ITUP
Insure the Uninsured Project

›› *2024 Regional Equity Collaboratives:*

Strengthening California's Health Care Workforce to Drive Equitable Access

October 2024

Key Takeaways of the Regional Equity Collaboratives

Each year, Insure the Uninsured Project (ITUP) hosts 11 regional equity collaboratives across California, spanning from San Diego County to Humboldt County, both virtually and in-person. Attendees of the ***ITUP Regional Equity Collaboratives: Strengthening the Health Care Workforce to Drive Equitable Access*** range from community champions, community-based organizations, managed care and health plans, and a multitude of health-related stakeholders engaged within their own local health care ecosystems, all of whom contributed to the conversations that culminated in this report.

Throughout each Regional Equity Collaborative, ITUP facilitated conversations across a variety of regional health and health-related stakeholders to dive deep into workforce challenges and promising opportunities to secure a workforce that is reflective of communities served and adaptable to a changing system. The Regional Equity Collaborative agenda included: opportunities for attendees to hear state-level policy updates from ITUP; share details and sentiments of the workforce challenges each region faces; and uplift any innovative solutions to bridge the gap to make the future of health care more accessible and equitable.

ITUP appreciates the dedication, engagement, and spirit of community advocates joining to provide valuable and insightful anecdotes about California's historic workforce shortage. The work and engagement of participants whose community conversations from the Regional Equity Collaboratives are highlighted in this report.

Key Theme #1: Economic Inequality & Resource Scarcity

Participants identified barriers impacting the workforce landscape into three categories or themes including:

- Affordable Housing Crisis
- Limited Career Opportunities for Spouses and Partners
- Exceeding Staff Capacity & Insufficient Wages/Benefits

#1: Affordable Housing Crisis

Many California communities are facing challenges in the housing market due to home prices being unaffordable for many residents. High housing costs deter potential health care professionals from relocating to California. Many prospective candidates and providers prioritize affordable living situations when considering job offers, and the steep housing prices can lead them to decline opportunities

contributing to the workforce shortage. In addition, existing health care providers may leave California or the profession altogether due to chronic housing instability. The inability to secure affordable housing can create stress and dissatisfaction, prompting providers to seek better conditions elsewhere. While some regions, particularly in the Bay Area and coastal cities, remain extremely expensive, other areas, especially inland and rural regions, may offer more affordable options, though they still face their own challenges. In rural regions, providers often struggle to find affordable housing, exacerbated by additional challenges like wildfires and limited property insurance – deterring relocation to areas already facing extreme workforce shortages.

Housing difficulties can delay health care providers from starting new positions, creating gaps in service and increasing the burden on existing staff *[read more in following section].* Overall, the affordable housing crisis creates a cycle of instability and dissatisfaction that directly affects the availability and quality of health care, and health outcomes of Californians.

#2: Limited Career Opportunities for Spouses and Partners

When health care providers relocate for work, their families often face a range of career challenges that contribute to the difficulty of recruitment and retainment of providers. Geographic relocation often means that the provider and their family members leave behind established careers or job prospects and finding new employment in new locations can be incredibly challenging, especially if the move is to a less economically vibrant area. In addition, there is a lack of diverse job opportunities in rural areas because they mainly offer government jobs, retail jobs, and health and human services jobs.

Not only do limited career opportunities for family members impact the likelihood of new providers relocating to different regions, but many families cannot afford to transition and uproot their family unit without the promise of financial stability. A partner's inability to find meaningful work can strain family dynamics, leading to financial pressures, reducing household stability, increasing stress for the health care providers, and ultimately impacting their job performance and well-being. In addition, the uncertainty of finding suitable employment can deter health care providers from accepting job offers, as they weigh not only their own career prospects, but also those of their families. This added stress can influence decisions and lead to a higher likelihood of declining opportunities in regions with limited job opportunities.

Over time, these challenges can lead to higher turnover rates in the workforce as providers may choose to relocate again or leave the field altogether if they cannot find a supportive environment for their families. Limited career opportunities for spouses or partners during relocation can create significant barriers for health care providers, ultimately influencing their decisions to accept positions and impact overall workforce stability in the health care sector.

#3: Exceeding Staff Capacity & Insufficient Wages/Benefits

Many participants voiced that their respective organizations are still affected by the aftermaths of the COVID-19 pandemic. Current staff face increased workloads, taking on additional responsibilities due to staffing shortages. Additional administrative duties (i.e., increased documentation, administrative meetings, insurance and billing issues etc.), patient care tasks, training and mentoring new staff, lead to overwhelming workloads. Providing adequate supervision and mentorship for new or less experienced staff becomes a herculean challenge when existing providers are stretched thin—hindering development

of new health care professionals. The strain of managing excessive responsibilities contributes to the existing burnout that many health care providers endure and with limited capacity, the quality of patient care may suffer as a result. Overextended staff have less time to dedicate to each patient, potentially impacting patient outcomes and overall satisfaction with the health care experience.

Many small organizations echoed similar sentiments as they face operational inefficiencies as staff juggle multiple roles and responsibilities. All staff are humans and fallible to mistakes – leading to errors, delays in patient care, and a lack of continuity of care and services. High levels of stress and burnout can lead to increased turnover rates, further exacerbating staffing shortages. This creates a distressing cycle where remaining staff must take on even more work, perpetuating the issue.

In Inland Empire and Humboldt's Regional Equity Collaborative participants echoed similar sentiments of financial resource constraints that add to the challenges of recruitment and retention of providers. Hiring additional staff or providing competitive salaries and benefits is necessary to recruit new health care providers or retain current providers to stay within their region. Without the ability to provide competitive salaries and incentivized benefits to attract new providers, many smaller community-based organizations (CBOs) and federally qualified health centers (FQHCs) are losing existing providers to larger organizations and health care plans. This leaves CBOs and FQHCs with higher turnover rate and constantly needing to try to recruit and retain talent.

In addition, the delay in both the Managed Care Organization (MCO) Tax and health care worker minimum wage increase from the 2024-25 Budget Act, represents a setback for health care workers who were promised gradual pay increases to $25 per hour over the next decade. The postponement offers no alleviation of the burden existing employees face and further contributes to burnout and insufficient workforce to address Californians health needs. The mandated health care worker minimum wage increases pose challenges especially for FQHCs. FQHCs are mandated to align with raising the minimum wage for health care workers, however FQHCs are not designated to receive any additional funding from the state to cover these increased labor costs. FQHCs provide essential health services to underserved communities, often operating on tight budgets and are heavily reliant on state and federal funding. The lack of additional funding to support the wage increase will result in many centers being forced to make difficult choices, such as reducing services, laying off staff, or cutting back on hours.

Proposed Solutions:

- *Recruit out-of-state physicians to temporarily offer relief for the existing workforce (see AB 2860 (Garcia), AB 2864 (Garcia), SB 227 (Durazo) and SB 233 (Skinner).*
- *Leverage existing grant programs from the Department of Health Care Access and Information (HCAI) to fund training programs for the next generation of health care professionals.*
- *Establish apprenticeship opportunities and pipeline programs with financial incentives and wealth building opportunities to attract and retain providers in rural regions.*
- *Create and foster an inclusive work culture reflective of peer-nominated recognition and appreciation for exemplary service to underserved communities.*

Key Theme #2: Integrating Allied Health Professionals into Traditional Health Care Systems

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative aims to reform the Medi-Cal system and enhance the delivery of health services to Californians, particularly those in underserved communities. A key component of this initiative was the inclusion of benefits for doulas (2023) and community health workers (CHWs) and Promotoras (2022). However, many participants shared confusion in the differentiation of definition between CHWs and Promotoras.

In addition, many non-traditional health care providers and CBOs are facing herculean obstacles in being included and integrated into CalAIM as part of the health care delivery system. The contracts, questions, and agreements currently being used are designed for the medical health care community, leaving social service and other non-traditional health care CBOs challenged with exhaustive administrative work. Without being fully integrated into the system, CBOs, CHWs, and doulas are unable to do the work they are trained to do. Instances of doulas being denied access to hospitals further highlight systemic barriers that impede their ability to provide essential support during labor. In addition, many doulas and CHWs are facing lengthy contracting processes with Medi-Cal and managed care plans (MCPs) contributing to burnout among doulas. The difficulty and challenges of becoming contracted with Medi-Cal and MCPs has been echoed by many CBOs in similar processes for becoming a certified Enhanced Care Management (ECM) provider or Community Supports (CS) service under CalAIM.

Not only do doulas and CHWs face challenges in being contracted with Medi-Cal and MCPs, but another critical barrier is the low reimbursement rates being offered. Despite the essential services that doulas and CHWs provide, many participants reported that CHWs and doulas are often seen as "cheap labor" contributing to the financial challenge and low reimbursement rates currently being offered.

Participants reported untapped reserves of doulas available, but systemic barriers and requirements prevent doulas from becoming accessible, such as bilingual requirement and immigration status. Many job opportunities necessitate full bilingualism, which excludes capable individuals from serving diverse communities, particularly in efforts to reduce maternal mortality rates for Black Californians. Undocumented doulas face inequitable access to employment despite being allowed to contract with Medi-Cal, complicating their ability to secure contracts due to burdensome application processes.

Proposed Solutions:

- *Clear definitions and defined standards and an expansion of these roles to encompass broader social determinants of health.*
- *Launch of statewide campaign to increase awareness and promote Medi-Cal's CHW and doulas benefits.*
- *Create guidelines for county Medi-Cal doula hubs; utilizing LA County as an example.*
- *Develop clear educational pathways for CHWs and Promotoras who are interested in advancing their careers as medical assistants.*
- *Utilize established partnerships and leverage trusted messengers to help disseminate and discern the differences and similarities between CHWs and Promotoras.*
- *Enhanced collection of community-informed utilization data of CHWs, Promotoras, and doulas to inform policymakers and negotiate fair reimbursement rates.*

Key Theme #3: Systemic Barriers Impeding Utilization of Data & Technology

Participants underscored the importance and need for improved accurate data collection to correctly reflect the communities they serve. The absence of data, especially for Tribal communities, perpetuates the misconception that Tribal members are not present. This is evident when data collectors mark zero (0) for community presence, when it should be recorded as a dash (-) to indicate more data needs to be collected. This hampers the ability of Tribal communities to advocate for better health care access as they are unable to provide evidence of needed services for their communities.

In addition, many participants stressed that the successful implementation of the Data Exchange Framework (DxF) must include counties as signatories in the Data Sharing Agreement (DSA). Read more about how effective, wide-spread data sharing can advance health equity in ITUP's Data Exchange Framework Policy Toolkit. Currently counties collect and maintain vast informative and critical health and social care information on Californians, however counties are not designated as a required signatory of the DSA and are only encouraged to sign onto the as voluntary signatories. Integrating the critical data that counties have into the DxF could improve data collaboration with MCPs and enhance both health and social care delivery based on community needs. These approaches can assist in targeting and locating underinsured and uninsured Californians and connecting them with needed services that could help improve their health outcomes. Learn more about the critical role of accessible data policy and infrastructure in ITUP's Issue Brief: Leveraging Data to Advance Health Equity and Success in CalAIM.

California has made strides in removing policy barriers to telehealth, particularly for Medi-Cal members, including payment parity and permitting different telehealth modalities. The use of two-way text messaging and closed-loop referral platforms has increased, helping to facilitate outreach to members. In the Shasta and Humboldt Regional Equity Collaborative, Partnership HealthPlan of California (PHC) highlighted their Tele-Video Specialty Care Program to provide specialty care access to patients and network providers through telehealth services. These specialty care services range from endocrinology, pulmonology, infectious diseases etc. to help bridge the critical workforce shortage their members face. While telehealth offers a means to address some of the workforce challenges faced, many patients still prefer in-person care due to personal choice or digital literacy barriers and broadband access issues. Learn more about the intersection of broadband and accessible health care in ITUP's Issue Brief: Addressing Digital Equity for Equitable Accessible Health Care. With high-call volumes and limited staff capacity to receive the calls, many members are left unsatisfied with the lengthy wait-times on the phone.

Proposed Solutions:

- *Clarify required signatories for the Data Sharing Agreement to further advance and facilitate the seamless interoperability of data exchange between different entities.*
- *Invest in statewide training and education for providers/patients/users of telehealth.*
- *Increase funding to support a workforce that provides language supports and translation services synchronously during appointments.*
- *Allocate funding dedicated to data collection pilots in various regions/counties to assist in creating digital literacy programs that serve communities. For more details, check out ITUP's Broadband Bootcamp Report.*
- *Outsource high influx of patient call volumes to other counties (see SB 1289 (Roth).*