instruction and learning.**
- 3. HPEIs give particular focus to instruction and learning modalities to increase awareness and sensitivity to health disparities.**
- 4. HPEIs establish formal affiliations with community-based health professions employers.**

Part Two: Health Professions Employers

Health professions employers (also referred to as “demand-side” organizations in this report) play a major role in increasing health professions diversity. To that end, CTD team members conducted key informant interviews that examined similar issues to those explored with HPEIs. In addition, there were some specific issues explored that were unique to the challenges, opportunities and innovative practices of health employers. The focus of the interviews were on understanding what health employers were doing to address health workforce diversity, the challenges and opportunities they encountered and their recommendations for how to advance progress within their organizations, sectors, communities and the overall pool. Based on recommendations from our Statewide Advisory Committee, the types of health professions employers interviewed included:

- Teaching hospitals
- Hospitals and health systems
- Health plans
- Public health departments
- Community health centers and clinic consortia
- Independent practice associations (IPAs)
- Biotechnology and pharmaceutical firms

Findings and recommendations for demand-side institutions are divided into three sections:

- Relationships with the Community
- Relationships with HPEIs and Training Issues
- Workforce Issues

This structure permits the examination of specific issues—internal and external to organizations—that call for and enable novel responses to the rapidly changing health care marketplace and the shifting demographics of California’s workforce, communities and regions.

As part of our inquiry into demand-side institutions, we also interviewed selected state health agencies and include related findings and recommendations as a separate section. As employers of health professionals, they represent another form of demand-side institutions and play an important role in facilitating efforts to increase health professions workforce diversity.

I. Relationships with the Community

Health professions employers have a variety of links to their communities. Their mission, goals and programs often focus on providing quality health services and improving the health of the community. Many are among the largest employers in their region. For example, Kaiser Permanente is the largest non-governmental employer in the State of California and in many regions. To the extent that they purchase goods and services from businesses within California, Kaiser and other health professions employers are important partners and contribute to the local economy.

Investor-owned health professions employers also pay sales and property taxes, some portion of which is ultimately allocated back to communities to fund public services. If the organization is a health care charitable trust such as a nonprofit hospital, then it has a more explicit set of community benefit responsibilities to be fulfilled.⁸² While public expectations are less formalized for investor-owned health professions employers, they are expected to operate in a manner that reflects an understanding of their role to meet broad standards of corporate social responsibility.

Health professions employers all engage in recruitment efforts, and to varying degrees, invest in programs and activities that increase interest in the health professions and support people at different stages of the educational and career progression process. The significant role that health professions employers play in local/regional economies gives them substantial influence in the policy arena. Depending upon the organization, this influence can be applied to varying degrees for self and/or the larger interest of the community.

Community members support and sustain public, nonprofit, and private health care institutions through commercial insurance dollars, state and federal programs such as Medicare and Medicaid (MediCal), federal, state and private grants to support certain kinds of activities beyond patient care, as well as philanthropy. Medicare and Medicaid

⁸² Community benefit is a term originally articulated by the IRS in Ruling 69-545 (1969), which defines the charitable obligations of nonprofit hospitals as “the promotion of health for a class of beneficiaries sufficiently large enough to constitute benefit to the community at large.” Community benefit contributions are expected in return for a variety of benefits, including but not limited to exemption from property and sales tax, access to tax free municipal bonds, and the ability to accept tax-exempt donations. Nonprofit hospitals in California must comply with state community benefit statute SB 697, which requires, among other things, the annual submittal of a plan that outlines what nonprofit hospitals plan to do to address unmet health-related needs in their local communities. While the most significant contribution of nonprofit hospitals tend to be in the realm of charity care and discounted services for uninsured and underinsured patients, there is increasing focus on a more proactive and strategic investment of charitable resources to address the underlying causes of health problems in local communities. Advocacy for K-12 reform and direct support to UR youth to increase opportunities for careers in the health professions are important examples of ways in which hospitals can fulfill their community benefit responsibilities. See also chapter 6, Community Benefit as a Tool for Institutional Reform (pp, 178-202), in the Institute of Medicine report “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce” for a discussion of the history and legal precedents of community benefit, and how similar principles and expectations might be appropriately applied to health professions education institutions.

also provide additional dollars to teaching hospitals to help support the costs of medical education of residents.

Given the important roles that health employers play in the community and their corresponding responsibilities and influence, our interviewers explore the role that they are playing on a community level and ways that employers can increase their impact on health professions diversity and the health of our emerging majority populations.

A. Investing and Participating in the K-16 Pipeline

One particular area of community engagement for health professions employers is investment in expanding the K-16 pipeline. Ongoing, coordinated investment by demand-side institutions helps to build “networks of support”⁸³ that strengthen the educational experience and career preparation for under-represented youth in urban and rural public schools. For example, one of the hospitals who participated in our inquiry matches high school students with medical residents who serve as mentors, holds a summer camp for high school youth, and leads a tour called “Health Professional 101” to provide students with a real-world understanding of hospital work. These programs can introduce young people to career possibilities they might never have imagined. As noted by an administrator at the hospital:

“I think we are opening doors for kids that wouldn’t otherwise have an opportunity. The reality for these kids is that a lot of them don’t have role models in their families and the community...we’re the hospital that has the health professionals to be these kids’ role models.... Sometimes they come back and they see one of the residents who graduate from their own high school. You can’t have a more powerful example [of success].”

In a similar fashion, the director of a county department of public health explained his commitment to stimulating UR youth interest in health careers:

“One of the things I’ve done is gone out to a bunch of junior high schools and high schools and talked about public health, talked about health professions in general. You know, I tell these students, particularly at schools that have high percentage of Latinos and Latinas, “Look, you can have my job. I’d like you to have my job. You have to earn it. Here’s how you get there. But you can [do it].” A lot of times they’re from families that don’t have anybody who graduated from college, so you have to help people to see the potential and overcome the barriers.”

⁸³ The concept of networks of support was described in the CTD report “Increasing the Diversity of the Health Professions: K-12 Networks of Support.”

Employees at all organizational levels, from executives to program staff—particularly at teaching hospitals, health systems, and health departments—are often involved in some of these outreach activities. At many organizations we visited, our impression was that engaging with young people was exciting and rejuvenating for seasoned leaders, just as it was thrilling in a different way for their young visitors.

Given a continuing debate in the field about the age at which mentoring and other career development activities have the greatest impact, we found many demand-side organizations engaging at different levels. Some had explicit strategies to engage youth of different age groups based upon their beliefs about which stage in the educational process would yield the most substantive and lasting impact. Some were influenced by where foundations and other funders earmark grants and contracts for youth programming. For others, the entry point for engagement was driven by the personal motivations and expertise of organizational staff who developed programs or where they happen to have developed relationships with certain schools or agencies that work with a specific age group.

Regardless of the debate about what age is most effective for mentoring students, interviewees commonly indicated their belief that early engagement is optimal. As stated by one informant:

“There has to be a mentorship program very early on at the elementary school level. They need to see a role model, someone that’s in the field of their same racial/ethnic background actually reaching out to them at a very early age. They don’t get those role models from home because most of their parents are not in a profession, particularly not in a health profession.”

A physician and community leader expressed a similar view about involving families in long-term recruitment beginning even before a child enters school. The programs developed by his hospital reach out to parents and young people of all ages.

One health system interviewee described her organization’s commitment to encouraging older youth to consider health professions careers. The organization runs a summer camp for young people from six different high schools. The campers take a career exploration class and are then placed in internships throughout the hospital. The organization just started two new summer camps for middle-school age youth. Among the activities offered is the opportunity to work in a lab at a local health sciences college.

Another health system in our study is involved in pipeline activities that span the age/grade spectrum. The range of its involvement extends from holding conferences and giving talks to grade school students about the breadth of health careers to working with a health professions high school; providing job shadowing opportunities, tours, and internships for college students in areas as diverse as marketing and finance; and offering a nationally competitive fellowship for master’s-level students. At the time of our

interview, a former intern had just been hired for a staff position. The interviewee described her situation:

“She didn’t even have a break in her service, so it was perfect. It was great. They wanted a Hispanic because that was their strong population. They needed someone who could do projects, who could speak to their community, and help work with their hospital system. And she was a great fit, obviously. So that was a big success.”

Another informant described a paid internship for high school students with a strong focus on mentoring. This program sponsors and pays four students a market-rate salary to fill one, entry-level receptionist position. (The salary is paid to their school.) It is easy to imagine the difference this opportunity makes for low-income young people who might otherwise get lost in the shuffle of the education system and the upheavals of adolescence. “Those students come from such challenged backgrounds. Many times these are the first kids [in their families] that have ever gone to high school. But they are expected to follow this very strict dress code. They’ve never been exposed with how to converse with people, let alone going to a business [setting].” Our informant considers it part of the organization’s mission to “invest in these young people.”

The variety of programs implemented by health professions employers to engage students and their families highlights both the breadth of needs and range of options to help UR students to prepare to enter the health professions. While most programs are small in scale, interviewees often cited examples of positive outcomes, particularly those where strong bonds have been established between young people, the health professional role models, and the health profession employers that serve as program hosts or sponsors. One academic medical center described particularly good results from their recruitment of students (predominantly UR) at the high school and undergraduate level:

“We’ve had four of our high school [pipeline program] members come back to do their residency training with us so the pipeline does work. It has a lot of leaks but it does work. But our biggest payoff has been at the college [level]. We’ve had 108 graduates from our residency program and 96 came through some form of recruitment for our program, primarily through their college. So by the time they come [to do their residencies], we’ve known them a good seven or eight years.”

With a similar goal in mind, one local health department undertakes outreach activities at a high school health academy, in the hope that high school students who become physicians will return to their “home” community to complete their residencies:

“For the high school students the challenge is going to be in a couple of years when the first [high school health academy] class is going to be entering medical school. They’re going to be ranking residency programs. The real test will be whether they rank the program in our city, come back

and train to be doctors here, and stay here. We're keeping our fingers crossed.”

Many health employers have programs that target community college students; particularly for nursing and allied health. For example, one non-profit health system made a significant investment in its local community and community college in response to the nursing shortage. It formed a multi-year, multi-million dollar partnership with a local community college to significantly expand nursing program capacity and to provide more opportunities for local residents. The partnership included funding for faculty, faculty from the health systems, increased clinical internships in the system's hospitals, loan forgiveness, and visible, state of the art training facilities. The results were increased nursing slots, graduates and jobs within a very short time. Given the diversity of the communities served by the community college, the diversity of nursing graduates significantly increased. The partnership also invested in health academies at the high school level to better prepare students for training at the community college level. The health system's CEO commented:

“We made a significant investment in the partnership and it really paid off for us, the college, the students and the communities. It also really leveraged the core competencies and assets that each party brought to the table in a coordinated way. We will pursue more of this kind of partnership model.”

By supporting pipeline activities, these demand-side institutions give back to the communities where their patients, clients, members, and employees live. Employers benefit from participating in pipeline activities by cultivating young people's interest in healthcare careers and developing relationships with individuals who might someday return to or join their organizations as trainees or employees. In addition, pipeline activities enable nonprofit corporations to fulfill some of their community benefit responsibilities.

Thus, when healthcare employers invest in K-12 and college pipeline programs, they generally have one or more common goals:

- Expose young people to the full spectrum of health professions.
- Provide hands-on opportunities for students already considering health professions careers to learn more about their identified interests.
- Strengthen skills to prepare youth for undergraduate and/or postgraduate health professions training health professions.
- Form a relationship with students that could ultimately result in the student coming to work for the organization or health sector.

- Advance diversity goals and demonstrate to accreditors, regulators, union or community or political constituents that they have meaningful plans and programs in place and are making progress.
- Fulfill community benefit responsibilities.

A key question, given competing priorities, is if these reasons are sufficient to sustain organizational investment and establish long-term commitment to these programs be of sufficient scale, impact and sustainability. Among the organizations we interviewed, most of these programs were supported with discretionary funds, and the “case” for more sustainable funding had not been made. We also found that many of the diversity champions that often ran the programs felt that they needed more assistance in effectively “making the case” to senior leadership. Others commented that sometimes diversity and workforce programs are held to a higher standard of “proof” than other types of initiatives that the organizations support.

Most health employers interviewed indicated that addressing workforce shortages and future needs was the most compelling “case” to be made for funding.

B. Reducing Health Disparities

While supporting pipeline programs in K-12 schools and colleges is one way that demand-side institutions engage with their local communities, these institutions also play other roles in the community. For example, assessing and responding to health disparities is one area in which health professions employers make important contributions. One hospital described its wider concern for the community’s health:

“We have an interest, whether the physicians practice here or not, because this institution is part of a larger complex that involves the public health department, the [county] health plan, and other elements. We have an interest as a county and in the interest of community health to make sure that there is access to physicians even for patients that we’re not directly responsible for. And we view [serving those patients] as part of our mission.”

As part of a community benefit initiative, another hospital participated in a multi-year city, county, and statewide immunization campaign to increase California’s “embarrassingly low” immunization rates—in the 40 percent range—for children up to five years of age. The Latino community was a focus of the program. The hospital formed a citywide taskforce of representatives from 30 agencies and organizations that included schools, health plans, and policy makers. It held immunization fairs and its CEO chaired a health summit with the mayor. Children seen in the emergency department and at hospital and public health clinics and admitted to the hospital were screened and, when necessary, received immunizations. Public health nurses and family practice residents were also involved with outreach to and screening of pre-school and

elementary-school children. While the campaign is over, the hospital continues to “do its part in making sure our patients are screened for and receive timely immunizations.”⁸⁴ This hospital also provides space for a dental school with extensive community health programs to hold its children’s clinic.

A national health plan that participated in our research views disparities in health as a matter of quality:

“...when you do it as a quality imperative, then everything else follows in terms of how you outreach to your providers to support it, how you train your employees to understand it, and the messaging that you send out as well as your philanthropic support.”

The health plan provides tools and resources to providers and hospitals that need leveraging support to care for high-risk populations.

The plan worked with a health system by funding a prenatal care program for African American women to reduce preterm deliveries and other birth-related complications. The health system, in turn, implemented certain practices and provided the plan with outcome data to assess the initiative’s effectiveness. Through refinement of the program and documentation of outcomes, the plan hoped to advance a model approach that would be replicated in other settings with predominantly African American populations and providers committed to improve quality of care and patient outcomes. Working together, the health delivery system and insurance plan hope to provide evidence that makes the ‘business case’ for programs to reduce health disparities, e.g., decreasing emergency department visits, hospitalizations, and use of the neonatal intensive care unit.

The plan has also worked with a smaller health system with hospitals in rural communities that were experiencing a severe nursing shortage. It provided scholarships to UR nursing students with a formal agreement that graduates would work for a fixed period in the health system’s understaffed hospitals. This is among the very few initiatives we have learned about from our informants that explicitly supported the training of UR nurses.

An important aspect of any concerted effort to reduce health disparities is ensuring that communication with different racial/ethnic communities is culturally sensitive and linguistically appropriate. One public health department leader explained that his department’s emergency preparedness program is delivered in “nine or ten languages”:

“We’re doing different ads based on cultural beliefs. It’s not just based on language. We’re not just routinely translating. We have a major language other than English here—Spanish—and so we have [a Latino physician] and others who often talk to the press. It’s very important to make sure that we’re trying to reach out.... We have a lot of community liaisons and we are part of a lot of community groups that also send messages.

⁸⁴ Email message to study team member, September 24, 2007.

Different messages resonate in different communities. One community wants to show a strong family. That's the reason you want to be interested in emergency preparedness. In another [community] the family isn't as important."

Clearly, when providing clinical care, communication with individuals from various communities must also be culturally and linguistically appropriate. As a health department director explained:

"We run STD clinics. A lot of HIV stuff. So you've got a lot of issues that people are not always too anxious to talk about. It helps us to think in terms of how to frame issues for different populations. How you want to talk about weight with one population isn't the same as how you want to talk about it for another population. So having that kind of sensitivity is important."

C. Advocacy Efforts With Communities

Forming collaborations at the local, state, and national levels is an effective strategy to advocate for increased investment in low income, ethnically and culturally diverse communities with disproportionate unmet health-related needs. Our informants and their institutions have worked with community organizations to advocate on the following issues:

- Pipeline initiatives
- School-based clinics
- Serving rural populations
- Translation/interpreter services
- Residency support
- Improving cultural competency

Elected officials are, of course, members of communities and they are expected to represent the interests of community stakeholders, particularly those who are most in need of support. One former State legislator emphasized the effectiveness of moving health issues forward through local school boards and city councils. One significant accomplishment she described was the development and passage of legislation to prevent childhood obesity. An important first step was to build a constituency for the issue by convening a series of meetings with Latino members of local health providers, school boards, city councils, and boards of supervisors to educate elected officials about the issue's urgency. The senator noted that these bodies serve as the "launching pad" for community stakeholders to work with the state legislature.

"I think the most innovative models are school boards at the local level that say, "We're going to make this a priority because it's in our best interest." If you want to build capacity in educational awareness, think of policy makers in education, or in health at the county supervisor level, or at the school board level. City councils are ripe because you have more people of ethnic background on city council than you have on boards of

supervisors. More importantly, if you're a Latino elected official on the local or national level, you know the realities of access to care and health disparities. It's a pretty sophisticated group.”

One community clinic consortium described its interdependence with the surrounding small business community, for whose uninsured employees member clinics provide health services. A consortium leader recalled that a problem had emerged with a construction project and a developer who wanted the consortium's property. The developer had been vocal at city council meetings and had apparently made financial contributions to council members to ensure that decisions were made in his favor. When the consortium's facilities were under threat, some of the small business owners appeared at city council meetings saying, “I am a patient there. And without them I wouldn't have my business here because I would be sick.” Community clinics and the consortia that link them can, through their advocacy efforts, make a significant contribution to their communities.

One important area where health employers could increase their advocacy efforts to benefit individuals, community and health workforce and diversity is in support of K-12 improvement. Many health employers we interviewed expressed serious concern about the quality of K-12 education in California and in their communities. They indicated that many graduates do not possess the level of knowledge and skills required as the foundation for entering or graduating from even entry level allied health or nursing training programs. Profound inequities in funding and support, and associated inadequacies in programs, materials, and infrastructure for urban and rural public schools predictably contributes to poor preparation for UR and low-income students... Much to our shared shame, given the relative wealth of our nation, a high percentage of youth in our urban and rural settings do not even graduate from high school. Naturally, the lack of sufficient educational preparation in these communities significantly reduces the pool of qualified UR candidates for all health professions.

Given the growing importance of health workforce development, cultural competence, and diversity to our health organizations, it is clear that health employers could do much more to target their advocacy efforts to support K-12 improvement, with a focus on urban and rural public schools. This was not reported to be a common practice among health employers we interviewed. Given the influence of health organizations and their employees, this could yield significant benefits, and is consistent with the larger social responsibility of all health professions employers.

D. Communities as Business Partners

In the context of this study it would be easy to think of “the community” as comprised only of health care consumers. Yet health care consumers are also service providers and business owners on whose economic well being health professions employers depend. A physician-informant described an initiative he led—the exception that proves the rule, perhaps—to support Latino-owned businesses in his hospital's vicinity.

After conducting research on his medical group's purchasing practices, our informant learned that most of its business contracts were with local vendors. When he gained a seat on his hospital's governing board, he discovered that most of the hospital's annual budget of \$200 million was spent outside the community. Through skillful negotiations, he worked with the hospital to develop a procurement agreement with an association of 600 Latino-owned businesses that gave the association's members a chance to bid on contracts.

In many cases association members offered the hospital savings, even beyond that of the group-purchasing cooperative to which the hospital already belonged and bulk purchasing through the health system. In other cases, the hospital gave association members its business as a goodwill gesture. In its turn, the hospital discovered a bottom-line return on investment beyond goodwill and support from influential community leaders and elected officials. The return ended up being instrumental to the financial turnaround of the hospital.

Through its relationship with the business association, the hospital demonstrated to employers who didn't offer health insurance that it was costing them more not to insure their employees than to offer coverage. It provided data showing that patients who came to the hospital because of a back injury, for example, who were covered by Workers' Compensation, had an underlying intent to get treatment for chronic diseases such as diabetes, asthma, or cardiovascular conditions. Ultimately a number of employers were convinced by the hospital's data and formed a purchasing cooperative for medical benefits through the business association. Many previously uninsured patients who sought care in the emergency department gained insurance because their employers had grown sufficiently to offer medical coverage.

In this way, the business case was made for providing medical insurance, purchasing goods and services from within the community, and supporting an association of Latino-owned businesses. Hospital expenditures for care to the uninsured were reduced (particularly for preventable illnesses), and the surrounding community of UR families, businesses, and workers benefited from the procurement agreement.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own 'gestalt' of what has been learned from some of the other CTD inquiries, we propose the following recommendations for health professions employers to increase diversity through working relationships with communities:

- 1. Nonprofit hospitals ensure that community benefit programming has a significant focus and produces measurable impacts in communities that experience health disparities.** Programming should focus both on addressing both the underlying causes of disparities and help create the conditions that increase opportunities for health professions career development in these communities.

- 2. Health professions employers actively engage in partnerships with HPEIs, colleges and universities, K-12 schools, and community-based organizations to create and strengthen networks of support for UR youth.** There is a wide array of small scale and innovative programmatic efforts that would benefit significantly from the establishment of partnerships with more strategic investment of limited resources.
- 2a. Health professions employers use school-based health centers as an entry point for exposure and education of elementary, middle and high school students to health professions career options.** In the course of the key informant inquiry, a number of health professional interviewees cited the importance of early exposure of UR youth to the full range of health professions through presentations in classes and/or special school events at all levels of K-12 education. An important avenue identified for the coordination of these efforts is California's school-based health centers. There are currently over 150 school-based health centers, and the recent passage of SB 564 creates a grant program that will help to significantly increase the number in the coming years. This option was strongly supported in a series of conference calls sponsored by the California School Health Center Association as part of this inquiry.
- 3. Health professions employers create and participate in regional workforce planning partnerships.** In order to effectively address health professions shortages and build a diverse and culturally competent workforce, health professions employers must go beyond immediate recruiting needs. Larger health professions employers, have special responsibilities to work to advance diversity goals for the health care workforce. Development of communitywide recruitment plans should sensitize financially stronger institutions to the health professions workforce needs of the community as a whole, rather than focusing solely on the needs of a single institution. The purpose of these networks would be to:
 - Project future needs for specific health professions based on community health and demographic trends and develop coordinated employer and educational institution plans for meeting them.
 - Coordinate pipeline programs and make optimal use of available resources.
 - Inform UR youth interested in health professions and adults considering career changes of emerging career opportunities by specific health professions discipline at the regional level.
 - Minimize the negative impact of recruitment strategies by mainstream health professions employers that lure UR staff from safety-net organizations such as community health centers.

4. **Nonprofit hospitals invest in the pipeline with attention to regional workforce needs based upon community benefit principles.** As such, estimates of the success of investments should not be driven by standard return on investment (ROI) measures tied to institutional needs. Rather, institutional expenditures that result in benefits for other regional health professions employers should be viewed as measures of success and documented as community benefits.
5. **Health professions employer leaders advance workforce diversity goals by advocating for relevant public policy reforms.** This involves the development of a regional framework for shared advocacy with a broad spectrum of stakeholders, and defining interests that are not typically viewed as priorities by health professions employers. For example, HP employers should be vocal advocates for K-12 reform initiatives that will strengthen the skills, preparation, and ability of local UR youth to serve as health professionals.
6. **Health professions employers place greater emphasis on evaluation and documentation of the results of pipeline partnerships.** The benefits would be to understand what makes them effective, measure impact and demonstrate the “business case” to facilitate sustained, appropriate scale investment.

II. Relationships with HPEIs and Training Issues

An important part of the decision to include demand-side institutions in the key informant discussions of the CTD initiative was the recognition that teaching hospitals (and increasingly other sites where patient care is delivered) play critically important roles in the training of health professionals. For example, as the sponsors of most physician residency programs, hospital-based training can profoundly impact the cultural competency and institutional climate aspects of diversity for future practicing physicians. From a structural diversity standpoint, hospital educational leaders play secondary roles, as they do not make the initial decision to offer entry into medical or dental school training in the US. Nevertheless, the ‘face of a particular hospital to its community’ may well be impacted by the diversity of physicians or dentists selected for postgraduate training programs.⁸⁵

With the evolution away from hospital-based nursing programs, and with only a small number left in California, hospital staff members do not directly admit students to nursing programs. Yet their affiliation with nursing schools is both essential and consequential, in that the cultural competency expectations and institutional climate concerns surrounding inpatient or outpatient care greatly impact the training experience and perspective of nursing students. And increasingly, as hospital based nurses are taking on greater faculty roles with greater presence and oversight of the clinical training experiences of students, they can directly contribute to the perspectives that students take away from the experience about the importance of diversity and cultural competency. Public health students also often have educational experiences at teaching hospitals; many work to apply their health management or epidemiologic knowledge to a variety of issues that as part of their internship, fellowship or other applied learning experiences.

For students in all health professions that train in teaching hospitals, efforts to increase cultural competence and create a more supportive institutional climate have important consequences. As such, the exploration efforts and successes in these areas were an important part of key informant interviews with teaching hospital leaders. These issues were also explored with health departments and community health centers that had training program affiliations. The following section details issues tied to teaching hospitals. Subsequent sub-sections detail community health center and health department intersection with training issues in the diversity context. The final sub-section deals with what our interviewees told us about interactions with health professions schools and advocacy opportunities to support greater diversity in health professions training which is relevant to all demand side organizations.

⁸⁵ As hospitals can and do accept foreign medical graduates into their GME programs, some of whom are American URM students who have gone abroad for their medical or dental school training, they arguably make some decisions which marginally contribute to the overall diversity of the physician or dental workforce.

A. Teaching Hospitals

Hospitals with physician residency programs are highly complex institutions with a broad spectrum of issues and concerns. From our interviews, it appears that concerns about diversity varied greatly among teaching hospitals and often (particularly for larger teaching institutions) varied among different residencies within the institution. Our interviews typically included conversations with Deans, Chancellors, Sr. Administrators or other top-level senior leaders. Associate Deans or Directors of Diversity also participated. In some cases we primarily spoke either with physician directors of medical education or those physicians heading primary care training of one form or another. Our conversations rarely included surgical or other sub-specialists.

Importance of Leadership

Almost all interviewees emphasized the importance of leadership and commitment as essential for advancing diversity efforts. As noted by one interviewee:

“I think part of it has been that the push for diversity has to be in the fabric of the institution. Like what you see in our mission statement and all those things, it’s not just something we plaster on the wall. We actually live by it in our budgeting decisions...”

Leadership was evident in one major teaching hospital interview, where we gleaned from the residency director that not only was diversity important, but he also saw it as an important part of his job to assure a diverse cohort of trainees came to their program. So, for example, he completely eliminated ranking candidates for interview based on board scores; instead factors such as strong interpersonal skills ranked high in the consideration process. At this particular program, there was an effort to create training tracks within the residency—in order to attract a diverse array of people. One particular track was designed to attract people interested in community health and health policy, and provided trainees with advocacy opportunities during their residency around a range of public health issues. Such a track was noted to be of particular interest to UR trainees. Faculty members with special skills in this area were also recruited to the residency.

Finally, even for those residents not primarily interested in community health, all trainees are required to complete a community health rotation which: 1) exposes residents to patients of diverse cultural, ethnic, and socio-economic backgrounds, 2) actively engages them in multiple child advocacy activities, and 3) provides residents with the opportunity to further develop strong educational, teaching, and presentation skills. This rotation takes advantage of the linkages with community providers and organizations in two racially and ethnically diverse communities near the teaching hospital.

Another interviewee who wears ‘hats’ at both the medical school as well as at the flagship teaching hospital and whose job primarily focuses on the vast physician training function at this academic health sciences center cited the importance of leadership:

“...my immediate work has been related to enhancing diversity of residents and fellows [over 60 training programs] and to assist in nurturing the diversity that we have. As the [higher ed post tied to graduate and continuing medical education], I've been involved with implementation of the statewide requirements that all graduate and continuing medical education be culturally aware and include elements of health disparities and language and access to language services and so forth for the diverse population.”

He also noted that making diversity a core part of the mission of the teaching hospital is an important step:

“...diversity is one of the five missions (of the medical center), and so that's very much front and center and ...leadership gives awards on a regular basis to staff, including efforts in diversity. They have a very strong conscious of diversity in the medical center.”

However, this individual also noted that leadership to advance diversity in such a large enterprise varies from specialty to specialty with control often at the level of the department, rather than centrally:

“Leadership, yeah, and putting the nickel down...I think what happens here is it's probably the same as happens everywhere else. You know there's battle, there's pseudo-debate between excellence and diversity. And so you know some departments put the nickel down and say diversity adds to excellence. And others just say we're going to go by more traditional measures of excellence and we'll see how the cards fall. That's reality. And so those departments that have been willing to reach out and therefore create systems to support people once they get here do better the next time because then people come in and they're not the only person of color in the room....”

Even when there is institutional leadership to do something such as develop a ‘core’ cultural competency curriculum for all residents, it is not easy. The domination over its own of each specialty area and their separateness from each other is a continuing struggle. As noted by one interviewee, however, the ACGME accreditation standards, in concept, create opportunities to work together:

“As you probably know, in graduate medical education, all of these programs, although I describe them as being distinct and silo-ized and somewhat controlled by departments and specialty boards, in fact all have the same common program requirements which make up a good chunk of their requirements. So there's a certain portion of it which is uniform across all, including certain of the competencies that we talked about. So theoretically, one could design a core curriculum [for cultural competency] across programs that was required for all. And that's

something we've tip toed into. So we have a GME grand rounds, for example, that meets regularly, and so we did a talk on health disparities and cultural competency, that sort of thing, as part of the core curriculum. And we formed a curriculum committee recently that is rather unique in GME, because it is trying to look at those things that we can teach across departments...”

Most teaching hospitals and their residency program directors that we interviewed have not been as ‘leadership focused’ on the topic of diversity as noted above. More often, interviewees told us that interest in diversity issues at teaching hospitals arises as a corollary to the pursuit of other interests and goals. In fact, more often than not, our interviews seemed to indicate that advancing diversity per se as a key goal was not generally on most hospitals radar screen of priorities. Most leaders expressed support for diversity, but action leading to greater diversity tended to occur as a result of pursuing some other goal than also happens to concomitantly advance racial or ethnic diversity. Some of the areas that interested hospitals and which may (sometimes by accident) advance diversity included:

Meeting Patient Care Needs

One teaching hospital residency director in an institution with 50% Latino residents and which serves primarily a Spanish-speaking population, noted that his/her hospital was responding to patient care needs that drove their diversity success:

“...I think that for us, the other things that happened is just naturally by the population that we serve, by our connection both with the hospital here and then with the community health center that's been very involved in caring for the Latino community for years. And so that I think that in some ways it's sort of a natural fit, the residents who come here and see that population feel very comfortable.”

Recruiting American Trained Residents

Some of the smaller teaching hospitals across the state have greater challenges in recruiting residents, particularly American UR graduates—even when they are located in communities with diverse patient cohorts. Isolation in terms of few UR faculty and peers who are at the smaller programs is one of the barriers. A typical comment about the problem that we heard:

“Sometimes they [UR graduates] don't choose them [smaller teaching hospital programs] and one of the reasons why they don't choose is because they're isolated and because there's not an African-American doc that sat down with them when they came in and said here's where you can get your hair done, here's where -- you know there are some realistic dynamics.”

Or as noted by another interviewee who cared greatly about diversity and cultural competency issues, but was frustrated:

“So I think my perception is that there's a critical mass problem within small programs. So people come and visit and say, "There's no one like me in this program. Why should I come and be the first?"

Often, for these smaller or less prestigious programs, they need to recruit international medical graduates—mostly ‘of color’ to meet their house-staff needs. These physicians sometimes have their own cultural competency challenges when dealing with the diverse array of American patients whom they encounter in California’s hospitals. Some of the teaching hospitals we spoke with who have difficulty recruiting American graduates noted that they offer special rotations to medical students, in the hope that a positive experience may help to recruit the student to their graduate training program:

“The student run free clinic project, which is very aligned with, we say sort of the stepping stone to our residency sometimes, but is very aligned with the values and goals that we’ve been talking about here... So, that helps select for recruiting students that might have those same community-based goals.”

Reducing the Costs of Physician Recruitment

In some racially and ethnically diverse communities, hospitals trying to meet basic care needs of patients have great difficulty with physician recruitment—particularly in primary care. In such instances, residencies can sometimes be cost effective ways to ‘build your own cohort’ of future practitioners. As noted at one hospital with recruitment challenges:

“And then we showed them [hospital administration] that physician recruiters would charge them \$50,000 a pop [to recruit a primary care physician] but we had seven doctors ready to come [out of training] and start practicing in East Los Angeles immediately saving them \$350,000. So it really helped the president, and gave him the armamentarium he needed to convince the powers that be that [investment in our residency program] this was a risk worth taking for the political, the economic, and the practical benefits.”

Addressing Nurse Shortages and the Content of Nurse Training

A major driver for teaching hospitals is addressing critical shortages in nursing. One hospital executive we interviewed where the institution was particularly active and has financially invested to expand a local nursing program happened to be located in an area where much of the population was racially and/or ethnically diverse. He observed that the hospital’s initiative to expand student enrollment in the community had the concomitant effect of expanding UR participation in the program:

“We are getting more diversity now in our nursing students than we've ever had...I think part of it is the fact that the sheer number of students that are coming through now, allows for more diversity. The whites that

typically were getting in before, they're still getting in, it's just now we've got a much more [open spots with diverse candidates filling them]. The increase in the size of the class at XXX college has been huge; and the fact that they have a couple of instructors that are African-American and Hispanic, has been a huge impact.”

Hospitals may also provide important support to help UR nursing students who are struggling with complex life and family situations to stay in school. At least one of our interviewees noted that their hospital has an emergency loan fund for nursing students—to help them avoid dropping out when faced with a financial crisis. In addition, in concert with nursing schools, they can provide role models and other forms of career support:

“We try to do things that will provide an opportunity for these students who have the academic skills, and have a certain level of interest. And what she really does [nursing school dean] is try to provide them with the psychosocial support that they need to pursue it. And then we, (the hospital), try to provide them with student clerkship opportunities and situations where they can work with a preceptor or a mentor that will give them a role model.”

Post-Baccalaureate and Pipeline Programs

Another role for teaching hospitals to advance diversity that emerged from our interviews was support for post-baccalaureate and pipeline programs. Here is what we heard from two hospitals interested and/or involved in post-baccalaureate efforts:

“So we know that what a good teaching hospital should do is invest in a post-baccalaureate program...or summer programs and fellowships for undergraduate students and high school students. So I think teaching hospitals could have a very strong role trying to identify those strategies that work.”

From a hospital leader that was more invested in the concept:

“Our hospital is very connected to some of the local university’s post-bac efforts. I don’t know if by coincidence, but many of those students that are going to community colleges and [those who] come and spend some time with us are now going into the medical school and other health professions.”

One residency director discussed a range of early interventions to expand the pipeline:

“You’ve heard me say that we start recruiting on the first pre-natal visit, because it’s about engaging the mother in the education of that future child, engaging the father in the raising of that child. So as family physicians we certainly endorse that but we really reach out. One of our

first community medicine programs that we established when we opened was the X program with Y where we adopted three schools – an elementary, the middle school that it fed into, and then the high school that it fed into to make a long term commitment for wellness, education mentoring. And it's become the basis of our pipeline recruitment. We've had relationships with high schools, through a program funded by AHEC called "JJJ", which is to stimulate the interest in high school students in college. But it really goes back to their younger siblings. And then going to the college cohort, that's where we've probably concentrated most of our energy in terms of the pipeline because these are students who have crossed that big barrier of getting to college and there's a large number of them saying they want to go into the health professions and so we want to nurture that whatever their career might be, whether it's nursing or something else..."

At the same hospital, their support of college pipeline efforts was also quite significant:

"We keep in touch with five pre-med organizations on a monthly basis, send them newsletters, go out and give talks to their pre-med clubs or other related organizations. We reconnect with them every year with the Latino medical student organizations and the Student National Medical Association, which is the African-American counterpart. They co-host an applicant conference every year that we co-sponsor with them. That's been going on since 1999 that the two are working together, which is really great. I mean it's collaboration between black and brown and that has to happen and it just unique leaders that made it happen and we were happy to be sponsors of that and it continues. So we have the five pre-med campuses. We also believe in two degrees of separation; they all have a friend or a colleague or a sibling who goes to another college that we don't necessarily concentrate on but they're going to get the benefit of the coaching and information that we provide. Again, it's just to finish college with their bachelor's. It doesn't matter what field they ultimately diversify into, it's just to finish college. But to the extent that they maintain that interest in health careers, we nurture it."

B. Community Health Centers

Our interviews on this topic were primarily with administrative leaders of health center consortia, and in some instances, administrative leaders of individual health centers. Accordingly, the views of how health centers intersected with HPEI training efforts and the advancement of racial and ethnic diversity tended to be at a more administrative level rather than focused on what individual trainees either brought to or got out of the health center clinical experience.

A common theme in our interviews was that given their racially and ethnically diverse patient populations, health center administrative leaders strongly desire a diverse staff, especially with respect to their clinical caregivers. Accordingly, for health centers with formal teaching affiliations, our interviewees told us about their hope that the sponsoring HPEI match (or provide in the case of nursing students) a cohort that includes UR caregivers. In addition, there was also a strong desire to have a cohort of caregivers (and particularly house-staff) with non-English language skills—especially Spanish in many communities across the state.

Notwithstanding the desire for such HPEI trainees and students, recruitment is not easy for health centers, especially in rural areas. Here is how one director described it:

“I generally have to visit three times [to medical schools]. First, when they come into the school as freshmen with bright eyes, you've got to let them know what you are. Then when they're ready to come out and do rotations, and finally, when they are considering residency, you've got to go visit them again. And generally if you establish those relationships you can have an avenue for recruitment.”

However, we did learn from our interviewees that their desire for residents has waned over the years for a number of reasons. Some of the main reasons tied to the economics surrounding the use of CHCs as training sites. Over the years, the reality for many health centers is that it is not financially advantageous to be a HPEI training site:

“UC VVV came to us with the Song-Brown obligation and said, “We're in trouble, we need a rural rotation, would you be our spot? We'll bring you a mobile home and a resident a month and it'll be free... Then pretty soon by the end of the 20 years, I was paying the university for the services and paying the rent and paying the so forth and so on. I couldn't do it anymore.”

From another health center administrator we heard:

“They [hospital residency directors] go to you and say ‘Yeah, we want to send our folks in there, but at the same time we're not going to pay you a dime. We consider this gratuitous.’ And that just smacks down the relationship. It used to be, we used to charge for those [resident provided] services.”

In other cases, with Medicare program changes in rules tied to resident supervision and the like, the effects on productivity and the costs of resident preceptors added real challenge to a health center taking on a teaching role. As another health center director told us:

“Because now, with how the structure [of physician training], the training environment needs to be, and our demands as far as productivity that we

require of our paid staff, we can't have our paid staff being preceptors, necessarily... With managed care coming on and what we have to promise in our contracts and what we have to execute with, it's just not feasible, administratively, to sign on trainees to take part of your burden that."

One other health center director noted that it might take policy changes to get him interested in being part of residency training again after having done it since the 70s for 25 years before abandoning the effort:

"I'm not opposed to revisiting the whole issue of trying to do [residency] affiliations if there could be some – I think it's going to require some policy changes at the level of Medicare and Medicaid ... It's going to take some changes in reimbursement and how that all works. Managed care, credentialing, how that all works."

Another noted the physical space limitations:

"The clinics are very crowded and it's not like we have huge exam rooms, so the ability to turn over exam room to residents or students in training... it's an issue."

Given these challenges, it may be easier for health centers to use their energies to recruit attending staff from UR backgrounds, rather than focusing on the establishment of residency rotations. Notwithstanding that view, at least one health center director noted that even though it is a continuing challenge, it is still worth doing and is contributing to a larger need in terms of workforce competency:

"We're trying to improve health in our communities. And I think that's the one I think important point is we're trying to reduce health costs, but we're trying to improve health in your community. And you can only do it with folks [who are trained to better] understand community, understand diversity, understand the culture. Just being bilingual doesn't mean anything, [if you are going to be an effective provider] you've got to be bi-cultural, and understand the community."

Community health centers also have challenges in recruiting nurses. A few have recognized that if they can be involved in nursing education, it may also help them with respect to recruitment. But like physician training, there needs to be nursing student supervision. Here is how one community health center nursing administrator described the challenge:

"People say, 'Okay, have the clinical practice at your site and you can recruit the nurses.' Part of the problem is that they want something more rigorous than perhaps what we have to offer. You have to have RN preceptors, so we have faced some obstacles here."

Another focused on the need of nursing programs to send out a preceptor with the students:

“Yeah, you have to backfill it. So those programs, where they're going to send a preceptor along with them, that is good, you know, to an extent. You know, that's better”.

C. Public Health Departments

Local health departments typically have a charge which includes both population health as well as individual care delivery (often services for vulnerable populations), and are well situated to provide teaching opportunities to HPEI students where work force diversity and health disparity issues are often a central concern.

Our interviews with health departments revealed significant variation in the level and form of relationships with HPEIs. A key driver was the degree to which such a relationship is viewed as mutually beneficial. One interviewee, for example noted:

“One program that we had was a partnership between xxx and the health department wherein they [the school] developed a website that faculty here could put their information on about projects that they had available for students, and then students could also go there and look and find out if there were common to their interests...We both gained from the training opportunity...”

Health department staff noted, however, that just having a relationship with a HPEI does not, by itself, necessarily serve to advance diversity goals per se. Nevertheless, it is important to note that having some sort of relationship is viewed as essential in order to be in a position to advocate for a greater HPEI focus on diversity issues. As one interviewee noted:

“Being very close to the academic institutions is essential. I mean, I'm a professor at UC YY, and there are a number of other people here that also do [have faculty appointments]. So it's that informal familiarity [with what is happening at the school]. Now, still if they don't have a diverse group of students going through, it's not going to be terribly helpful [to the health department's ability to attract and hire a diverse group of future public health UR graduates]. But that is probably job number one in terms of trying to get people in, is having a close relationship with local schools.”

In physician training, health department experiences can sometimes educate and attract young physicians to consider the challenging but invigorating careers that are available in public health practice. As one of our interviewees noted:

“And the doctors that do come to [our health department] to do residency training, they rotate with me ... And a lot of them, they’re just like, their jaws drop and they’re just amazed at everything that public health does.”

In nurse training, there is also a desire to both sensitize future nurses to public health careers as well as use the rotations to help in recruitment. One typical comment:

“One of the advantages that we have is that we have affiliation agreements, actually contracts, with the local universities that are putting the Baccalaureate nursing students... We have them rotate through our health centers right now and we’re trying to get them into the program. So they get an early take - in their fourth year, just before they graduate, they’re looking for employment, they actually rotate through public health. So we try to, you know, use that time to really impress on them [that] we do have a lot to offer...”

For trainees in graduate programs of public health, governmental public health agencies serve as important training sites—especially in meeting school requirements tied to a required ‘agency experience’ in public health practice. Should the school have a diverse student cohort it can help in health department recruitment of a more diverse staff:

“At least now we have a local university that does have a Masters in Public Health, Masters in Health Administration, and Masters in Epidemiology that is providing that sort of educational opportunity for our local students [many of whom are racially and ethnically diverse]... and that has really turned around our ability to hire at least in those positions where we’re looking for the person prepared at the Masters level in public health. So that’s been a significant improvement locally.”

For public health schools that offer training in health administration, non-governmental agencies see the value of relationships with graduate programs that have diverse student cohorts. For example, we heard from one hospital executive:

“We are actually really trying to bring in diversity through that [MPH] program into our executive level positions. So we’re hoping that through an Administrative Residency Fellowship, we can start recruiting diverse candidates and funnel diverse candidates through our pipeline of development.”

We heard a similar sentiment from a health plan executive, who also noted that HPEIs need to do a better job at outreach with respect to demand-side employers:

“Well I can talk from my perspective having been in some of the major institutions here, as being a UUC xx and UC yy graduate. I think that the academic settings haven’t really formalized their ability to do this as much as they could [establish relationships with health plans to hire their diverse

cohort of graduates]. Particularly in the Bay Area, as an example, there are so many of us who are graduates who are in [positions] situations where there could be a lot of cross-fertilization. And you know, I think I have personally taken it upon myself to make that happen, with the links to UC, with the health professions program. And as a result of that you foster informal networks and ways of doing recruitment of under represented minorities...”

D. Institutional Advocacy

One of the important areas we explored with health professions employers was to ask about the ways in which they communicate to HPEIs in the region the importance of prioritizing diversity goals at their schools. We were struck by how often we heard from a health employer leader a response along the lines of “that’s a good idea; I never thought about that.” In the midst of other obligations, it appears that most leaders do not consider that simply communicating this as an organizational priority might make a difference. (It is important to note exceptions among some major teaching hospitals which have established diversity as a high priority and which, by their operational nature, are significantly intertwined with their affiliated medical schools).

Despite this lack of attention to advocacy with HPEIs, our interviews did yield a number of calls by health professions employer leaders for HPEIs to act in a more community responsive way. In summary, these comments included:

- Increased awareness that student exposure to community settings is highly valuable to HPEI student education.
- Increased recruitment of students from local communities (and less focus on foreign students) to increase racial and ethnic diversity and fulfill social contract obligations.
- Include language courses as HPEI course requirements to increase the language competency of the workforce.
- Adapt HPEI curriculum to reflect the experiences of the community health center environment in and expand conceptions of “legitimate” rotations to include community health centers.
- Calls for the UC system in particular to deal with the reality that their admission criteria limit access to HPEI training for UR students.

At a profession-specific level, we also heard the following from our interviewees:

- There is a lack of “part-time” nursing programs (in particular) that can truly accommodate a working adult (many of the “part-time” programs still require 30+

hours/week), which is impacting the ability of diverse employees/community members to return to school.

- The community health centers and consortia indicate that nurses are not adequately prepared to work in the community health center environment. As such, they are calling for nursing programs to revamp their curriculum to reflect this setting and its particular considerations (e.g., including rotations via community clinics).
- Call to public health schools to place an increased emphasis on the practice side of public health and its research efforts, as opposed to focusing so intensely on theoretical work.
- Increase exposure to public health issues and curricula in medical school (and to a lesser degree nursing) to enhance the ability of providers to provide services to these populations and increase the likelihood that providers will serve in these settings.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as other CTD inquiries, we propose the following recommendations for health professions employers to work with HPEIs on education and training issues:

1. Health professions employers, particularly teaching hospitals and other HPEI-affiliated training sites emphasize multicultural education, training, and patient care by:

- Providing education on ways to decrease health disparities
- Increasing structural diversity among faculty and trainees
- Strengthening health care providers' linguistic competence
- Exemplifying cultural and class humility in interactions and relationships with patients and staff

5. Teaching hospitals that lack a critical mass of UR residents establish partnerships with other teaching hospitals within their geographic area.

These partnerships could involve the development of shared rotations that bring together UR trainees from different programs, provide exposure to different training sites, build common areas of interest and inquiry, and create opportunities to share insights with trainees from different backgrounds. These steps will help these types of teaching hospitals to compete for UR candidates and create a more supportive learning environment.

6. Health professions employers encourage HPEI-affiliated staff to participate in HPEI administrative / decision-making structures to educate their academic colleagues about the benefits of diversity and influence decision-making. Particular attention should be given to the following areas:

- Admissions processes
 - Faculty and staff hiring and promotion
 - Creating a supportive environment
 - Delivering a culturally competent curriculum by including an array of community settings and experiences in their teaching
4. **Teaching hospitals create emergency loan funds to reduce attrition or disruption of educational experiences for health professions students and postgraduate trainees.**
 5. **Teaching hospitals support UR faculty through the hiring, retention, tenure, and promotion processes at their own institutions as well as at affiliated HPEIs.** Support can take many forms, including: financial, work-duty scheduling and responsibilities, mentoring, and career planning and advancement.
 6. **Develop creative funding mechanisms through public/private partnerships to increase clinical rotations in rural and urban community health centers.**⁸⁶ These investments are increasingly important given the movement toward a dispersed model of residency training among existing programs such as the Charles Drew School of Medicine and the approved UC Riverside School of Medicine. Resources are needed to build the training capacity of hospitals and community health centers that serve these communities, and revenue sharing arrangements between hospitals and community health centers are needed to cover the ongoing marginal costs of the training process.

Possible strategies to build training capacity include, but are not limited to tax credits and other incentives for health professions employers such as health plans, biotechnology and pharmaceutical companies to invest in hospital and community health centers, required investments by new programs (e.g., UCR School of Medicine), and State-private sector matching grants.

For ongoing marginal costs (particularly for community health centers who do not receive clinical training subsidies), an analysis of federal and state funding streams is needed to examine possible revenue sharing arrangements. A current pilot program involving the placement of trainees from the five California dental schools for rotations in community health centers⁸⁷ suggests that revenue sharing arrangements can yield significant benefits for all parties. Preliminary results indicate a dramatic increase in access to care for residents in underserved communities and an increase in the number of graduates who choose to practice in these areas after graduation.

⁸⁶ This recommendation was developed in conjunction with the California Health Professions Workforce Diversity Advisory Council (HPWDAC), a body convened by the CA Office of Statewide Health Planning and Development (OSHPD) as part of a project funded by The California Wellness Foundation. The recommendation was one of nine recommendations in a final report published in May 2008.

⁸⁷ The CA Dental Pipeline Program is funded by The California Endowment, and is documented in CTD report, "Profiles in Leadership."

7. **Teaching hospitals with primary care training programs should seek medical school affiliations for their staff physicians.** These affiliations will provide the means to increase exposure of medical students to primary care issues, dynamics, needs, and opportunities in the region.

8. **Hospitals and health systems create, participate in, and financially support partnerships with nursing programs.** Particular areas of focus include:
 - Increase the number of nurses-in-training
 - Improve nursing program facilities, e.g., classrooms and laboratories
 - Expand faculty
 - Increase clinical internships
 - Increase retention and graduation
 - Strengthen mentoring
 - Increase financial aid
 - Improve the overall quality of the nursing education experience

Partnerships should establish clear time commitments for institutional resource allocations and develop strategies to ensure the sustainability of capacity building investments.

III. Workforce Issues

Health professional employer involvement in the community has many dimensions, from being responsive to a community's needs and fulfilling community benefit obligations to being dependent on the community to provide a skilled and capable workforce. Yet for a variety of reasons, few California communities have the capacity to meet the workforce needs of local health professions employers.

In this section we discuss some of the most pressing workforce issues described by health professions employer leaders in our sample and the strategies these organizations employ in an effort to address their workforce needs.

A. Workforce Shortages

In light of current health professions workforce shortages and geographic maldistribution, workforce development has become a priority issue for health care delivery organizations. In general, we found that the immediacy of these shortages for some organizations has meant that increasing diversity can be viewed as a second-level priority. Instead, recruitment efforts are directed toward finding people who are credentialed or otherwise qualified to “do the job now.” While California's nursing shortage is well known, there are also reported current or emerging shortages in nearly every health and allied-health profession, including:

- Primary care physicians
- General Surgeons
- Dentists
- Pharmacists
- Radiology and laboratory technologists
- Respiratory care specialists
- Medical coders
- Medical assistants
- Occupational and physical therapists
- Public health professionals

The aging of the baby boomers combined with the dramatic growth projected for California, increasing rates of chronic disease and technologic advances will significantly increase the demand for health care. At the same time, projected retirements from the aging health workforce, a lack of capacity in health professions schools and reduced ability or desire to import out of state workers will adversely affect the supply. These factors will exacerbate these shortages and increase the number of professionals and leaders needed in almost all professions. Having a well-trained health workforce that is sufficient to meet local health needs is essential to the viability of individual health institutions in all sectors and has important consequences for access, affordability, and quality of care in communities throughout California.

Health employers are pursuing numerous strategies to recruit and retain a sufficient current and future health workforce. While workforce development is a broad endeavor, the changing demographics of the state will require particular attention to the needs of

our emerging majority populations, and building a workforce that understands how to best meet their health needs.

Workforce shortages, the desire to provide career advancement opportunities to existing staff, current K-16 pipeline limits and the, increased demand for UR professionals has led an increasing number of health employers to focus on incumbent worker development. Incumbent workers are those already working for a health employer. These educational and career development efforts often involve partnerships—for example, between hospitals and health professions educational institutions (HPEIs).

While the primary goal of these efforts is to address shortages in particular health professions disciplines, the racial and ethnic profile of entry level and/or less clinically skilled hospital workers means that incumbent worker training programs often increase staff diversity. As the CEO of a rural teaching hospital explained:

“What we’ve tried to do is look at people who, from a career ladder [standpoint], want to get into nursing. They generally are single women and ethnic minorities. They’ve not had an opportunity to go to college. They’re working, they have families, and those barriers have been fairly difficult. So when you have scholarship programs where they can continue to work but you’re paying for their school and you’re also working your schedules around their colleges, they generally tend to be the most loyal and the most supportive employees. You’re giving your lower paid employees an opportunity to advance economically. That’s a significant part of advancing our values.”

In addition to providing scholarships, release time and flexible work schedules, educational support, skills development, mentoring, and on-the-job training are essential components of incumbent worker programs. The labor-management partnership between SEIU-UHW and Kaiser Permanente of Northern California⁸⁸ is an example of one such program that provides these opportunities and benefits. In addition to some of the teaching hospitals and health systems in our sample, our informants at county departments of public health and community clinics also told us about career ladder initiatives sponsored by their organizations. Benefits and resources provided by these programs can include, but are not limited to the following:

- Full or partial tuition payment or tuition remission
- Full- or part-time salary and release time while attending school
- Loan forgiveness
- Workforce training center support
- Coaching
- Nursing or allied health courses with in-house instruction
- Funds to support emergency, child care or other needs

⁸⁸ This program is described in CTD report “Profiles in Leadership.”

Some health professions employers forge partnerships with HPEIs, often community colleges or CSU campuses, to fill projected needs for nurses, various allied health professionals, medical records staff, and business office personnel. By underwriting the cost of tuition and support services that ensure students' academic and professional success, these institutions invest in both the pipeline and their future workforce. Sometimes programmatic support is provided directly to HPEIs in the form of classroom and laboratory space and/or in-kind faculty support. We learned of several hospitals that provide funding to increase the number of slots in nursing departments at nearby community colleges and CSUs, while also paying the tuition of ADN- and BSN-level nurses and the cost of related student support services. In return, students agree to work at the hospitals for a set number of years—usually one or two—upon licensure.⁸⁹

Workforce shortages for rural safety-net provider organizations and public health departments can present unique challenges. Most of California's medical schools are located in urban areas. Overall, little attention is paid in medical school or residency curricula to rural or public health issues.⁹⁰ One informant, whose rural health department has ongoing relationships with a UC medical school, told us that

“We have vacant physician positions right now, in this department, and the docs that are graduating have no clue that there are physicians here.”

Even when residents at a major medical center have first-hand experience rotating through a rural public health department, “they still don't quite understand what the opportunities are,” according to the previous informant. This can make it difficult to attract medical residents (who might choose to stay on as staff physicians after passing their boards), as well as licensed physicians as employees at rural health centers, hospitals, and county departments of public health. Physician recruitment problems are compounded by the fact that working in a rural area like the Central Valley just doesn't have the cachet of a major metropolitan center. As another informant explained,

“As long as you admit kids from Marin County to the medical school in Berkeley, I'm going to have a hell of a time getting them to “Weedpatch”. It's just not going to work real well.”

While the cost of establishing a residency program is prohibitive for most community clinics—rural and urban alike—individuals do enter residency training with the goal of taking care of rural populations, particularly persons who themselves grew up in rural areas and would like to return home. Indeed, working in a community that demographically resembles one's hometown is one of the strongest draws of providers to a given area. One informant suggested that competition between the most selective teaching hospitals to fill residency slots with medical graduates who chose their institution as a top match contributes significantly to the geographic mal-distribution of

⁸⁹ For examples, see profiles of East LA College's Bridge to Nursing program and Long Beach Memorial Medical Center CSU Long Beach Department of Nursing in CTD report “Profiles in Leadership.”

⁹⁰ A notable exception is Rural-PRIME at UC Davis, a new program to increase access for underserved populations in rural areas. See http://www.ucdmc.ucdavis.edu/medschool/rural_prime/index.html

physicians in general and UR physicians in particular. One interviewee suggested that rotations through rural, community clinics should become mandatory. This exposure could open new doors for young physicians who may have a narrow view of the settings in which they might eventually practice.

Some rural interviewees mentioned that an increasing challenge for the California rural health workforce is a growth in prisons and their demand for health professionals. Numerous new prisons and prison health facilities are being built in California. The demand for the additional prison health workforce is growing dramatically. In addition, higher compensation offered by prisons is attracting health professionals away from other health and public health providers in many areas.

In light of projected rates of population growth and provider retirement,⁹¹ many workforce shortages are expected to worsen unless definitive action is taken.

Policies and practices that support career development for health professionals are essential to leadership development, employee retention, and creating a supportive work environment. They may take the form of:

- Offering scholarships or fellowships for employees to return to school
- Tuition reimbursement
- Flexible work schedules to allow for class attendance
- Mentoring
- Leadership development institutes

These practices have been implemented by many of the health professions employers in our sample, including health plans, teaching hospitals, health systems, community clinics, county health departments, and IPAs. One community clinic leader explained her view of the conditions that foster employee retention:

“Besides the pay, people really want to look at the opportunity for advancement. They want to learn. They don’t want to just go into a place where they’re going to be stagnant. [They want] their voice to be heard.”

Physician shortages⁹² have encouraged internationally-trained medical graduates (IMGs), who are also referred to as foreign medical graduates, to emigrate to the U.S. in

⁹¹ California’s efforts to increase nurse graduation rates are making a difference. According to data collected by the California Board of Registered Nurses, the percentage of RNs in California is increasing. 7,528 new graduates of California nursing programs received their initial RN licensure in California in fiscal year 2005-2006. The number of internationally-trained nurses who passed the NCLEX-RN exam and received initial RN licensure in California during the same period is 4,062, or slightly more than half the total number of new graduates of California nursing programs who received comparable licensure during the same 12-month period. To arrive at high and low estimates of the actual number of newly minted RNs in fiscal year 2005-2006, both of these numbers would have to be adjusted for “inflows” and “outflows.” See Joanna Spetz, “Forecasts of the Registered Nurse Workforce in California.” <http://www/rn.ca.gov/> (accessed on November 26, 2007).

increasingly large numbers. However, some of our informants expressed concern that cultural differences between providers and patients from different countries and cultures sometimes create communication difficulties and conflicts that are not easily overcome. Problems can also arise in the working relationships of IMGs and U.S. trained nurses, as one informant explained:

“A lot of the doctors are foreign born. They bring with them some of their cultural attributes and, perhaps, do not share the same perception of women in the workforce as we who have grown up in this country have been indoctrinated in. That’s been a huge issue because every time we bring up the whole diversity-inclusion thing, the first thing the nurse leadership says is, “Who’s going to educate our doctors that it’s not appropriate to say certain things or act a certain way to the nurses?”

This sensitive issue poses a difficult problem that is as old as the origins of nursing and medicine in America. Whereas the health system leader quoted above would be unlikely to tolerate a pattern of racism etched in the culture of her organization, she describes a gender/ethnicity dynamic in which she feels helpless to intervene.

However, a recent report by the AMA IMG (International Medical Graduate) Governing Council presents a different picture of IMG physicians, praising their sensitivity to cross-cultural patient care:

“The diverse backgrounds of IMGs are especially valuable in caring for a multiethnic and increasingly diverse U.S. population. Not only do IMGs have diverse language capabilities and the natural openness and sensitivity in caring for members of different ethnic groups, but they also are able to assist in developing sensitivity and understanding of cross cultural issues among their non-IMG colleagues. For some time, the openness, understanding and sensitivity of IMGs to other ethnic groups has been recognized in the delivery of psychiatric services. More recently, the recognition or understanding and sensitivity to ethnic and cultural issues has spread to other specialties such as obstetrics and gynecology.”⁹³

⁹² 24, 510 international medical graduates have completed U.S. residencies and now practice medicine in California, comprising 22.7 percent of the state’s physician workforce. See AMA IMG Governing Council, “International Medical Graduates in the U.S. Workforce: A discussion paper,” October 2007, p. 7, citing “Physician Characteristics and Distribution in the U.S., 2007,” American Medical Association, Chicago, IL. In the 1990s, a steep rise occurred in the number of incoming IMG, which is attributed to the breakup of the Soviet Union, changes in the licensing exam, and new immigration laws.

⁹³ AMA IMG Governing Council, “International Medical Graduates in the U.S. Workforce: A discussion paper,” April 2006, p. 8. <http://www://ama-assn.org/ama1/pub/upload/mm/18/workforce2006.pdf> (accessed on November 30, 2007).

B. Diversifying Leadership and Management

Leadership development and succession planning are key areas of focus for health professions employers in efforts to increase diversity. There is growing recognition that the dearth of UR senior administrators and the “graying” of current leaders present both a challenge and an opportunity. Often overlooked is the fact that diversity among senior health administrators and board members is often even less than in clinical health professions.

The Institute for Diversity in Health Management and other major initiatives were created to address the significant national under-representation of senior health executives from under-represented groups. This creates a significant challenge given that people in these positions within health organizations often have the most influence and authority about resource allocation, policy and strategy decisions that affect the entire organization and the communities they serve. In addition, interviewees consistently indicated that commitment from senior leadership is one of the most important factors in advancing diversity efforts by health employers. In fact, many of the organizations in our sample that have made significant progress on diversity issues were led by UR senior leaders.

Two major health employer CEOs interviewed also strongly expressed that as their senior leadership team became more diverse (including race/ethnicity, gender and background) and more reflective of the populations they served, the quality of the decisions they made and the results they achieved improved dramatically.

In recognition of its importance, an increasing number of organizations are engaged in programs with a particular focus on increasing diversity in management. Many are actively working to hire UR leaders and managers, including board members. Some take the view that doing so is necessary to facilitate positive change in the workplace. As one CEO explained,

“We’ve been looking at how we reflect our community. And we looked at it from two standpoints. One is how does our board reflect the constituency of our provider network? And we had been, I think, a standard governance structure of old white males. We made a conscious decision to break that cycle and to go after a more diverse representation of people on our board, both [along lines of] gender as well as ethnicity.”

Another informant addressed the need for a strong internal leadership development process that begins with graduate administrative fellowships:

“We’re ramping up with regard to developing our own diverse leadership because gone are the days... You can’t buy it anymore. So you’ve got to build it.”

Another organization developed an administrative residency fellowship to recruit a diverse candidate pool. Upon successful completion of the program, fellows are funneled into executive positions. Still another organization tries to groom some people who may not be interested or ready to be on the board and gradually bring them in through participation on key committees.

In order for organizational-level diversity initiatives to succeed, leadership must be directly involved in and committed to building, expanding, and investing resources in a diversity-supportive culture. Leaders—executive management, boards of directors, fiduciary boards, and community boards—all can facilitate (or obstruct) an organization’s readiness to take on this highly charged issue. They can take the bully pulpit to change hiring practices or bemoan the dearth of qualified, management-level candidates. Since leaders inevitably have numerous priorities and competing interests, sustaining an organization’s commitment to and focus on diversity is often immensely difficult. One informant explained his view that

“...it’s a responsibility of the leadership to set up an environment where these issues are dealt with. It’s tough to do because the first thing people say is, “Well, I don’t know if we want to raise an issue because it might open a can of worms.” Well, dammit, when do you open this can of worms? We spend a lot of time tiptoeing around it and I don’t have the answer. But the only thing that I know to do is to talk about it and to trust that our colleagues are experiencing some of the same things.”

Commitment to diversity is sometimes expressed by convening a mission or cultural diversity committee that reports to organizational leaders. Designation of a diversity manager is another approach that establishes lines of accountability through a specific staff member. One health professions employer has taken a different approach to advancing diversity—broadly defined—by helping to incubate “employee networks,” a grass-roots initiative enabling employees to connect with one another:

“First and foremost employee networks are about creating a sense of belonging within the organization of people who are like them, whoever that group happens to be. We have many employee networks that are not based on race and gender [and others that are].... The idea is first and foremost [for employees to] develop their own capabilities within [the organization]. If we can do that really well, they’ll be more engaged, they feel that we know they matter, we value them for who they are, and we respect them.”

Major health plans and a major health system interviewed indicated that they invested heavily in developing and supporting employee networks. They also invested in regular employee surveys and follow up actions to improve workplace inclusiveness and supportiveness for employees of all backgrounds. Aetna reported significant financial and productivity benefits from an extensive commitment to this approach.⁹⁴

⁹⁴ Aetna’s experience is described in CTD report “Profiles in Leadership.”

We also found that having satisfied, diverse employee networks within health organizations can provide employers with access to larger pools of qualified racially and ethnically diverse candidates. Many organizations that had the most diverse workforces at all levels utilized their extensive employee networks for recruitment.

Race and ethnicity is difficult to discuss and identifying—not to mention changing—prejudiced behavior and attitudes, especially when they are institutionalized in a mainstream organization’s culture, can be extremely challenging. As an African American public health department leader told us:

“So the thing that we try to avoid is the issue of race. We often talk about diversity but not what that really means. We talk about disparities. And so the department is doing a strategic plan and part of that is [implementing] a process by which we can learn more about diversity.”

Health professions employers with the active involvement of a critical mass of leaders committed to diversity is essential to ensure that this priority does not die with the departure of a particular diversity champion. By the same token, lack of diversity among individuals in leadership positions often has a negative impact on an organization’s ability to move its diversity agenda forward, including its ability to recruit UR candidates. This point was vividly illustrated by one interviewee, who described the dearth of Asian American leaders at the health system for which he formerly worked:

“We had a huge minority problem in management. There were no senior minority managers and, at that time, myself and another guy were the only two Asians in senior leadership positions or tracks. Just getting twenty, fifty, a hundred of us (non-White administrators) together over the years was a challenge because many didn’t feel safe to speak about being ethnic.... For these folks to get out and the risk taking—someone had to support that effort! So when you talk about the same kind of issues, trying to bring that forward now, it’ll take a lot leadership to pull this off.”

While the support of leadership is critical, so, too, bottom-up efforts initiated by students, health care workers, and community activists can be an effective way to develop and implement diversity initiatives. Such efforts, however, can obscure the lack of commitment by leadership.

One key sector in which significant leadership development and succession planning is needed is in California community health centers. In 2007, The Blue Shield of California Foundation of California launched a major Clinic Leaders Initiative to address this issue. The initiative was based on some surveys they and done that found that 70% of senior leaders in health centers expected to retire in the next 5-10 years. They also found a dearth in the pool of qualified emerging leaders to carry on after current leaders retire. Given the demographics of the communities most health centers serve, having leaders that represent those communities and are devoted to the mission and values from which

community health centers developed and operate is critical. Schools of public health, business and community leaders and others must partner with health centers to inspire and increase the pool of diverse leaders. Clinics along with government and private health employers also need to find solutions for compensation and other factors that many influence recruitment and retention.

C. Recruitment and Retention

While employers are increasing their efforts to expand the pool of qualified diverse health leaders and professionals, almost all we interviewed are facing significant challenges with recruitment and retention of diverse candidates for immediate needs.

A common response from interviewees was that they valued diversity and often consider it in recruitment efforts. While their first priority was typically finding the best qualified candidate, they indicated that they would welcome and in many cases strive for a pool that includes strong UR candidates. However, typical responses were either that “they just aren’t out there” or that strong UR candidates “have their pick of where they want to go and often go to the highest bidder.” Both of these were viewed as barriers to effective recruitment efforts. One health plan CEO commented that senior leadership commitment to ensure that searches include qualified UR candidates is essential. He gave examples of where search firms that were hired did not produce diverse candidates. In one example he asked them to go back again and again until they produced a strong UR candidate that was ultimately hired. In another example he had the human resources department fire the firm and find new firms that did produce candidates. He commented that in both examples he would not have had diverse candidates unless he personally pushed. A key issue for employers is how to put incentives and systems in place to ensure that diversity is a priority and that recruiters and people responsible for hiring decisions go the extra mile.

One health system has implemented strategies to increase the likelihood that senior leaders will ensure that diversity is a major consideration in recruitments. The system established diversity in leadership and workforce goals for facility CEO’s. These goals were a central component of the CEO’s evaluation and included as part of the key “dashboard” measures. As one interviewee said “what gets measured, gets managed.” Taking it a step further a meaningful percent of the CEO’s compensation was tied to meeting their diversity goals and they could ultimately lose their job if they beyond a certain deviation of their goals compared to other CEOs in the system. This incentive system resulted in major advances in diversity for this system.

Measures and incentives can also influence the success and organization has at retention of UR employees. Often employers invest more in recruitment than retention efforts. However, some interviewee’s indicated that UR people hired can become disenchanted with the culture and lack of supportive environments, particularly if they are the only UR person in the workplace. Others reported that UR candidates get frustrated with the “glass ceiling” or lack of advancement opportunities, particularly in middle management

positions. Some interviewees reported that staggering turnover costs were on the rise and provided a strong justification for investment in meaningful workforce development and retention efforts. Hopefully these and other factors will strengthen the case for more effective retention efforts.

D. Cultural and Linguistic Competence

For a health workforce and leadership that better reflects the racial and ethnic makeup of our communities to ultimately result in improved quality care and outcomes, health employers must create the conditions for staff from all backgrounds to become more culturally competent. Cultural and linguistic competency system development and training for clinicians, management, and boards of directors is also needed on an ongoing basis to advance patient-provider relationships and strengthen relationships that may be strained by misunderstandings over cultural and other differences. The rapidly changing racial/ethnic demographics of California's communities and regions make advancement in this area more urgent. The leaders of the health professions employers in our sample are well aware of the cross-cultural communication concerns faced by many of their patients/clients and employees. Indeed, increasing the variety and accessibility of language services and coordinating interpreter and translation services with other institutional providers to avoid duplication of effort are among their priority concerns. But like increasing the diversity of their boards, it is but one among dozens of priorities.

Cultural Competency

The organizations in our sample described a variety of initiatives to ensure that employees at all levels receive some cultural competency training and that their clients/patients receive culturally appropriate administrative services and care. Among the formal and informal cultural competency activities undertaken by the organizations in our sample are:

- Multicultural health lecture series
- "Tools for Tolerance" training facilitated by the Museum of Tolerance in Los Angeles
- Required diversity course for new and incumbent executives, managers, and first-line supervisors. A refresher course is also required.
- Training about employment laws regarding discrimination based on race/ethnicity and gender
- Social justice dialogues for staff
- A standing cultural diversity group for employees to learn about each others' cultures of origin
- One-on-one cultural competency coaching for physicians to improve patient satisfaction ratings
- Informal training by individual supervisors
- Use of case examples and feedback from actual patient-provider experience
- Films

Most of these efforts, however, are ad-hoc and tend to be funded with soft money. Furthermore, their outcomes, for the most part, have not been evaluated. Moving this agenda forward presents significant challenges, particularly in the context of staffing shortages.

Providers and non-patient care staff who reflect the demographics of the population served by their organization and the wider community have a positive impact on clients' perceptions of the quality of and satisfaction with the care they receive. However, we have not found literature that indicates whether or how patient outcomes are affected when individuals are cared for by providers whose race/ethnicity is concordant with their own. There is increasing evidence, however, that an organization with an ethnically/racially diverse workforce that matches the composition of the local community contributes to the development of trust that can lead to effective community partnerships and projects. Still, these partnerships and projects have no documented relationship to clinical outcomes.

Conversations with some of our key informants confirmed findings from other studies that African Americans often distrust the Caucasian medical community and may be reluctant to utilize services delivered by white providers. While this is not a novel finding, it is a reminder that the legacy of racism in health care, combined with contemporary institutional racism, affects health care access for African American and other UR populations. According to one informant from a safety-net organization:

“I continue to have things come across my computer screen about racial disparities in treatment, you know, people not being comfortable going into a Caucasian environment. But it really is a trust [issue]. As an African-American, am I going to trust this white doctor to give me the straight scoop? Or am I going to think that I'm going to get something put into me that's going to hurt me or kill me?”

Another informant from a safety-net organization noted that individual provider-patient dynamics can be substantially impacted by the overall clinical environment:

“There's a broader segment of the population who, if you have some basic, culturally sensitive approaches by virtue of the kind of staff that are hired, the languages that are spoken, the understanding of culture, it doesn't matter who's the provider.”

Several informants identified cultural competency as crucial to the training of house staff at safety-net hospitals. Yet after becoming attending physicians, doctors may be reluctant to participate in additional cultural competency training efforts. It may be necessary for the sponsoring organization to provide CME credits or other incentives to entice physicians to attend seminars and other trainings, as attendance at such programs is at an individual's discretion. It cannot be mandated by an institution or even by a law such as SB 853, “Cultural and Linguistic Requirements for Commercial HMOs.”

Physicians may need to be shown metrics or patient feedback indicating that they need to improve their communication with and care of UR patients in order to become motivated to attend a cultural competency training session. One health system in our study had implemented a pilot program at some of its facilities whereby providers were provided patient satisfaction results by race/ethnicity, age and gender. They were given feedback on areas needed for improvement and offered training and support resources. A portion of their incentive pay is tied to improvement in their measures. The early anecdotal results were that physicians were receptive and that it had influence awareness and behavior.

One health plan leader recalled a successful, optional, role-play activity that was planned for physicians affiliated with his organization:

“It was really kind of neat. I did it with the docs and it was very cool. They stumbled through it, you know, and so I think it helped them understand that they could improve.”

Another organization offers a required course that creates “a forum to dialogue and openly discuss some of the fears that managers and supervisors face—the trepidation of having to deal with these sensitive subjects or, quite frankly, not wanting to deal with them.” Our informant further explained:

“It’s not necessarily comfortable to be in a leadership position when you have to insert yourself in these types of very [delicate situations] and they can be very, very sensitive, whether it’s a sexual harassment issue or it’s racial discrimination.”

Still, our informants at community clinics, health systems, and teaching hospitals told us that they have received requests for additional cultural competency training from physicians, employees, and faculty. We interpret this as a positive sign of their desire to enhance their interpersonal competencies. It may also be a sign that they recognize the importance of becoming skillful listeners and communicators across lines of culture and language.

Language services

One out of every five Californians—over six million people—are limited English proficient (LEP) and would benefit from the services of health care interpreters.⁹⁵ Yet many health care organizations lack bicultural and bilingual staff and services, thereby constraining their ability to provide high quality, culturally appropriate care to their LEP clients and patients.

One informant suggested that a lack of interpreters may have a negative impact on the average length of MediCal patients’ hospital stays, of whom a large proportion are non- or limited-English proficient. Another informant expressed frustration that her employer doesn’t participate in a federal/state matching program that funds interpreter and

⁹⁵ “Health Care Interpreters in California,” Center for the Health Professions, UC San Francisco, 2003.

translation services.⁹⁶ Our data suggest that many organizations use employees, such as front office staff, to assist with medical interpretation (in addition to performing their primary job responsibilities) but such services are inadequate, unreliable, and highly inappropriate.

At the same time, many demand-side providers are engaged in efforts to assess the cultural and linguistic competency of their organizations. SB 853, signed into law in 2003, requires health plans that operate in California to provide and evaluate language interpreters for their LEP members. (Hospitals are also required to provide language assistance at the point of service.) Thus, some of the activity surrounding provision and assessment of language services is in response to State as well as federal laws and regulations.

Regulations for implementation of SB 853 require managed care organizations and insurance plans to assess the number of LEP enrollees, translate important documents, establish requirements for timely access to interpreter services, and ensure the competency of interpreters and translators. Progress on several cultural competence measures must also be reported annually to the legislature.⁹⁷ As one of our informants explained, the purpose of collecting and disseminating this data is that “public reporting creates accountability, which then creates, hopefully, change.” In addition to the public reporting influence, surveyors evaluating the compliance health plans have with the regulations should be trained and supported to ensure that plans, investments and progress are reasonable and at scale for the organization and population served.

One informant indicated that she believes her organization is “kind of going on faith” with regard to the language services offered by its providers. She told us she wished that her health plan could work with its physicians to ensure their maximum proficiency but without “more time and resources,” doing so is out of the question at this time. However, her organization is collaborating with a health system to refine and pilot a test to assess physicians’ Spanish language proficiency. The instrument would provide standards for measuring medical language proficiency using patient satisfaction and emergency department visits among the metrics. Fifty physicians affiliated with both the health system and the health plan participated in the pilot project to develop a valid tool.

⁹⁶ Federal Medicaid and Title XXI matching funds have been available for some time for expenditures on interpreter and translation services. In addition, through the Department of Health and Human Services’ Office of Civil Rights, technical assistance is available to states for a variety of promising practices, including community language banks, state-supported language offices, simultaneous interpretation using off-site technology, translated print and on-line documents, telephone information lines with frequently spoken languages on recorded messages, and signage. Ann Morse, “Language Access: Giving Immigrants a Hand in Navigating the Health Care System.” <http://www.ncsl.org/programs/immig/SHNarticle.htm> (accessed on December 10, 2007). Excerpted from NCSL’s State Health Notes, 23:381 (October 7, 2002).

⁹⁷ California Immigrant Welfare Collaborative, *California Update 7:5* (October 21, 2003): 2. <http://www.nilc.org/ciwc/nwsltr/CAUPD5-03.pdf> (accessed on December 11, 2007). See also GF Kominski, C. Reifman, ME Cameron, and DH Roby, *Language Barriers Pose a Risk for California HMO Enrollees*, Los Angeles: UCLA Center for Health Policy Research, May 2006. http://www.healthpolicy.ucla.edu/pubs/files/Lang-Barrier_HMO_PB.pdf (accessed on December 11, 2007).

While the tool still needs refinement, statistically significant, validated correlations were found between certain items, performance, and self-declared level of proficiency. In the meantime, the health system will decide whether to bring the tool to scale for its entire workforce. In this way the tool could become a national standard. Among the innovative language access programs we learned about are:

- A partnership with a college-based certified interpreter program.
- A monthly, medical Spanish course for medical residents.
- Incentives for a management team to become bilingual.
- Simultaneous interpretation of board meetings for non-English speaking board members and audience.
- Evening English and Spanish classes for entry-level through master's-prepared staff at a rural community health center.
- A language access coalition formed among providers and payers from all sectors in a county to increase language access capacity and have more coordinated, synergistic efforts and results.

Yet health professions employers report that there is a general lack of funding to hire certified interpreters, despite the fact that certifying and paying for professional interpreter services are essential health care services. The allocation of funding, of course, is a matter of priorities. This situation is compounded by institutional short-sightedness in recognizing the ROI of interpreter services. One COO informant explained that his view of the medical interpreter goes much deeper than proficiency with medical terminology:

“It’s actually knowing the language, the psychosocial part. I’m not so concerned if they’re black, white, yellow. I just want a competent person with great skills to be able to interact.”

Another informant reported a lack of basic infrastructure, such as multilingual signs at her hospital. As one CEO observed:

“If you go to [one hospital] you’ll see things in English and in Spanish and maybe in one Asian language. If you go over to [another hospital], you see a list of things—just basic directions—how to get around the hospital, how to find the departments, making the hospital an environment where people feel, “Oh, they’re paying attention to my needs when I walk into the front door.” We’re trying to reach out to a diverse population. You need to make sure that you’re taking care of people and making them feel comfortable.”

A longtime community clinic leader shared this observation with us:

“The mere process of language training is cross-cultural training and one of its best and most effective methods. It changes the paradigm within how people relate to one another. If we can take all the non-Spanish speakers and push them into a Spanish immersion of some kind, even if it’s for a moment, at the end of all of that there’s a residual comfort with cultural differences that maybe hasn’t existed prior to that language [immersion].”

Health professions organizations employ formal and informal strategies to allocate responsibility for and oversight of their organizations’ language services and cultural competency activities. Some have created a dedicated office led by a senior manager, an approach that has obvious advantages. However, a safety-net provider expressed concern about the consequences of siloing this responsibility:

Informant 1: “I just made it clear that [cultural competence is] something that we do across the organization. It’s not the responsibility of a single department. I don’t like having it in one place because it absolves people from the responsibility to be thinking about it.”

Informant 2: “Yeah, I agree with that. I was here when we started the program. And it did allow people to say, ”Oh, that’s an XYZ program thing. Just push it over here, instead of having it more widespread throughout the organization.”

E. Collaboration/Competition Among Health Professions Employers

Collaboration and competition among health professions organizations emerged as salient themes in our discussions with informants about the challenges and opportunities they encounter in implementing diversity and other workforce initiatives. Collaboration is essential to the health of individuals and the communities where they live.

In many cases organizations work collaboratively and competitively at the same time. It is widely recognized that some health care delivery organizations hire clinicians away from safety-net providers with offers of extremely attractive salary and benefits packages that incumbent employers cannot match. This kind of competition between health care organizations at a time of severe workforce shortages places an enormous burden on safety-net providers and other community-based organizations that already struggle to fill positions and lose their investment in the training and building cultural competence among clinicians when they leave the organization to accept more remunerative positions elsewhere.

On the other hand, partnerships between safety-net providers and other organizations, particularly hospitals and health systems, can benefit the participating parties and wider community by reducing duplication of efforts, increasing economies of scale through strategies such as bulk purchasing, and building platforms for shared policy advocacy.

An informant observed that duplicated translation efforts occur nationally and statewide:

“Why is everybody paying for this? Is it any wonder that the number of vendors providing language services, both interpreter and translation, is growing? Where’s the process to identify the quality organizations, instead of leaving us to fend for ourselves to find out by experience whether or not they’re perfect?”

This informant’s questions point to some of the drawbacks, from an administrative standpoint, of our multi-payer, market-based system of health care financing, such as failure to reward cooperation and collaboration among provider organizations and inability to inspire the development of innovative, cost-saving business models. This is an arena where much work remains to be done, as suggested in the recommendations developed for this section of the inquiry.

Yet one health system executive spoke with us in highly favorable terms about sharing his organization’s language services resources:

“We can provide all that templated stuff here, all the educational material that they need and get it translated. Discharge instructions, you name it. We can do it here. There’s no reason for them to reinvent it over there. When we ask our physicians to provide services to a community clinic, we try to look at the makeup [of the clinic] and if we have a physician that’s competent in Spanish or whatever the language, those are the doctors we ask to try to help out with those clinics.”

This was not the only instance we learned about of a health system providing support to safety net organizations. Two informants from safety-net organizations indicated that their facilities have working relationships with a large health system. The first interviewee stated that “We have [health system X’s] computers here now and you just see the power [of the electronic medical record].” The second interviewee explained that:

“A lot of the clinics in our county have been doing chronic disease management and lifestyle management programs. [Health system X] has really given us a bunch of support to train people to do that. And trains peer facilitators to run those groups.”

Yet many safety net organizations, particularly community health centers, are losing UR and/or culturally competent nurses and primary care physicians to mainstream health professions employers that offer better salary and benefits packages.⁹⁸ While our safety-net informants conveyed broad understanding of and empathy for ecological factors that affect an individual’s choice of workplace (e.g., cost of living, especially housing, the desire to pay off student loans, lifestyle considerations such as working an eight-hour day

⁹⁸ Health system X was sometimes characterized as the state’s highest paying healthcare organization.

with weekends off)—most have been adversely affected by mainstream providers’ recruitment practices. In the words of one community clinic leader, “We can’t compete.”

For major metropolitan areas such as San Francisco and Los Angeles, cost of living is a particularly important factor. As one community clinic director reported:

“We got to talk to somebody that’s already working at [X] who’s willing to take a cut in salary to come to work for us. But we can’t figure any way to structure the very low-cost home loan that [X] arranged for that person to buy a house in the Bay Area. So even though we got an interest [from someone] willing to take a cut in salary, [X] and other competitors as well are taking steps that the community organizations have a hard time competing with.”

Several informants suggested that health conversion foundations and health systems should help to support the recruitment activities of community clinics:

“Maybe some kind of loan thing [would help to level the playing field]. This doesn’t help the medical assistant but at least it would help the docs if they reduced the mortgage rates a couple of points and The [California] Endowment or [health system X] underwrote the difference.”

Another informant expressed the view that health conversion foundations should support initiatives that enable clinics’ to retain their staff:

“If we could get some help from The [California] Endowment or [The California] Wellness [Foundation] to enhance educational opportunities among our staff, I wouldn’t have to worry so much about the other employers stealing everybody.”

In general, the combination of increases in costs, demand for services, and shortages among various disciplines means that safety-net employers have more competition than ever and fewer resources. They recognize and appreciate that other health professions employers seek to build a more ethnically and culturally diverse staff. In doing so, however, it is essential to approach health professions workforce development from a more holistic perspective that takes into consideration the critically important role of safety net institutions in urban and rural communities.

This requires attention to the complementary roles of different health professions employers in addressing the health needs of all California residents in the most cost-effective manner. Just as important, it also requires a balance in emphasis between addressing near term staffing needs and the long-term goal of building a more diverse and culturally competent health professions workforce. While health professions employers will continue to compete for insured populations and the best providers to serve them, it is essential to move towards a more collaborative approach to workforce development and addressing the health needs of underserved communities.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from other CTD inquiries, we propose the following recommendations for health professions employers:

- 1. Health professions employers develop strategies to increase diversity across all job categories.** An important part of any strategy should be the establishment, expansion, and institutionalization of incumbent worker programs. Particular attention should be given to facilitate the emergence of UR senior leaders through leadership training and succession planning and pipeline development.
- 2. Health care providers and health plans share cultural and linguistic competency resources and exemplary practices.** Better sharing of resources, innovations, and lessons is needed to both make optimal use of limited resources and to expedite quality improvement in the field.
- 3. Organizational leadership and demonstrate commitment through ongoing involvement in the development of diversity-supportive organizational culture.** Vocal leadership is essential, but not sufficient in and of itself to create a supportive environment for UR staff. Commitment must be demonstrated through ongoing involvement, policies and practices, and investment of resources.
- 4. Health profession employer managers at all levels are responsible for meeting specific diversity objectives.** Monthly dashboards, annual evaluations and bonuses, and reports to governing bodies should include an assessment of how effectively they have met these goals.
- 5. Nonprofit hospitals share employment of clinicians with community health centers and pay salary/benefit differentials as a community benefit.** These actions will reduce the negative impact of the loss of diverse and/or culturally competent clinicians at CHCs associated with the aggressive recruiting practices of mainstream providers. These actions also create the potential for clinicians in shared arrangements to play a role as intermediaries, facilitating increased cultural competency in the mainstream provider organization, and sharing clinical and administrative innovations with community health centers.
- 6. Health professions employers provide targeted funding for community health centers to support community-based career fairs and other activities.** In the examination of options to increase awareness of health professions career options for UR youth in underserved communities, CHCs were identified as a key stakeholder with the visibility and credibility to convene youth and families. The joint convening of UR youth and their families helps to familiarize parents and encourage parents to support youth aspirations that are stimulated by the exposure to the range of career options and UR role models. Targeted investment by health professions employers, particularly nonprofit hospitals, is one way to help compensate for recruiting practices that lure clinicians away from CHCs.

Part Three: State Health Agencies

State health agencies play many critical roles in efforts to increase health professions workforce diversity. At the core, they administer and finance essential health care and public health functions, and assess performance to ensure service quality and access. This includes monitoring compliance with critical legal and regulatory requirements, such as the composition of health plan benefit packages, hospital scope of services and licensure, and the qualifications of providers. They also administer a number of programs intended to ensure an optimal flow of students into our health professions educational institutions, and a similar flow of highly qualified graduates to practice in our communities. Some programs are intended to increase access for residents from low income, racial and ethnically diverse communities into the educational process, and in some cases, facilitate their practice in underserved communities upon their graduation. Agencies also collect and report on health professions utilization and workforce data and offer workforce development programs. Finally, the State is a major health employer, including many employees whose functions directly interface with or are critical to the provision of care, services or coverage to racially and ethnically diverse communities.

Given these roles, our team interviewed State agency leaders to gain insights into how the State can enhance its impact on development of a health professions workforce that effectively and efficiently serves the residents of California. We conducted a series of five key informant interviews with leaders of State health agencies with relevant roles and responsibilities. We also conducted two individual interviews with State leaders who have a stake in ensuring that our health professions workforce effectively addresses California's current and future needs.

Given the small sample and a single, focused set of entities, this part of the report is represented as one major section, with the following subsections:

- Programs and Financial Support
- Data Collection and Performance Monitoring
- Language Access Assurance and Monitoring
- Internal Capacity – State Agency Staffing
- Workforce Planning and Development

The findings in these sections highlight issues and challenges faced by State health agencies in fulfilling historical and current responsibilities related to health workforce diversity. In the course of our dialogue with State agency leaders, we also explored opportunities to expand the scale and effectiveness of the State's impact on health workforce and on important health issues to our increasingly diverse population. A number of the recommendations suggest opportunities for enhanced public-private sector collaboration to leverage combined resources and expertise for greater impact.

A. Programs and Financial Support

One significant way in which the State contributes to health workforce and diversity is through administering and funding a variety of programs that support health professions workforce development and reduce financial obstacles to health professions education. Most of these programs were developed through legislative mandate driven by one or more champions and each reflects the particular passions of the legislative sponsor(s), as well as the interests of their constituents. While many of these programs can cite substantive impacts upon beneficiaries, through our interviews and documentation provided we found that the relative cost-effectiveness of these investments has not been determined. Moreover, and perhaps even more significant, there has been no effort to date to assess the gap between the scale of current programs and current and future needs at the state and regional level.

Many programs are quite small, and while individual program and student successes are important and provide compelling stories to share in public hearings, it is fair to ask whether the impact at the population level is significant. Of equal importance, there should be an evaluation of the relative cost-effectiveness and sustainability of alternative approaches. At a time of constrained resources, it is more than appropriate to take steps that ensure an optimal use of public dollars. It is also appropriate to examine whether better coordination across programs (and associated State agencies) may yield significant benefits unrealized to date. Given the lack of meaningful progress to date in increasing diversity in California's health professions workforce, these are all relevant and appropriate questions.

While many State programs increase awareness and financing to encourage students from all backgrounds to pursue health professions training, some informants expressed concerns that the impact on health workforce and diversity will be limited in effectiveness unless California Health Professions Education Institutions (HPEIs) have the capacity to accommodate the increased pool. One state agency leader acknowledged structural obstacles:

“From a workforce issue or a training issue it’s really hard to see what can be done, at least in terms of recruiting diverse populations into training because the training system doesn’t have the capacity to spit out people fast enough, assuming that they even had the ability to recruit students. So, we don’t even both – not – I wouldn’t say ‘bother,’ we don’t address that because it just isn’t a realistic structural kind of thing.”

Another leader suggested that health professions employers should play a role in encouraging HPEIs to expand capacity in this regard. As training sites for clinicians, and given recent direct investments to expand nursing training capacity, employers are in a position to call upon HPEIs to reserve explicit slots for UR applicants:

“The fact that the hospitals [are] throwing in a couple hundred thousand dollars or whatever and opening up those slots. Those are slots that could

be diverse, minority. Maybe they're reserved; maybe there's a percentage of them that get reserved for people in communities of color."

One interviewee referenced the use of MOUs and other formal requirements to influence HPEI policy and capacity building in this area:

"I think the MOU is an example of a lever that we had with the University of California. It actually did shape university policy big time. The question is how successful was it really in accomplishing the goals...but that was a major lever and that came to us only through the legislative process."

Given the training program capacity constraints that exist in numerous health and public health professions, interviewees suggested that State agencies and legislators pursue greater collaboration with private sector health employers and HPEI's on creative solutions increase training program capacity and opportunities for UR applicants.

Another potential for State agencies to encourage recruitment of UR providers and increase the diversity of the workforce is by using positions as major purchasers. Through purchaser positions (e.g., guiding principles/mission, contracting terms, legislative mandates, etc.) agencies can leverage health plans/systems to make meaningful progress by linking it to compliance and return on investment. As stated by one informant:

"Medi-Cal and Healthy Families have been rather effective in leveraging their contracts to get plans to do things that they wouldn't normally do or they don't do for the commercial members. If commercial purchasers were to also come forward and say, 'Hey, look, I want this and I want that too,' whatever, then the plans will respond because now you're talking about kind of their core thing of ROI, dividends for the stockholders, to the extent that we're talking profit."

One State leader noted that the Executive branch has the potential to facilitate a systematic, regional approach to enhance coordination and actions among schools (i.e., UC with CSU with Community Colleges) to expand training program slots, enhance pre-requisite access and other things that can lead to an increase in the pool of UR students. For example:

"Given the authority that the governor has where the governor could write a letter and say that: 'I would like to see the UCs, the CSUs, and the CCs work as a system, even if it were some type of tri-coordinating council or something.' ...you can build sort of an advisory group process."

Of equal importance, the Legislative branch has the means to establish clear-cut requirements through policy development. As stated by one informant:

"That is probably the most direct and sustainable way to do something like that, to put something specific into statute. And if you do that then it

would be required that we would move forward pending some statutory modification. That's a technique that definitely works.”

Some State agency leaders noted the importance of the legislature influencing and holding the University of California System, UC leaders and campuses accountable for meaningful progress on workforce and diversity through the budget process. As one informant commented,

“Given the autonomy UC has, the most effective way to leverage and ensure their commitment is through the budget. They should have to report their plans, investments and progress related to diversity to legislators at the time they request the new budgets. This provides an opportunity for scrutiny about how dollars have been spent, a forum for accountability and a point of leverage for ensuring that State dollars are really providing opportunity and results.”

State agency leaders also acknowledged the need to do more at the state and regional level to increase the flow of UR youth into the health professions through financial support and expectations of programs. As stated by one informant:

“We've got some really good programs at the state level on loan forgiveness...but clearly, much more needs to get done if we're going to transition into more of a system...I think we need to recognize that we're a diverse state and one size does not fit all and that we ought to be incentivizing and trying to provide opportunities for those in various communities to be able to take the plunge and become health professionals.”

A number of leaders referenced the Song-Brown program, and its importance to preserving family practice programs in California medical schools. As stated by one informant:

“I would say that the Song-Brown program has had a huge impact on the production - on the sustainability of family practice - family medicine and now family practice entirely in the state of California. Not every family practice program receives Song-Brown funds but the program directors that I talk to would tell me that if they didn't have Song-Brown funds their programs would probably not exist.”

That having been said, Song-Brown has not been able to prevent the shrinkage of many programs, at a time when expansion is needed to address the growing shortage of primary care providers. This and other interviews highlighted the need for an analysis in California to evaluate the effectiveness of current programs at the state and regional level, and the gap between the capacity and current and projected needs. One leader noted the need to engage and inform policymakers, but highlighted challenges to continuity:

“...the composition of the committees, as you know, changes and then with term limits the legislature and their staffs often change.”

B. Data Collection and Performance Monitoring

A number of State officials acknowledged the importance of data as a starting point for discussions and workforce planning, and noted that there is a need for greater awareness of the current state of affairs. As stated by one informant:

“I think it would be helpful for us too to frame an initial discussion... maybe some sort of a fact-based sheet that we can say, “Hmm, here’s what you need to know. It’s 4% of Latino/Latinas, it’s 6% African-American physicians, whatever the Asian is and then the rest is - white people.”

The same State leader indicated that his knowledge of the current figures on proportional representation of different racial and ethnic health professionals was a revelation and a shock:

“I was stunned when I heard it was three or four percent of physicians in the state were Latino/Latina. I mean 4%? That’s just not appropriate and given where the demographics of the state are moving, that’s certainly not appropriate.”

One informant discussed how the issue of diversity is framed as critically important to the engagement of key stakeholders, as well as elevating the role of State agencies:

“...to me it’s an issue of quality and it’s an issue of providing good customer service. And to the extent that I don’t look like you and you don’t look like me and we may not have an understanding about each other - I mean we may not know where each other comes from but if I had a general understanding about issues that you might - or that I might face as an African-American or you might face as a white male, to me that’s just good customer service and it transcends itself into good customer care, quality health care.”

One role of State health agencies is to establish and monitor compliance with standards for the delivery of culturally competent care. These federal standards were established in part in an effort to reduce medical errors in the provision of services and to reduce health disparities associated errors and other forms of differential treatment. The most obvious tool was the federal CLAS standards,⁹⁹ but practical application of the standards has

⁹⁹ The Office of Minority Health developed national standards on culturally and linguistically appropriate services (CLAS) to improve access and quality of care and health outcomes. These CLAS standards were published in the Federal Register on December 22, 2000. As noted in the standards, “it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounters.”

become a major challenge. As a result, while the standards serve as a general benchmark, compliance is not required. As noted by one informant:

“The decision to move away from the CLAS standards was due, in part, to the “high expectations” of the CLAS standards, such that no one would be able to meet them. And, from a metric standpoint, this is problematic; if no one comes close to meeting a standard, there is no distribution in the data and therefore no ranking of plans: everyone fails, if you will. This is questionable at the very least with regard to what exactly is being measured and then reported: “quality” as defined by whom?”

The informant continued:

“I think they were a nice starting point to kind of define the issues but in terms of metrics, which is what we're interested in, they weren't that easy...”

The State contracted with a university partner to create a survey that would measure access to language services, using the CLAS standards as an organizing framework. Based on survey findings, they established standards based upon some of the better performers. As stated by the informant:

“Ultimately we ended up measuring things maybe that had been mentioned in CLAS, some of them, but really were things - we kind of looked for the high bar with the best plan and started listing all of those things with the ideal that the rest of the plans would reach for that. And it was, I think, more meaningful than saying, “Well, you should do all these things.” It's just like “Well, you should hire bilingual physicians.” Okay, fine, where are they? So that worked for us and so we saw some steady progress on the part of plans and trying to do these interim steps like face-to-face interpretation and telephone interpretation and translating the written materials, etc.”

The fragmented nature of the health care delivery system also presents significant obstacles to State oversight of quality of care for diverse populations. One informant cited a key challenge:

“With the exception of Kaiser, the managed care system here is really built on a delegated to medical group model. So the purchasers buy coverage through the plans, the plans contract for care with medical groups. Typically, the medical groups take on the responsibility of the delivery of care and maybe even the financial risk in many cases. So a lot of the action may be actually happening at the medical group level and the

U.S. Department of Health and Human Services, OPHS, Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services in Health Care - Final Report. March 2001. U.S. Department of Health and Human Services, Washington, D.C.

medical group can have two hundred and fifty practices within their purview, and all of them are doing different things. So when you ask even a medical group “Do you do X?” “Well, yes, we have ten groups that do that and we have ten groups that do something like that.” So the data collection is extremely difficult and complicated and you have to take it when you get it with a lot of faith that, well, generally speaking, it’s not precise.”

A number of informants also noted that different State agencies use different data collection and reporting methods, which complicates monitoring processes and impedes the potential for interagency collaboration. As stated by one interviewee:

“As a result, the ability of these agencies to collaborate (share ideas, suggestions, etc.) on this issue, if they are unable to view each other’s progress through the same lens, may be impacted.”

He noted further:

“We have a report card on Medi-Cal, Medicare, Healthy Families, hospitals, nursing care, all of those things are there, but we don't do those ourselves, but we link to them and at some point. In fact, one of our roles is to try and help consumers sort all of this information out because we're all doing separate things and somebody’s got to try to integrate it. We're going to try, but it isn't going to be easy.”

The data, information collected and published in reports cards by the State is disseminated to consumers, but one informant noted that an important target is hospital and health plan leadership. There is growing evidence that the report cards may be effective in making the case to leadership and creating peer pressure for improvements:

“We say it’s for the consumers, so that they can make rational choices and all that good stuff but the real impact is really - our primary target is the CEO and the board of directors and they see that and when they see their plan at the bottom, they're asking their operations people, “Why are we the worst plan in California,” and Why does Kaiser or whoever do better than us?” It’s kind of just an embarrassment...”

This comment suggests at least one way in which report cards, combined with data on demographic trends may help influence and accelerate progress on health professions diversity. A number of health plan leaders we interviewed cited their research and strategies to pursue California’s “emerging markets” of diverse populations, and their importance to the growth and profitability of their organization. To the degree that health plans actively pursue these “emerging markets,” language access, cultural competence, and provider-patient race concordance will likely become more important. As such, public documentation of deficiencies in areas such as language access would be viewed as threatening the organizational bottom line. Diversifying the workforce would be an

important part of a long-term strategy to ensure positive consumer ratings and sustained/improved profit margins in these diverse markets.

Some State health agency leaders discussed obstacles to the collection and reporting on health care disparities and their influence on quality, but complexities, dearth of research evidence and a lack of focus in this area by national groups such as NCQA make it very difficult. According to one informant, it is a relatively straightforward issue:

“These are people are trying to get care and they're not getting it. Maybe it's harder because they're poor or uneducated or whatever the case may be but the fact is they should be getting the care and it just means that they have to work harder or different or something to get the care. This is not really complicated; this is not like heart surgery. We're talking [for example] about whether or not diabetics get screened each year. But, yes, I don't know what we do but I think we should and it certainly is supported by the IOM's definition of quality. Everybody agrees but nobody seems to be moving beyond [the identification of] disparities to measure it. Where do we go from here?”

One State health agency leader addressed the importance of data, not only to monitor quality and language access, but also to support a more targeted allocation of public and private resources. One example cited is the Health Professionals Shortage Area (HPSA) designation, which documents regions of the state where there may be a lack of facilities and health professionals to address the specific population demographics of a given area. As noted by this interviewee:

“We haven't done a specific study around that but I think certainly we have some of the data resources available... We've been talking about doing things much more proactively out of that unit, because it has the ability to leverage so many different resources, whether it be federal, foundation, private, other types of resources into the state. I think last year it was over \$400 million that was leveraged just off of those designations alone. So it's a real reason for the office to more proactively identify areas of underserved.”

A number of State health agency informants cited a lack of California-derived data as impeding evidence-based discussions and planning around diversity. The common practice of using national-level diversity-related data is problematic due to limited quality and applicability to the unique demographics in California. A common lament, for example, is the inability to disaggregate data for the diverse and growing Asian/Pacific Islander populations in California.

There is also a lack of data on whether people select or are satisfied with the quality of care provided by their provider based on the provider's race/ethnicity. While numerous studies have documented the link between provider-patient race concordance and patient

satisfaction¹⁰⁰, OSHPD is not collecting these data, with the exception of coronary artery bypass graft surgery (which was linked to a legislative mandate). It was suggested, however, that there might be “one-time sources of these data,” such as various professional boards that include this information at the time of initial licensure.

Informants also discussed the need for regional level data by health profession to document current gaps and facilitate more accurate projections of future workforce needs and demographics related to the general population, talent pool. This is a critically important planning tool for governmental, education and health employer, business and community stakeholders understand priority health workforce needs in their region. Review and discussion of these needs provide the basis for targeted investment of current resources or the acquisition of additional resources, and for the development of coordinated, interdisciplinary strategies.

To date, there is no resource available to private and public sector educational institutions and employers to strategically invest resources to address near and long-term workforce needs. As stated by one informant:

“..It’s [workforce data] not centralized in one place where people can go and really get a good idea of the numbers that California’s producing, where people are practicing, doing any type of supply and demand projections. I mean we have to go to so many different sources to try and get a complete picture and I think that’s a large frustration for those who are trying to inform policymakers about the issues. So there’s just - the data collected is not easily obtainable. And this is part of the reason why we like the idea of a clearinghouse because instead of its work being tied to specific products that may come or go as funding for them comes and goes, this is an entity whose job it is to focus on this area and can have permanent staff associated with it.”

The recent passage of SB 139,¹⁰¹ to establish the California Healthcare Workforce Clearinghouse within OSHPD, creates an important resource for state and regional health professions workforce planning. As the State office charged with implementation of SB 139, OSHPD is in a unique position to provide guidance. As stated by one leader:

¹⁰⁰ Saha et al. found that African American patients with African American physicians were more likely than those with non-African American physicians to rate their doctor as excellent and to report receiving preventive and necessary care. In the same study, similar results were revealed for the Hispanic population. The following year, Saha et al. found that African and Hispanic Americans sought care from physicians of their own race because of personal preference and language.

S. Saha et al., "Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care," *Arch Intern Med* 159, no. 9 (1999): 997-1004.

¹⁰¹ Pursuant to [Senate Bill \(SB\) 139 \(Chapter 522, Statutes of 2007\)](#) the Office of Statewide Health Planning and Development (OSHPD) was directed to establish the California [Healthcare Workforce Clearinghouse \(Clearinghouse\)](#). The Clearinghouse will serve as the central source for collection, analysis, and distribution of information on the healthcare workforce employment and educational data trends for the state. OSHPD will retrieve data from the Employment Development Department’s Labor Market Information Division, state health licensing boards, and state higher education entities.

“Our geographic information systems technology actually helps us to do that because we can layer the data that we get from the licensing boards along with the census data and really help to do regional and local area planning, if you will, to identify what resources are available in terms of providers.”

SB 139 offers great potential to enhance data collection and health workforce planning. Some informants expressed concern, however, that the legislation does not go far enough in requiring key data elements to be collected and submitted to the clearinghouse. It states that the Employment Development Department’s Labor Market Information Division, state licensing boards and state higher education institutions collect key health workforce and diversity data elements, “to the extent available.” The challenge is that for many professions, many of the essential data elements, including race, ethnicity and language spoken are not being collected. This will seriously limit the usefulness of the data for making the case and meaningful workforce planning and monitoring.

State health agencies such as the Department of Managed Care are encouraging collaboration and sharing of best practices around data collection and programs, but must contend with obstacles associated with market dynamics:

“We want to find ways to [overcome] the proprietary feelings - territorial, who share these best practices. For some, the view is ‘Here we’ve made all these great strides toward accomplishing this and that’s supposed to give us a market benefit and if we file it with you and you make it public then all they [competitors] have to do is copy it and replicate it and we’ve made the huge investment.’ So that’s a constraint there and we have to recognize that and acknowledge it.”

C. Language Access Assurance and Monitoring

In our examination of the issue of cultural and linguistic competency, we found that the State health agency monitoring in this regard is largely limited to language access. It is unclear the degree to which monitoring of language access will contribute to an increased focus on health workforce diversity among provider organizations. One informant suggested that there is at least a broad linkage:

“In some ways, I think it will follow because a plan can very easily provide a language- availability of languages by increasing diversity of their workforce if that diversity also brings a diversity of languages.”

At the same time, the informant continued to note that:

“We really geared it [monitoring of compliance] to the language. So if they were able to provide language assistance services even through video

- they could have an all-white staff as long as they're providing the language access.”

“Within the context of language standards, the plans are required to collect data on race, ethnicity, and language of their membership. They aren't necessarily required to tell us what they've collected. They have to tell us how they collected it to make sure that it's valid but they don't have to tell us how they collected it. We have another source for that; the CHIS¹⁰² will give us that. Around doctors - I don't-, they may have that for all I know, I don't think they do - again, from our perspective it's all about language access. The ethnicity of the physician isn't as important to us as the language that he or his office people speak.”

The focus on language is justified based upon data collected to date:

“We're focused on language because it turns out, at least according to the data we have, that language is much stronger than race and ethnicity in terms of risk for quality care and that's what we're concerned about. So we focus in on language, it's even stronger than income and education - which is amazing because that's usually the big thing. So we have focused in on language capacity.”

“Now there's clearly a workforce issue around that because how do you provide services in another language if you don't have a workforce that speaks - that's bilingual or trilingual, or whatever. But that doesn't really come out often because it's really very pie-in-the-sky for right now. When we're asking people, “What are you doing today?” The issues really are more around interpretations services, translated materials. We also ask about physicians who speak other languages and how they're made available to members, etc. But the whole issue of workforce recruitment whether it's in language or diversity in the workforce really is not relevant to how we're doing this.”

At the same time, State health agency leaders acknowledged that greater clarity and standardization is needed to ensure minimum language access:

“But we have in the regulations sort of a range. Plans may demonstrate that they're providing access through use of a range of methods for providing language assistance. So they could use any person, they could contract with outside vendors; they could hire and engage providers and staff who have dual linguistic abilities, those sorts of things. But there are also some standards on how to make sure that those folks are qualified. You can't just walk in off the street and say, “Yes, I'm fluent in whatever language.” But because there's no - we're limited by not having any standardized or uniform testing for proficiency in a particular language,

¹⁰² California Health Information Survey.

spoken or written. So we have some generalized standards that there has to be demonstrated proficiency and you can see that in the reg, how that's framed to provide flexibility in the absence of accepted standards."

"There are no standards in terms of what is an acceptable interpreter. ... "interpreting," "translating," "adapting," there's all of these little terms you've got to be careful... So what we ended up measuring is things that everybody agreed they understood and it wasn't "certified interpreters," it was just "interpreters." We ask 'Do your interpreters go through any training,' from five days to five years or whatever it may be?' But I think what we ended up measuring was the quantity of things that plans do but not necessarily the quality of those services so that if they say, 'Yes, we have interpreters,' that could mean someone with five hours of training or somebody that's gone through the Kaiser program that, I think, is several months." And they're all - they're both the same answer, 'yes,' for both. So we only measured quantity and we rated on quantity with the idea that the more they do the better it is. That may not be true but that's all we can measure because that's all there is."

These complexities point out the need for investment and development of State monitoring standards that validate meaningful investment and progress toward creating optimal language access. Monitoring and documentation of how these standards are met and what constitutes meaningful progress would go a long way toward meeting the intent of State language access requirements.

At least one State health agency leader cited obstacles to the development and promulgation of standards in the absence of explicit statutes:

"I think that in a large part being a government agency there's a hesitancy to go out on that limb too far, okay. Because if you go out too far or too strongly with a policy then you're challenged for having some kind of an underground regulation. So if there's any rule of general application as opposed to 'This is what we really would like you to see because we've identified this as best practices... The other - there's another side to that too. I think there is a desire within the Department to do that; it's just really difficult if you don't have the statutory authority... we're in the executive branch. So our policy derives from the Governor's Office policy and so there're often some fluctuations."

This quote and prior discussions illustrate some of the complex dynamics that influence the ability of State health agencies to monitor practices, address priority needs, and stimulate positive change in the field. Practical challenges and political considerations often impede the ability of agency leaders to take definitive action, even when such action represents the most logical solution to a particular problem.

D. Internal Capacity – State Agency Staffing

An important factor in State agency efforts to build a more culturally competent and diverse health workforce is their internal capacity. This is reflected both in terms of their ability to build a critical mass of diversity in their own workforce, and whether they have the breadth and depth of expertise to effectively fulfill their stated mission.

On the first issue, a number of leaders cited the importance of hiring UR employees in State health agencies. These employees can then play an informal role in facilitating additional UR recruitment:

“...we found that when you’ve hired like folks, folks go out in their respective communities and talk about X state agency. So our recruitment has become more diverse. For example, currently I’m recruiting for a leadership position in the county and I’ve noticed that folks of different communities have been responding to my call.”

Increased diversity among staff can in turn increase the effectiveness and ability of State agencies to engage increasingly diverse communities. As noted by one informant:

“I think it definitely shows in the applications that we receive from prospective grantees of the office. I think the ability of the office to go out and engage in different community venues that we hadn’t been able to before...we’ve been welcomed and we’ve been invited and we’ve been at the table with more community and grassroots organizations, which lends itself to greater exposure for the office...that’s huge, and I think that’s a lot because of the staff’s ability to get out and interact with different communities.”

In the context of budget, hiring process and other bureaucratic constraints at the state level, there are obstacles to State agencies playing an ongoing role in planning, development, and oversight for new functions. As stated by one informant:

“...you have the limitations of recruiting staff, and so once we do fund something like this how do you actually sustain it? Because if you get positions approved you can either get them on a limited term basis, which is only two years max - up to 24 months, and then if you have a permanent position then the issue becomes how you pay for that position beyond that project period.”

Sometimes obstacles to State staffing can be in play even when there is funding available. As stated by one informant:

“...even though we might have the dollars we still have to have approval from the legislature to actually staff personnel years or positions. And so sometimes you have to do some legwork up front; even so, the budget

change proposal process sometimes doesn't lend itself to a quick turnaround, regardless of whether you have the dollars available. So sometimes that's kind of a barrier."

Changes in administrations often present challenges to building and retaining staff with much needed expertise, given shifts in priorities and levels of funding. Across the board hiring freezes can also result in the loss of key personnel who are funded through legislative mandate for special projects that may have involved substantial investment of time and resources. In the absence of more "surgical" approaches to budgetary fluctuations that more carefully weigh consequences, there may be substantial missed opportunities for State leadership.

E. Workforce Planning and Development

The lack of a comprehensive workforce planning and development for California to date at the state and regional level impedes efforts to expand pathways of opportunity for UR youth through greater coordination, targeting, and enhancement of the patchwork of current programs. In many cases, while the interest in a health professions career is established somewhere along the path for UR youth, the current fragmented approach to support and facilitation leaves many obstacles that are difficult, if not impossible to overcome. There are immensely important contributions that can be made by educational institutions, health professions employers, and community-based organizations, if provided with the knowledge, guidance, coordination, and incentives. State health agencies and political leaders are in a unique position to provide this kind of support.

State health agencies can "set the table" through data collection, planning, and facilitation, but it is critically important to bring stakeholders together at the regional to coordinate efforts. This level of engagement is required in order to accommodate unique characteristics and make optimal use of available assets. Of equal importance, stakeholders disaggregate data collected at the state level and more closely examine regional variations in current and projected needs for different disciplines. As such, it will be important for any legislative or executive action in this regard to accommodate both levels of planning, development, and capacity building. One interviewee drew parallels to initiatives by the current administration to address the growing problem of obesity through community-based prevention:

"We were talking earlier today and have been talking with the governor a lot about the notion of our prevention agenda that he has set out and how different communities will receive those messages and you need to use different strategies to do that and I think that's the same thing as you need in health professions workforce planning and development... there's got to be a piece that recognizes the diversity of the state and the diversity of communities and testing different approaches to obesity prevention in different communities."

Health workforce development with a focus on increasing diversity should be an ongoing effort in California, but key elements can also be integrated into major reform efforts currently under consideration. A number of State agency leaders acknowledged the importance of workforce development as part of comprehensive health reform in California. At least one informant acknowledged that it was not explicitly integrated into the recent process:

“I think it’s a huge part of it [health reform] but I don't think - right now it’s not - everybody talks about it but it’s one of those [issues] where I think that a lot of people are not in their comfort zone. What does workforce development mean? What do we have to do? What do you mean “pipeline?” You just can't like turn it on today and tomorrow you have doctors. And I'm not sure people get that.”

While issues around workforce development and diversity were not included in the Governor’s Healthcare Reform Initiative, there appears to be interest in moving the agenda forward via legislative authority. One mechanism under consideration by legislators and the administration, given current budget constraints is the development of a public/private partnership with health professions employers, foundations, and other key stakeholders. One informant made the case for integration:

“The Governor’s Healthcare Reform does not [currently] address workforce, but they recognize that they missed that and I know they're talking about it now. We have six million new people coming and I think the last time I looked we had shortage areas already in California. So isn't that going to make the problem even worse? What are we going to do when all these people show up for care? Not that they will, but what if they did? Just the general supply alone, not to mention diversity. So maybe that is the opportunity to ramp up on this issue.”

Another State leader shared a similar perspective:

“I've challenged some of the groups that we've talked with to bring forward recommendations for sort of where potentially does this fit in. What do we do? What is a governmental role? What is a public/private sector role? And what is - with a governor who that has this sort of bully pulpit who can maybe advance some of the things like xxx of concept given sort of our budget shortfalls.”

This informant continued to by articulating a specific role for the governor:

“I think it’s a bully pulpit role. With this governor I think - as I've seen with sort of healthcare reform overall, he has a wonderful ability to sort of stake out a comprehensive view and people do at least when he says it see it as an issue. Maybe it doesn't get done in that way but the bully pulpit in

this thing. I think he has a wonderful ability to help - especially if this is part of healthcare reform.”

One near term strategy to increase health professions workforce diversity examined in The Connecting the Dots Initiative is the credentialing of health professionals trained in other countries. One State leader acknowledged the need to give more attention to this as part of any comprehensive strategy:

“I see too many, I've talked with too many people who were physicians in other countries that are working as techs or whatever, and I do think that that's a key part of the workforce development and the health professions funding strategy is to do that training and education to allow people to recognize that they have those skills. I don't have a problem with our requirements being different but I don't think we're doing what we need to do as a government to help get those folks to a level to which - we have a doctor shortage; we have a physician and nursing shortage. So we're having someone go be a lab tech somewhere when they can fully practice medicine and probably - I don't know what it is, maybe it's a year, whatever, but we ought to be doing something about that to assist those folks who, I think, very quickly could become - because I've heard some of the issues even with Mexican physicians that have - have sort of come here and are just sort of like completely under utilized.”

Harnessing the positive potential of targeted strategies such as this and moving a comprehensive agenda that engages education, employers, and community stakeholders will require strong leadership and coordination among State agencies. While State health agencies are major players, other State agencies must also be substantively engaged in the process.

Shortly after the completion of the key informant interviews conducted for this inquiry, a dialogue was initiated with key leaders in the State Labor Agency. In the course of discussions, it became clear that the Workforce Investment Board at the state level and the 49 local boards can play a critically important role in building a sustainable framework that accommodates regional dynamics. Similarly, ongoing engagement and coordination with the State Department of Education is essential to build a long-term strategy that creates networks of support for UR youth, particularly in our urban and rural public schools.

Considerable momentum has been established through the hard work and passionate commitment of individual leaders in our academic institutions, among our health professions employers, and in our communities. Data collection, comprehensive planning, coordination, and ongoing support from our State agencies will be necessary to translate the current momentum into a positive reality for the people of the state of California.

RECOMMENDATIONS

Based on these findings from key informant interviews as well as our own ‘gestalt’ of what has been learned from some of the other CTD inquiries, we propose the following recommendations for State health agencies to effectively fulfill their roles in ensuring the development of a highly competent, diverse, and culturally competent health professions workforce:

1. **Strengthen state level data collection and reporting on workforce and diversity.**

The passage of SB 139 mandates the establishment of a data clearinghouse by the Office of Statewide Health Planning and Development (OSHPD) that will provide invaluable information to support the development of a comprehensive health professions master plan. Unfortunately, however, the mandate indicates that OSHPD will work with other entities to collect “*to the extent available*”¹⁰³ data on current supply, geographic distribution, and diversity of health care workers. Currently, there are many licensing agencies and other entities that do not collect much of this data, and they could choose to not comply with requests based upon language in the current statute. In order for SB 139 to produce the quality data needed to assess current status and project future needs, all data sources must be in compliance. Additional legislation may be necessary to address this significant shortcoming.

2. **State legislators and relevant legislative committees require annual reporting from HPEIs on accomplishments to date and plans to increase diversity in the coming years.**¹⁰⁴ Reporting should address a set of explicit criteria established by the legislature in dialogue with academic representatives, health employers, and community leadership. Examples of areas of focus for criteria include:

- Evidence of outreach, support, admission, matriculation, and graduation of UR students from communities within the immediate region.
- Evidence of functional and ongoing links between UC-CSU-CC campuses.
- Evidence of progress to create an institutional climate that ensures the accrual of the benefits of diversity.
- Evidence of partnerships with health professions employers, community leaders, and other key stakeholders at the local and regional level.

3. **State legislators and relevant oversight agencies (e.g., OSHPD) require evidence that nonprofit hospitals and health systems undertake definitive efforts to increase the diversity of their workforce** through formal internal mechanisms and through partnerships with the full spectrum of local and regional stakeholders.

¹⁰³ SB 139, summary section 2.

¹⁰⁴ A version of this recommendation was advanced by Governor’s Health Professions Workforce Diversity Advisory Council and included as Higher Recommendation #2, page 14 of the report released in May 2008.

These definitive efforts are viewed as an essential component of their commitment to fulfill their community benefit obligations. While investments in training, and recruitment of new UR staff and/or the advancement of UR incumbent workers are not reportable in financial terms, documentation of definitive efforts provide qualitative evidence of commitment to fulfill tax-exempt obligations. Investments in training of medical and administrative staff who are subsequently employed by other organizations can be financially counted as community benefit contributions.

In order to move effectively in this direction, it will also be necessary to establish integral links between community benefit staff and HP training programs, to take optimal advantage of emerging opportunities, minimize redundancy, and to ensure alignment with the community benefit mission.

- 4. Develop local and regional collaboratives to build common understanding and establish priorities, goals, and strategies to increase health professions diversity through shared investment of resources and expertise.** Particular attention should be given to identify local/regional needs and opportunities (e.g., gap analysis) and to develop measurable objectives that reinforce an ethic of shared accountability for ALL stakeholders.

Public universities and colleges have special responsibilities to participate in these collaboratives and coordinate efforts with other campuses. Representation from community-based organizations, public and private HPEIs, undergraduate education, K-12, government agencies, health professions employers, and other local business should be sought to ensure inclusivity, buy in, transparency, and the development of agendas that speak to the needs of the broadest possible constituencies.

- 5. Create a sustainable funding mechanism to create an infrastructure for collaboration that effectively leverages the expertise and experience of diverse stakeholders at the local and regional level.** Public and private sector funders can play an important and cost effective role in this regard. Health professions schools and other stakeholders should also explore incentives and strategies that support the creation of a network of support (for example, funding and participating in planning and implementation of cross sector collaborations).
- 6. Develop and implement a comprehensive, multi-year health professions master plan for California that addresses both diversity and cultural competency.** The plan will address the needs of, include roles for and have input from key stakeholders from multiple health professions, sectors, educational institutions, state government, workforce boards and regions. It will also include key dialogue and alliances with representatives from K-12, community college, CSU and other colleges. The plan should address the forecasted demand barriers and problems for key professions and include strategies and action plan that could be used to focus and track progress. The plan will focus on alignment and sufficient capacity of vision, skills, incentives and action plans to lead to systems change. It would have long and short-term components

and a critical path for priority investment and coordination. It would be multilevel with policy, professional, regional and institutional strategies.

7. **As part of the master plan process, conduct a gap analysis¹⁰⁵ of current government, regional, professional and CA state initiatives to identify major strengths and gaps relative to local and regional needs**, as well as their potential to implement the framework and recommendations or other priority initiatives. As part of the process, profile successful multi-sector private or government workforce and diversity programs in other states.

8. **Establish an organizational “home” or other mechanism for planning, coordination and implementation for statewide health workforce diversity initiatives.** The home would have an identity and staff dedicated to convening, planning, coordination and advocacy. It could serve a forum, catalyst, communicator and potentially a resource for promising practices and technical assistance. If not a governmental entity it would coordinate closely with key government agencies. The entity could be the “go to” place for key stakeholders and multi-sector health and non-health partners, as well as monitor, coordinate and lobby for increase federal and state funding. The “home” would have responsibility for developing and overseeing the implementation of the strategic and coordination among other stakeholders. It would play an appropriate convening and coordination role among leading California initiatives. Alternatives and potential alliances for a formal organizational “home” could include:
 - Continue the Health Professions Workforce Advisory Council to lead policy and other recommendations and engage the support of the Governor and other key policymakers and state agencies.
 - Form a Health Workforce and Diversity Alliance or Coordinating Council with multi-sector representatives and with a staff to lead and carry out initiatives.
 - Fund and coordinate with statewide coalitions such as the California Health Professions Consortium.
 - Develop profession or sector specific plans with accountability among health profession associations or adequately funded coordinating bodies with staff.
 - Support development of regional plans and meetings to coordinate efforts and share promising practices.
 - Develop a greater shared understanding of promising practices and models.

¹⁰⁵ A version of this recommendation was also advanced by the Governor’s Health Professions Workforce Diversity Advisory Council as Overarching Recommendation #2, page 10 of the report released in May 2008.

Appendix A: Sample Pre-Interview Survey



Increasing Health Professions Workforce Diversity in California Survey of Residency Program Leadership

1. Please indicate if any of the following official documents address racial/ethnic diversity or cultural competence as priority concerns:

- | | |
|---|--|
| <input type="checkbox"/> Mission statement | <input type="checkbox"/> Residency recruitment plan |
| <input type="checkbox"/> Vision or values statements | <input type="checkbox"/> Residency selection materials |
| <input type="checkbox"/> Policies, e.g., recruitment or retention | <input type="checkbox"/> Program materials |
| <input type="checkbox"/> Strategic plan | <input type="checkbox"/> Other documents (please list) |
-
-
-

If you checked any of the above boxes, please provide us with a copy of the relevant document when you return your completed survey or indicate the URL.

2. Are there individuals at your institution or in your training program who are formally charged with:
- A. Leading diversity initiatives:
 Yes No
 - B. Leading efforts to recruit URM trainees:
 Yes No
 - C. Leading efforts to encourage shared learning among trainees, faculty, and fellows from different racial, ethnic, and cultural backgrounds:
 Yes No
 - D. Leading efforts to recruit and retain URM faculty:
 Yes No
 - E. Leading efforts to increase cultural competence among trainees and faculty:
 Yes No
 - F. Leading efforts to ensure that your program's curriculum effectively addresses:

- Culturally competent and linguistically appropriate patient care
 Health disparities
- G. Leading partnership initiatives or professional practicum programs with underserved communities:
- Yes
 No

3. If you checked the any of the boxes in Question #2, please list the name and titles of the appropriate individual(s) and the efforts they lead:

Name	Title and Program/Initiative
------	------------------------------

Name	Title and Program/Initiative
------	------------------------------

Name	Title and Program/Initiative
------	------------------------------

4. Does your institution or program undertake formal efforts to increase the interest of and resultant match rates of URM trainees?

- Yes
 No

5. If you replied “Yes” to Question #4, which of the following practices has your institution implemented?

- Inviting prospective URM applicants to residency recruitment events
- Recruiting and inviting medical students, i.e., prospective URM applicants, to participate in clinical rotations at your institution so they may become familiar with your training programs
- Targeting communication from faculty, trainees, administrators, or training program alumni to prospective residency applicants
- Making the residency particularly attractive to URM candidates by providing opportunities during training to engage in practice, research, or health education activities with URM communities
- Educate and motivate individuals involved in the match ranking process to value a diverse cohort of trainees, including URM trainees
- Other

If you replied “Other,” please explain:

6. Which of the following factors, if any, have positively contributed to your program’s efforts to recruit and retain URM trainees?

- Accreditation standards
 Legal guidelines

- | | |
|---|--|
| <input type="checkbox"/> Accreditation standards | <input type="checkbox"/> External pressure, e.g., community or advocacy groups |
| <input type="checkbox"/> Legal guidelines | <input type="checkbox"/> Economic incentives (business case) |
| <input type="checkbox"/> Mission of your institution or program | <input type="checkbox"/> Research supporting benefits of culturally competent care |
| <input type="checkbox"/> Institutional leadership | <input type="checkbox"/> Commitment to social justice |
| <input type="checkbox"/> One or more individual's leadership | <input type="checkbox"/> Other – please explain |
| <input type="checkbox"/> Internal pressure, e.g., trainee or faculty committees | |
| <input type="checkbox"/> Media coverage, e.g., articles about the benefits of diversity | |

If you replied "Other," please explain:

7. Which of the following factors, if any, impede your school's or program's efforts to recruit and retain URM students?

- | | |
|--|---|
| <input type="checkbox"/> Accreditation standards | <input type="checkbox"/> Media coverage, e.g., stories about "reverse discrimination," such as op eds questioning the benefits of diversity |
| <input type="checkbox"/> Legal rulings | <input type="checkbox"/> Other |
| <input type="checkbox"/> Regulations | |
| <input type="checkbox"/> Threat of legal action | |
| <input type="checkbox"/> Competition with other institutional priorities | |

If you replied "Other," please explain:

8. Please indicate whether your training program provides the following forms of support to URM trainees:

- URM or other faculty or fellow mentors
- Ethnic/cultural resources, e.g., speakers or film series
- Housing support
- Financial counseling

- Support for career development
- Support for participation in national or regional meetings
- Support for board exam preparation
- Other

If you replied "Other," please explain:

9. Does your institution or program undertake formal efforts to increase the number of URM faculty?

- Yes No

10. If you replied "Yes" to Question #9, please state the efforts in which your program is engaged or indicate the URL where these efforts are described:

11. Is it your observation that your URM faculty colleagues carry a disproportionate burden of administrative duties, such as serving on internal and external committees and mentoring/advising trainees?

- Yes No

12. If you answered “Yes” to Question #11, please indicate whether your institution or program formally acknowledges this disparity by providing any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Funding for research on priority issues for URM stakeholders | <input type="checkbox"/> Reduced clinical responsibilities |
| <input type="checkbox"/> Reduced administrative responsibilities | <input type="checkbox"/> Reduced publishing requirements for tenure and/or promotion |
| <input type="checkbox"/> Reduced teaching responsibilities | <input type="checkbox"/> Special consideration in the promotion and tenure process |
| | <input type="checkbox"/> Other |

If you replied “Other,” please explain:

13. Does your institution or program undertake steps to help faculty in general develop the skills to practice and teach culturally competent patient care?

- Yes No

14. If you replied “Yes” to Question #14, please explain:

15. Through which of the following modalities do your trainees learn about culturally competent patient care and health disparities?

Culturally Competent Care

- First-year orientation
- Grand rounds
- Teaching rounds
- Web-based instruction
- Weekly/monthly conferences
- Periodic workshops
- Other

Health Disparities

- First-year orientation
- Grand rounds
- Teaching rounds
- Web-based instruction
- Weekly/monthly conferences
- Periodic workshops
- Other

16. If you replied “Other,” please explain:

17. Do your trainees and/or faculty engage in clinical care, teaching, or public health practice to benefit individuals and/or programs in the communities surrounding your institution, e.g., health centers, clinics, schools, or other public facilities?

Yes

No

If you replied "Yes," please explain:

18. Do the leaders of your residency programs encourage proactive coordination with your hospital's community benefit staff?

Yes

No

If you replied "Yes," please identify several past or ongoing partnership efforts or activities that you consider particularly successful.

Appendix B: Sample Interview Guide

Increasing California Health Professions Diversity: A Statewide Initiative of the Public Health Institute and the University of California, Berkeley

Teaching Hospital Interview Guide for

<p><u>I. Welcome, thanks, and introductions</u></p>	<ul style="list-style-type: none"> • Introduce interviewers and key informants • Reiterate confidentiality of institutional and individual identities • Brief overview of project • Interview objectives. We want to learn about: <ul style="list-style-type: none"> -- Your experiences and lessons learned in implementing relevant policies and practices — Issues and challenges you’ve encountered in your efforts to increase diversity -- Your view of promising areas for future focus and the next steps you’re considering • Explain handout
<p><u>II. Questions from interviewees</u></p>	
<p><u>III. AREAS OF INQUIRY</u></p> <ul style="list-style-type: none"> • <u>Leadership and commitment</u> <p>(Key institutional policies; most significant challenges)</p>	<p>What specific steps have been taken by the leadership of xxx that demonstrates a commitment to increasing the diversity of the health professions? What would you identify as the most significant challenges to the elevation of this issue in teaching hospitals?</p> <p>In your view, to what degree is xxx viewed as the local entity that does the “heavy lifting” in terms of increasing diversity and addressing disparities, and such areas of emphasis are of secondary importance to xxx themselves?</p>
<ul style="list-style-type: none"> • <u>Hiring practices</u> <p>(For administrative and clinical staff) (For faculty)</p>	<p>What efforts have been made to recruit African-Americans as either house staff or faculty--as they are a group that have been traditionally difficult to come to xxx?</p>

<ul style="list-style-type: none"> • <u>Trainee recruitment and selection</u> <p>(Efforts to date and most significant challenges)</p>	<p>At xxx Hospitals, as a leader in medical education, do you (your hospital) see any special responsibility with respect to offering GME training opportunities to people from UR backgrounds?</p> <p>In general, should major teaching hospitals view their having a special role with respect to training future UR leaders for the medical profession?</p> <p>In our interview with xxx leadership, they lamented the small numbers of UR trainees who they could successfully recruit, and the resulting sense of isolation. One option they identified was to explore the potential sharing of residents across training programs among xxx teaching hospitals as a means of reaching critical mass and creating a stronger support network. What is your reaction to this suggestion?</p>
<ul style="list-style-type: none"> • <u>Create a supportive environment for URs</u> <p>(For trainees) (For patients)</p>	<p>What responsibilities do you see for teaching hospitals to create a supportive environment for UR trainees?</p> <p>What are the most significant challenges you've faced in this regard over the years?</p>
<ul style="list-style-type: none"> • <u>Curriculum</u> <p>(e.g., efforts to integrate cultural competency and addressing health disparities into experiential learning)</p>	<p>In our focus groups with trainees, we hear from some that they experience negative reactions from attending physicians to their application of cultural competency knowledge gained in their educational process. What is your reaction to this claim? To the degree that it is a legitimate concern, what steps should be taken?</p> <p>What kinds of policy/advocacy/community public health experiences can house staff obtain while in training? Is there any increasing flexibility for people in primary care medicine or pediatrics to do this sort of work?</p>
<ul style="list-style-type: none"> • <u>Pipeline Initiatives</u> <p>(Collaborative efforts and/or advocacy at local, state, and national level)</p>	<p>What in your view is the responsibility of teaching hospitals to invest in expanding the pipeline of UR populations preparing for a future in the health professions? What would you identify as the most cost-effective and rewarding investments?</p> <p>Can you identify current or proposed joint efforts with other institutions that offer the greatest potential to advance diversity/disparity goals?</p>
<ul style="list-style-type: none"> • <u>The Business Case</u> 	<p>What in your view is the business case for increasing diversity in the health professions? Where do teaching hospitals fit into that equation?</p>
<p><u>IV. Final thoughts</u></p>	

Appendix C: Schematic Drawings of Interview and Analysis Process

Figure 1: HPEI Data Analysis Strategy

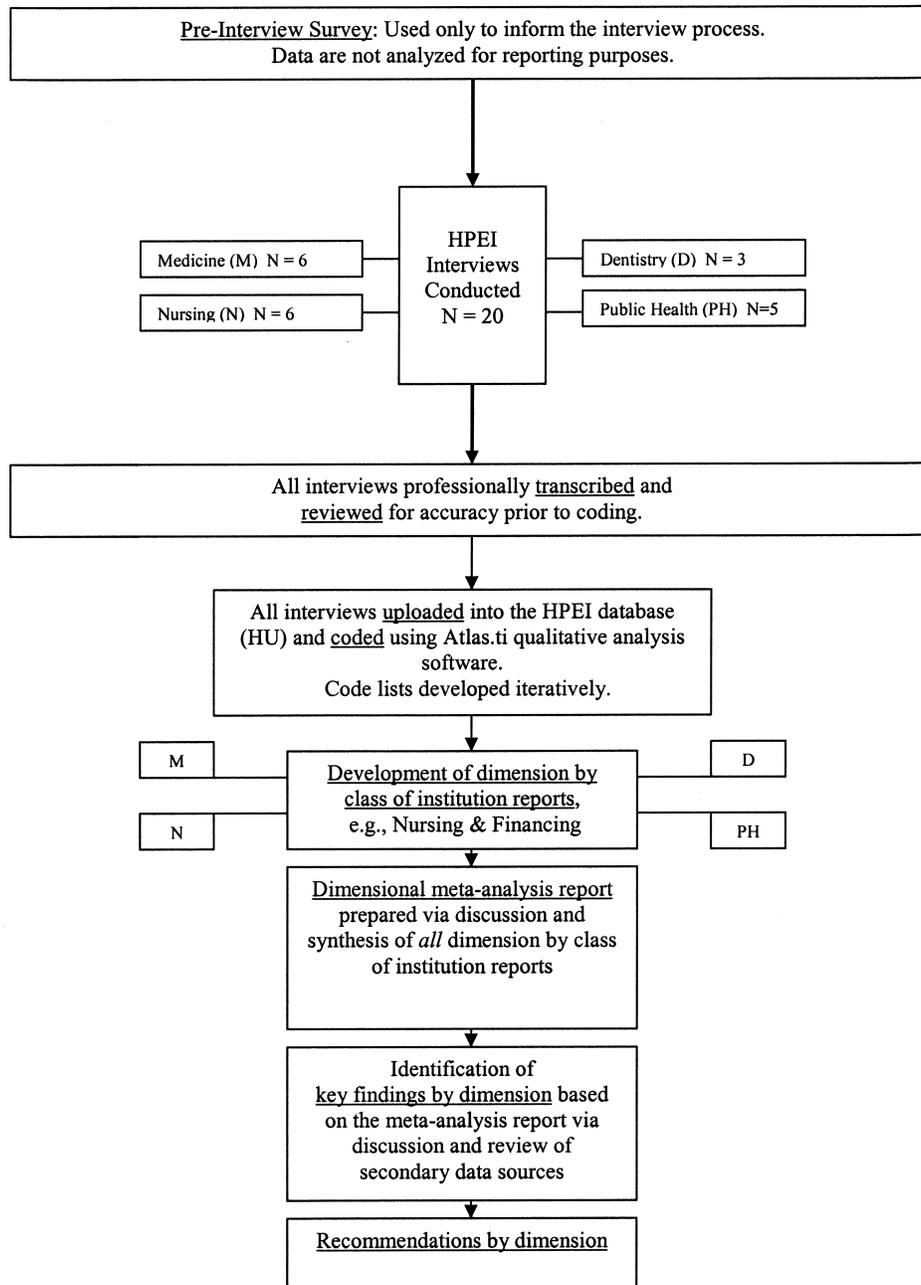


Figure 2: State Health Agency (SHA) Data Analysis Strategy

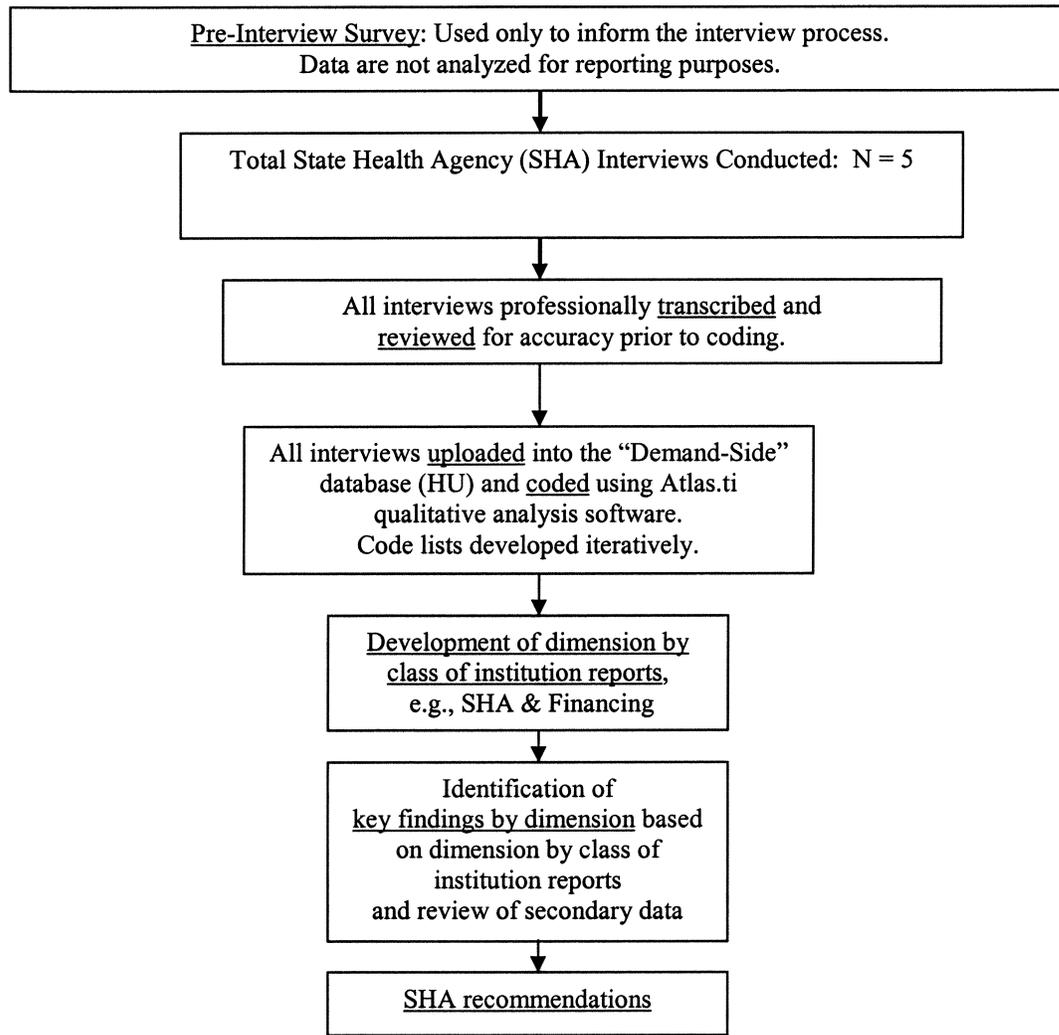


Figure 3: Health Professions Employer Data Analysis Strategy

