Department of Health Care Access and Information

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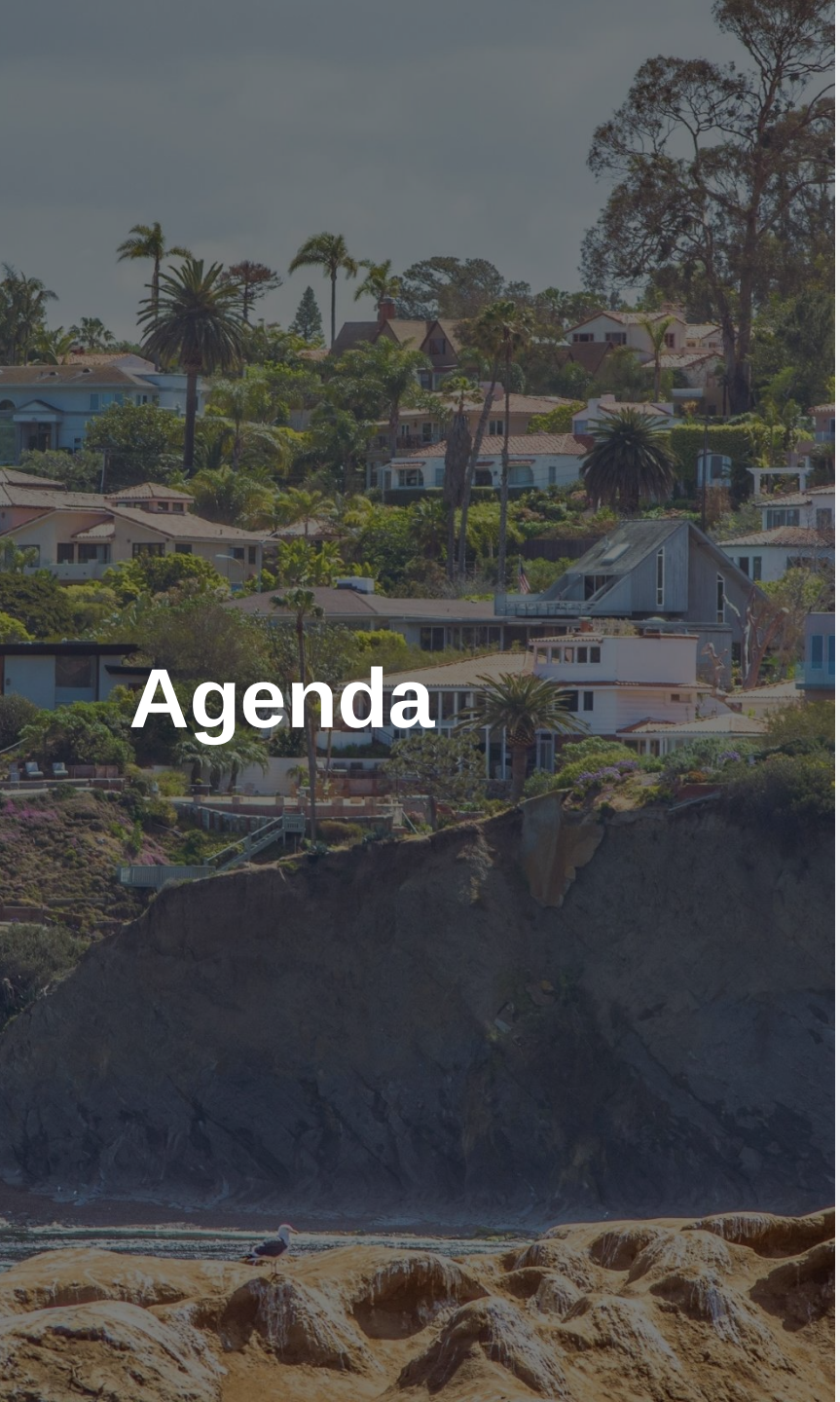
Agenda Item 6:

Detailed review of nursing workforce strategy

Facilitator: HCAI



Agenda

Overview of supply / demand model

- Summary of supply and demand model to identify critical workforce gaps

Detailed review of behavioral health workforce strategy

- Behavioral health findings and preliminary supply / demand modeling results by role
- Deep dive on behavioral health strategy, including specific interventions for roles and geographies

Detailed review of nursing workforce strategy

- Nursing findings and preliminary supply / demand modeling results by role
- Deep dive on nursing strategy, including specific interventions for roles and geographies

Our ask of you

Engage in discussion, think about your entity's role in the strategy, and share relevant knowledge

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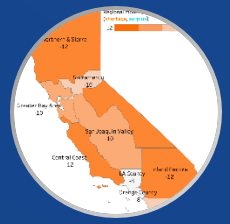
Nursing: Findings and preliminary supply / demand modeling results by role

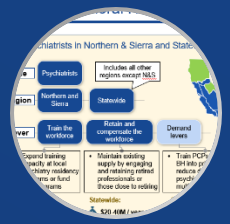
Summary of findings | Nursing Workforce



Registered Nurses, Midwives and Nurse Anesthetists have a **statewide shortage** with some regional variations. **Northern & Sierra** regions face a shortage of all nursing roles, and **San Joaquin Valley** faces a shortage of all roles except Licensed Vocational Nurses. There are **racial and linguistic disparities** between populations and providers.

Gaps are largely driven by **insufficient education and clinical placement capacity** to accommodate all qualified applicants, and **insufficient upskilling opportunities** in some cases (e.g., RN to midwife, LVN to RN).

Additionally, **maldistribution exists across nursing roles** today, with some roles (Nurse Practitioners, Licensed Vocational Nurses) facing shortages in certain regions but sufficient supply in others. **Registered Nurses have a statewide shortage, but some regions have a surplus, also suggesting maldistribution**.



HCAI should take a **multi-pronged approach to supporting the nursing workforce**, including significant investments in **expanding training capacity, clinical placement opportunities, retention, scholarships, and upskilling,** with a focus on equity to ensure the workforce reflects California's diversity.

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Recall | The model assessed roles, geographies, and populations to understand the workforce shortage for roles with data

What **roles** are facing a shortage?

What **geographies** in California?

What **populations** (e.g., racial, linguistic)?

Summary | Model findings on **roles**

Maldistribution of nurses creates regional shortages for almost all roles: Shortages in some regions and overages in others for registered nurses, midwives, nurse practitioners, and licensed vocational nurses (e.g., RNs in San Joaquin Valley)

RNs and midwives face statewide shortages:

- RNs face a ~2% supply/demand gap statewide
- Midwives face a ~17% supply/demand gap statewide, with largest gaps in San Joaquin Valley, Inland Empire, and Northern and Sierra regions

Gaps projected to continue: Gaps forecasted to persist and even widen in some cases (e.g., RNs), and slightly shrink for midwives

Data Gaps: Data on demand by specialty (e.g., for NPs) is not available, but would help further break down any gaps

For discussion: What stands out among these findings? How will you approach interventions for the nursing workforce, given this regional variation?

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With the findings from our model and associated research, we can better clarify role-specific 'Problem Statements' to direct our work (1/2)

Registered Nurses *(Registered Nurse, Public Health Nurse, Clinical Nurse Specialist)*

- ~2% statewide supply/demand gap[1] (~4,700 in absolute terms) with some regions showing an overage of RNs (e.g., Greater Bay Area, Orange County, Sacramento, and San Diego) & other regions a gap (e.g., Northern and Sierra regions, San Joaquin Valley, Los Angeles County) – **suggesting maldistribution**
- **Based on middle of projected confidence interval, statewide gap forecasted to grow slightly, but remain moderate overall**, reaching ~11% by 2029 (~37k RNs) and ~16% by 2033 (~60k RNs); gap is mainly driven by increased demand due to aging population, while **variation in assumptions of current workforce retention & education capacity could significantly reduce that gap**[2]
- Forecast suggests an additional ~10-11k slots needed to close the gap by 2033 (~50% of gap closed by 2029); in order to quickly produce a diverse workforce, ADN programs should be prioritized
- In San Joaquin Valley and Northern & Sierra, gaps are driven by insufficient training capacity (didactic and clinical), relatively low wages, overburdened staff, limited voluntary migration to areas, and insufficient LVN upskilling in San Joaquin Valley despite LVN surplus
- In Los Angeles County, gaps are driven by high concentration of health infrastructure, high cost of living, and poor working conditions (e.g., patient load, admin burden), especially in community and safety net hospitals
- Experts and providers also cited long commute times for this role (e.g., from Inland Empire to Los Angeles County), which may explain some surplus vs shortage region imbalances
- Latine providers are underrepresented vs the CA population (~17% of providers vs 40% of CA's population is Latine)
- Spanish-speaking providers are underrepresented (~14% of providers speak Spanish vs 28% of CA's population speaks Spanish at home)

Midwives *(Certified Nurse Midwife, Licensed Midwife)*

- **~17% statewide supply/demand** gap[1] (~150 in absolute terms), **with largest gaps in San Joaquin Valley, Inland Empire and Northern & Sierra regions**
  - Statewide gap projected to slightly shrink, at ~13% by 2029 (~120 providers) and ~11% by 2033 (~100 providers), driven primarily by lower demand
  - Licensed midwife supply has grown (~25% increase 2016-2022) while the supply of certified nurse midwives has stayed flat
- Modeled demand based on need for maternity care overall (including OB-GYNs) with midwives serving a portion of that need
- Gaps are driven by insufficient training capacity (didactic and clinical), differing interest in rural vs urban locations, insufficient supply and upskilling of RNs to become CNMs and retention (burnout, challenging work conditions, high retirement rates)
- CNMs are nearly all in hospitals, while LMs tend to be in other settings such as home birth (split is largely a function of where they have traditionally worked)
- There is only 1 certified nurse midwife training program in operation in CA; 0 active licensed midwifery programs; to reach the ideal number of midwives, California will need ~120 additional midwives by 2029, suggesting an additional ~15-20 CNM and ~10-15 LM training spots needed to close the gap by 2029, ~5 – 10 additional CNM and ~5 – 10 LM training spots needed to close the gap by 2033[4] (as gap shrinks, and more cohorts have time to complete training)
- Asian and Latine providers are underrepresented across CNM and LM; Black, Pacific Islander, or American Indian Licensed Midwives are significantly underrepresented, indicating a significant disparity in those populations.
- ~35% of Certified Nurse Midwives and ~20% of Licensed Midwives speak Spanish, which is generally in-line with CA's population (well represented for CNM)

1. Current state (2022) model output, calculated as (demand-supply)/demand 2. Note: UCSF 2023 forecast show statewide RN gap closing by 2027 3. HCAI CA Health Workforce Education Pathways dashboard 4. Assumes same split of CNMs and LMs as today (60% vs 40%) and CNM and LM FTEs are equivalent

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With the findings from our model and associated research, we can better clarify role-specific 'Problem Statements' to direct our work (2/2)

Certified Registered Nurse Anesthetists (CRNA)

- *Given CRNA demand best understood as need for anesthesia services and could be combined with anesthesiologist demand, shortage drivers were not explored for this role. The absolute number of providers is also very low (~1,630 providers in current state), so small shifts make the difference between surplus and shortage at the regional level.*
- Latine, Black and Spanish-speaking providers are underrepresented relative to the CA population

Nurse Practitioners

- **Regional maldistribution of nurse practitioners today** with Northern & Sierra regions experiencing a shortage while supply meets or exceeds demand in other regions; statewide overage of ~3,670 providers, or ~24% of demand[1] today, but forecasted to significantly narrow reaching just ~5% overage by 2033; Latine providers are underrepresented relative to the CA population (~15% of NPs vs ~40% of CA's population); Spanish-speaking providers are also underrepresented
- **Note**: *Given the under-utilization of NPs in primary care settings and the fact that our data is based on historical practice patterns, this could overstate this statewide "surplus" and a shift in care models could drive greater need for NPs*
- ***Model also does not break down NPs by specialty**, so employers may experience shortages of certain NP specialties, despite statewide results*

Licensed Vocational Nurses

- Statewide overage of licensed vocational nurses (surplus of ~4,120 providers, or ~6% of demand[1]), with **maldistribution across regions** (e.g., Northern and Sierra regions, Central Coast, Los Angeles County face supply-demand gaps while San Joaquin Valley and Inland Empire have surpluses); statewide surplus forecasted to continue
- Some regions with overage of LVN correlate with RN shortage (e.g., San Joaquin Valley), suggesting LVNs could be upskilled to fill RN gap
- LVNs have the lowest wages across nursing roles examined (~$77k annual mean wage)[2]
- LVNs have the lowest share of White providers across nursing roles examined (~18%) and are largely at parity in all other races (except for a slight underrepresentation in Latine providers)
- ~25% of LVNs speak Spanish vs ~28% of CA's population speaks Spanish at home – indicating close to parity

1. Current state (2022) model output, calculated as (demand-supply)/demand 2. BLS May 2023 California OEWS; Salary.com; Indeed.com; Glassdoor.com

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California Statewide | Nursing gaps by role

Role	Current state (2022) gap	2029 forecast gap	2033 forecast gap	Gap trend
Registered Nurse	**2%** (~ 5K)	**12%** (~ 40k)	**19%** (~ 68K)	↑
Licensed Vocational Nurse	**-6%** (~ -4K)	**-5%** (~ -4k)	**-4%** (~ -3K)	—
Nurse Practitioner	**-24%** (~ -4K)	**-12%** (~ -3k)	**-5%** (~ -1K)	↑
Nurse Anesthetist	**23%** (~ 0.5K)	**14%** (~ 0.3k)	**9%** (~ 0.2K)	↓
Midwives (CNM & LM)	**17%** (~ 0.2K)	**13%** (~ 0.1k)	**11%** (~ 0.1K)	↓

↑ *Worsening gap or decreasing surplus* — *Steady gap or surplus* ↓ *Improving gap or widening surplus*

Note: Negative gap implies 'surplus'

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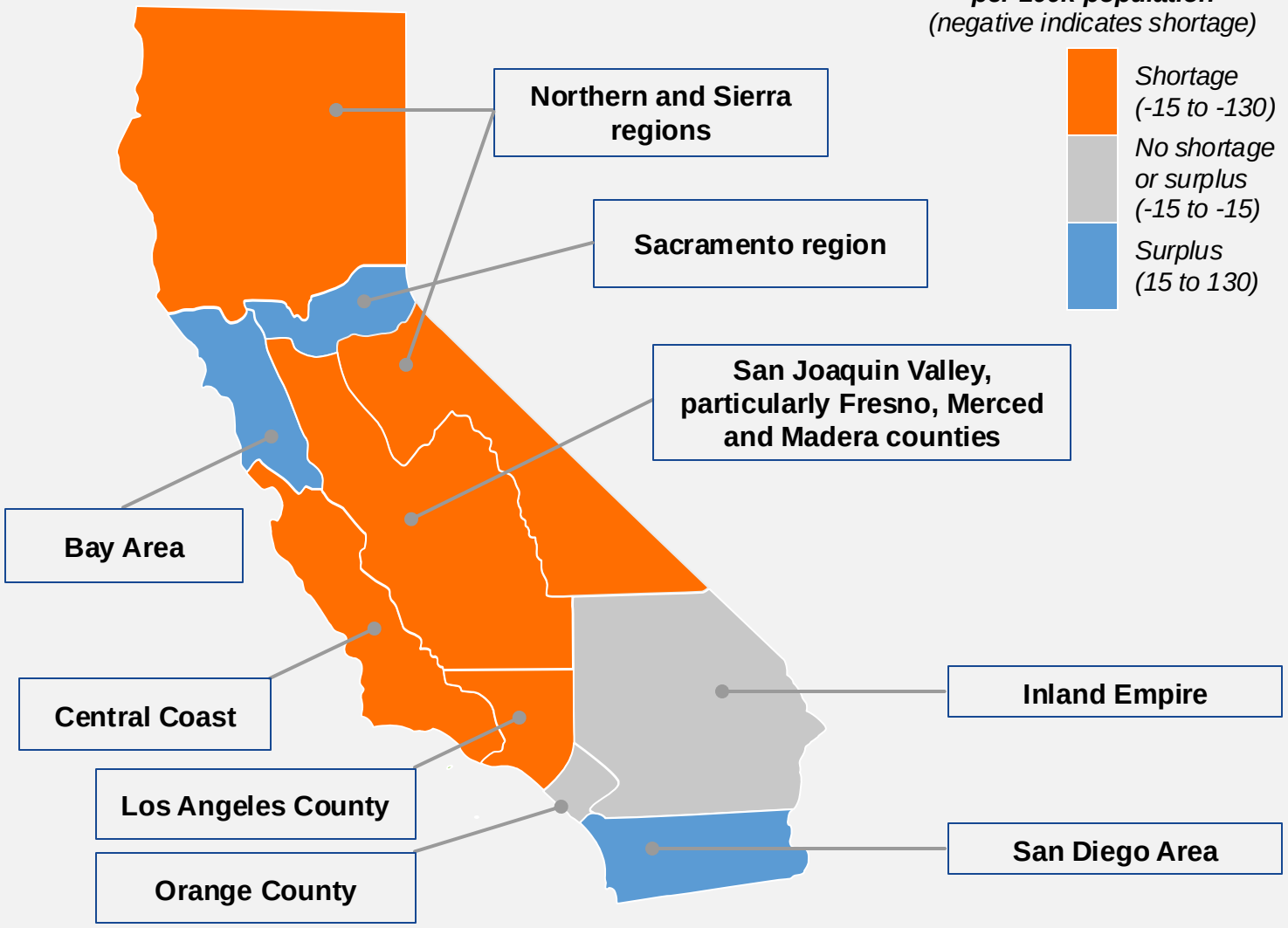
Summary | Model findings on RN regional shortages & surplus

*Shortages in **Northern and Sierra regions, San Joaquin Valley, & LA County**; overall statewide shortfall is small at around 2%*

Registered nurse workforce shortages & surplus
(4 regions shows registered nurse shortages)



Note: Appendix includes regional shortage maps for other roles

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Summary | Model findings on populations

Racial representation of providers is imbalanced relative to population

- Latine providers are underrepresented across all roles relative to their population percentage
- Black providers are likely underrepresented across RN, CNS, nurse anesthetist and licensed midwife roles (e.g., 0% of HCAI license renewal survey respondents were Black)[1]

Language barriers persist across the workforce

- Spanish-speaking providers are underrepresented in all roles except certified nurse midwives
- Asian and Pacific Island language-speaking providers are well-represented in most roles relative to the population, except for nurse anesthetists and midwives

1. 2022 – 2024 HCAI Survey of Race and Ethnicity of California's Health Workforce

Observations across roles and geographies

These observations were the foundation for our statewide strategy

Although there are **nursing shortages in some roles and geographies** (e.g., RNs in San Joaquin Valley), there is currently a significant maldistribution at the regional level. For the **largest roles** we see:

- **RNs:** ~2% statewide supply/demand gap[1] (~4,700 in absolute terms) with some regions showing a surplus (e.g., Greater Bay Area) and other regions with a gap (e.g., San Joaquin Valley, Northern & Sierra regions, and Los Angeles County); the gap may reach ~11% by 2029 if it falls in the middle of the forecast confidence interval
- **NPs:** Maldistribution with shortage of NPs in Northern & Sierra regions. Statewide supply exceeds demand by ~3,600 providers, or ~24% of demand today, but that overage is forecasted to significantly decrease narrowing to just ~5% by 2033
- **LVNs:** Statewide surplus (surplus of ~4,100 providers, or ~6% of demand), with maldistribution across regions

A **range of drivers emerged** which point to **potential solutions and interventions:**

- Across areas with current and projected shortages, **educational capacity emerged as a leading constraint**, with additional bottlenecks at specific training steps especially **clinical placements** for students in the public system
- **Imbalances across roles** (e.g., LVN surplus in San Joaquin Valley but RN shortage) point to **opportunity for upskilling** (which also offers economic mobility)
- **Retention problems** especially in safety net settings, driven by low wages, overburdened staff (e.g., high patient load), workplace violence, admin burden, etc.
- **High cost of living**, especially in Los Angeles County and for nursing roles with lower wages (e.g., LVN), which indicates **financial support for providers is needed**
- **Maldistribution** can potentially be alleviated via incentives to **redistribute existing workforce** (e.g., loan repayment) and **stay long-term in underserved areas**

1. Current state (2022) model output, calculated as (demand-supply)/demand

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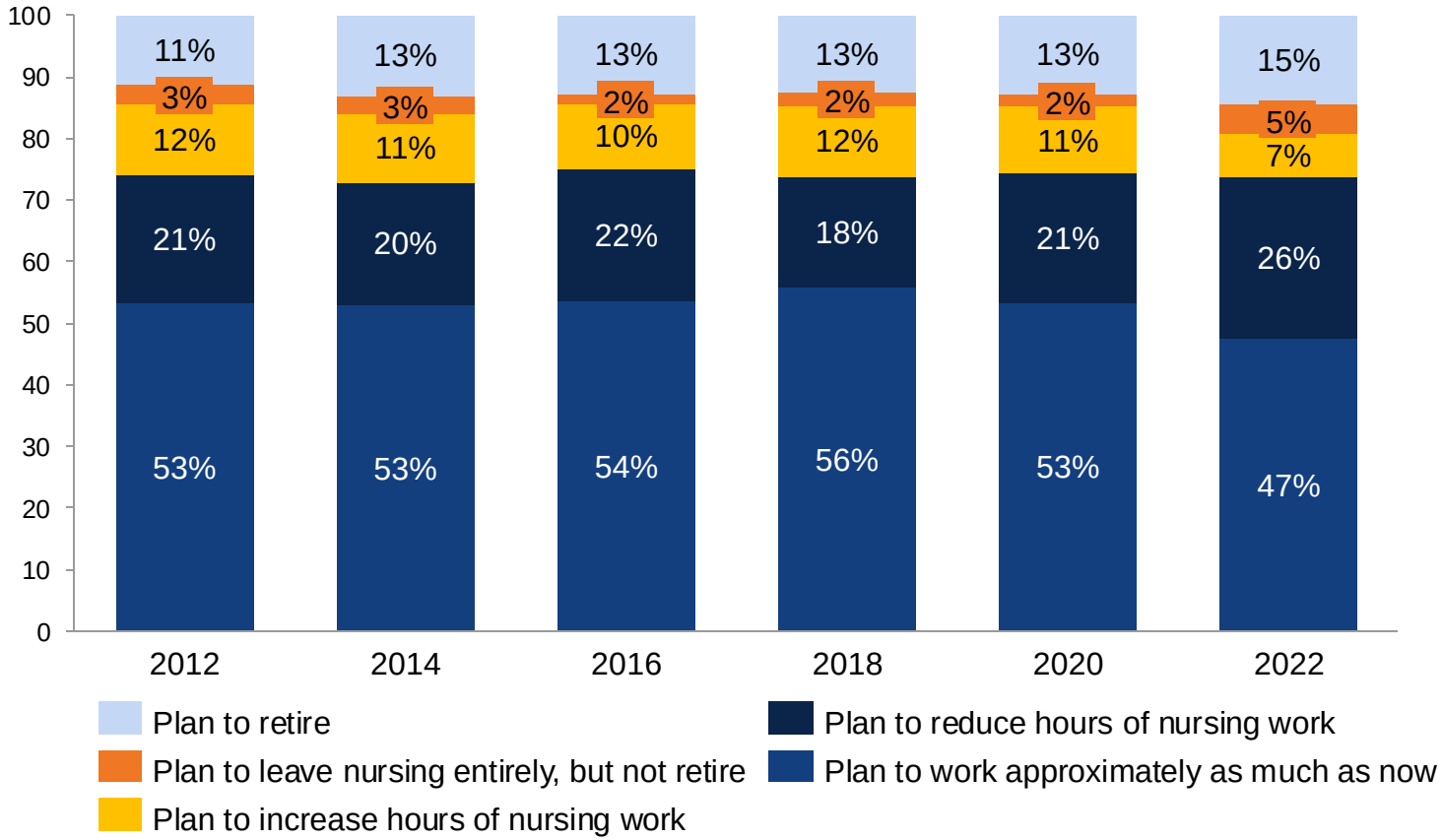
Addressing nurse retention is crucial to mitigate the impact of declining retention rates on nursing shortages according to BRN survey of registered nurses

Plans for the next five years of RNs who resided in California and were employed in nursing, by survey year



Greater share (~26%) of RNs **planning to reduce the hours they work** in 2022 vs previous years

Growing share of RNs plan to retire or leave nursing entirely for another vocation

Percentage of RNs planning to **maintain the hours they work decreased significantly** from 2020 to 2022

Critical that HCAI and its partners prioritize retention strategies to prevent worsening shortages**. Given the limited nursing retention budget for FY24-25, we **aim to enable partners to lead in this effort.

Source: California BRN 2022 Survey of California Registered Nurses by Joanne Spetz & Lela Chu

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Turning findings into actionable strategies for specific roles and/or geographies

Before exploring findings and potential interventions, it is important to ground in the nursing programs that HCAI leads or has recently led

HCAI's nursing workforce programs

Ongoing programs

Song-Brown suite of programs (~$2.7M in funding for FY 24-25)

- Education capacity funding to train a range of nursing roles (e.g., NPs, midwives, RNs)

Reproductive Healthcare Access Initiative (one-time funding in FY 22-23, no funding in FY 24-25)

- Scholarship and loan repayment programs for advanced practice nurses, RNs, LVNs, CNMs, and licensed midwives
- California Reproductive Health Service Corps: Statewide consortium that creates new and expanded training pathways and fills provider gaps; open to a range of nursing roles

Scholarship and loan repayment programs (~$2.3M in funding for FY 24-25)

- Individuals pursuing nursing careers, including ADN degrees, LVN degrees, LVN to ADN degrees, and BSN degrees

Retired programs

CNA training programs (e.g., Leading Age Gateway-In Project)

- Training, wraparound service, financial support, job placement assistance, incentives for career growth, and more – programs include CNAs

Home and Community Based Services (HCBS)

- Caring4Cal: Training, coaching and financial incentives to grow the home and community-based care workforce

HCAI's nursing dollars have decreased significantly for the upcoming year (nursing program funding was over $60M in FY 2023-24 and over $100M in FY 2022-2023). Going forward, HCAI will need to be thoughtful about how to target earmarked funds in a limited funding environment and how best to partner with other entities.

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Key considerations for HCAI programming in Nursing

Key considerations:

Funding will prioritize candidates or programs who are most likely or have committed to working in **underserved geographies** (while gaps identified in the model should will used to guide this funding, the model will not be used as an ‘exact science’)

Funding will prioritize **roles with the highest shortages** (while gaps identified in the model should will used to guide this funding, the model will not be used as an ‘exact science’)

Funded interventions will be **evidence-based** (e.g., scholarships), or could also be **innovative** (e.g., apprenticeships), when possible

Collaborate with other stakeholders to **coordinate funding efforts**

Where possible, funded interventions should not only **increase supply of providers** but should **increase equity of access / diversity of providers** (e.g., linguistic diversity) such as through known equity pathways (e.g., ADN programs, scholarships, upskilling)

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From the model results, some **nursing** role x geography combinations had especially severe shortages, while others had statewide strategies (e.g., to address maldistribution)

Role / geography combinations with especially severe shortages

- **RNs** – *Northern & Sierra regions, and San Joaquin Valley*
- **RNs** – *LA County*
- **NPs** – *Northern & Sierra regions*

Roles with statewide strategy

- **Licensed Vocational Nurses –** *statewide, focused on redistribution across surplus vs shortage regions*
- **Midwives –** *statewide*

Recall | Deep dives are an opportunity to provide feedback

We have done deep-dives for 5 role-geo combinations (see appendix in pre-read); we will walk through two roles live – please flag if there is a specific role the group is most interested in

We would like to provide **an open forum** for feedback, so Council members can **focus on the sections / roles where you individually have the most expertise** (e.g., midwives)

Your pre-read Appendix includes a more **extensive set of deep dives** – for today's discussion, we'd like to ask the following questions:

- In general, where did you **have questions?**
- What **resonated or may be missing**?
- Are there additional ways we can incorporate **innovative or promising ideas** into our strategy?

We'll take comments/questions on other roles at the presentation's end

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Nursing Summary | Each "deep dive" details key interventions for a role/geo based on identified shortage drivers

Registered nurses

San Joaquin Valley and Northern & Sierra approach (~7,500 more needed by 2029)

- Provide **incentives to redistribute existing workforce** from surplus to shortage regions
- Offer **tuition reimbursement and loan repayment** to existing providers in San Joaquin and Northern & Sierra regions to help improve retention, prioritizing those serving in safety net settings (e.g., Medi-Cal)
- Fund **increased clinical placement opportunities** for students, prioritizing students at public schools and, if possible, students are from San Joaquin Valley or Northern & Sierra regions
- Offer **programs that reduce time and effort to upskill** (e.g., LVN to RN bridge, 30-unit option)
- Expand education capacity, particularly at public institutions (e.g., CCCs, CSUs, UCs), including ADN, BSN, concurrent enrollment

Los Angeles County approach (~12,000 more needed by 2029)

- Offer **tuition reimbursement and loan repayment** to RNs who live and/or work in LA County
- Fund **peer and mentor networks** for RNs who work in LA County to improve retention, prioritizing those serving in safety net settings (e.g., Medi-Cal, FQHC)
- Maintain existing supply by **retaining those close to retiring** and engaging retired providers in Los Angeles County
- Expand **education capacity**, particularly at public institutions (e.g., CCCs, CSUs, UCs), including ADN, BSN, concurrent enrollment

Note: Appendix includes complete role deep dives

Nursing Summary | Each "deep dive" details key interventions for a role/geo based on identified shortage drivers

Nurse Practitioners

Northern & Sierra approach (~900 more needed by 2029)

- Provide **incentives to redistribute existing workforce** from surplus regions to Northern & Sierra regions (e.g., stipends, loan repayment, signing bonuses)
- Provide **financial incentives to stay long term** (>5 years) in Northern & Sierra regions

Licensed Vocational Nurses

Statewide approach (~4,000 more needed by 2029 in California's shortage regions)

- Provide **incentives to redistribute existing workforce** from surplus regions to shortage regions (e.g., stipends, loan repayment, signing bonuses)
- Provide **financial incentives to stay long term** (>5 years) in shortage regions (e.g., Central Coast)

Midwives

Statewide approach (~120 more needed by 2029)

- Expand **educational capacity for CNMs** at existing or new programs, including funding clinical placement opportunities as well as incentives for faculty
- Expand **educational capacity for LMs** with 2 new programs in Greater Bay Area and LA County
- Offer **scholarships for low-income and underserved students** from key shortage areas (e.g., San Joaquin Valley) to in-state CNM or LM programs

Note: Appendix includes complete role deep dives

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Example deep-dive to walk-through in live discussion
(remainder in appendix – option to choose other(s) for live discussion)

RNs in San Joaquin Valley and Northern & Sierra regions

Preliminary

Summary

Increasing supply and diversity of RNs in San Joaquin Valley and Northern & Sierra regions

Region: San Joaquin Valley, Northern & Sierra regions
- Counties with most significant gaps in current state are Modoc, Yuba, Madera

Role(s): RNs

Time period: 5 years

Potential investment required: TBD

Equity: Key disparities include American Indian, Latine, Pacific Islander, Black, Spanish-speaking

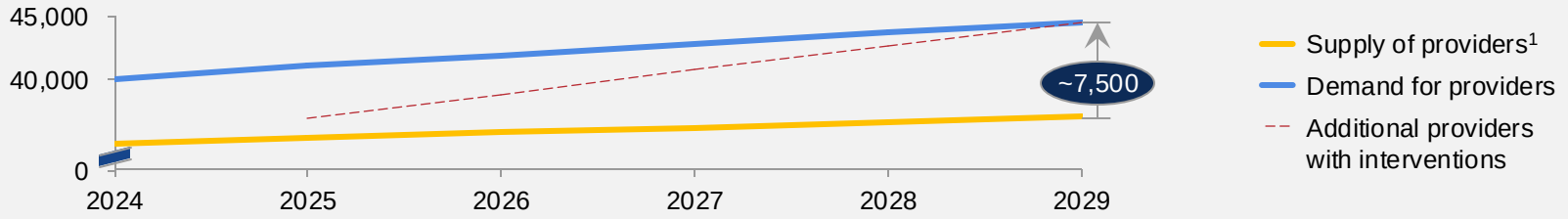
Note: we are continuing to refine targets as we obtain more information about expected impact of interventions

HCAI has, or had, an existing program for intervention

Key professional-to-population disparities:
- ~0.4 representation for Latine providers in San Joaquin Valley; ~0.5 in Northern & Sierra regions
- ~0.4 representation for Spanish-speaking providers in SJV; ~0.7 in Northern & Sierra regions

Forecasted supply and demand

RNs in San Joaquin Valley and Northern & Sierra regions



*By **2029**, we will **need ~7,500 more RNs in San Joaquin Valley and Northern & Sierra** regions to meet forecasted demand*

We conducted deep-dives on the following eco-system intervention options:

Intervention #1: Provide **incentives to redistribute** existing workforce from surplus to shortage regions (e.g., loan repayment, stipends, signing bonuses for RNs in Sacramento to move to Northern & Sierra regions)
- **Target**: Support ~900 providers relocating over 5 years, based on 2029 forecasted surplus in surplus regions

Intervention #2: Offer **tuition reimbursement and loan repayment** to existing providers in San Joaquin and Northern & Sierra regions to help improve retention, prioritizing those serving in safety net settings (e.g., Medi-Cal, FQHC)
- **Target to close gap:** Support ~30k – 40k providers for 2-years or 4-years, retain all existing providers
  - **Realistic target:** Support ~6 – 7k providers, limited to providers estimated exit supply who also have student loan debt

Intervention #3: Fund increased **clinical placements opportunities** for students, prioritizing students attending public nursing programs and, if possible, students are from San Joaquin Valley or Northern & Sierra regions and settings that serve safety net and complex populations
- **Target:** Support ~7,500 additional placement spots over the next 5 years

Intervention #4: Offer programs that **reduce time and effort to upskill** (e.g., LVN to RN bridge, LVN to RN 30-unit)
- **Target:** Support ~1500 LVN upskilling to RN over 5 years, based on expected surplus of LVNs by 2029[2]

Intervention #5: Expand education capacity, particularly at public institutions (e.g., CCCs, CSUs, UCs), including ADN, BSN, and concurrent enrollment programs
- **Target:** Support ~7,500 additional students over the next 5 years, which is an estimated ~1-2k ADN slots and ~3-4k BSN slots, based on current proportions of ADN vs BSN in San Joaquin Valley and Northern & Sierra regions (however, preference should be given to ADN to quickly produce a diverse workforce)[3]

For discussion: What players, funders, and partners would need to be engaged in each intervention?

1. Includes pipeline, as projected supply 2. LVN shortage estimates continue to be refined with commuting patterns 3. HCAI CA Health Workforce Education Pathways dashboard

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Midwives statewide

Preliminary

Summary

Increasing supply and diversity of Midwives statewide

Geography: CA statewide
- Regions with shortages in current state are San Joaquin Valley, Inland Empire, Northern & Sierra regions
- Counties with most significant gaps in current state are Colusa, Yuba, Modoc

Role(s): Midwives

Time period: 5 years

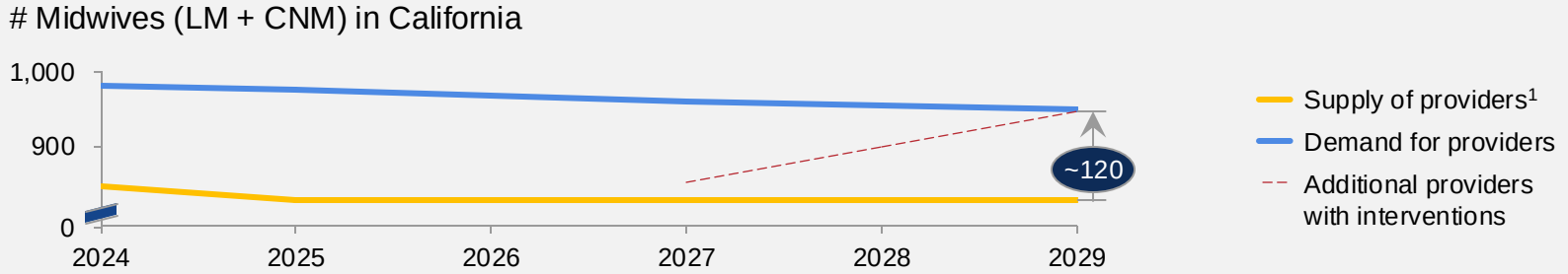
Potential investment required: TBD

Equity: Key disparities include Pacific Islander, American Indian, Asian, Latine, Asian & Pacific Island language-speaking, Other Indo-European language-speaking

HCAI has, or had, an existing program for intervention

Key professional-to-population disparities:
- ~0.4 representation for Latine providers in California; ~0.2 for American Indian; ~0.0 for Pacific Islander
- ~0.2 representation for Asian & Pacific Island language-speaking providers in California

Forecasted supply and demand



*By **2029**, we will **need ~120 more midwives (LM + CNM) across California** to meet forecasted demand*

We conducted deep-dives on the following eco-system intervention options:

Intervention #1: Expand educational capacity at existing or new CNM programs, including funding clinical placement opportunities as well as incentives for faculty
- **Target**: Support ~70 additional CNM spots[2] over 5 years (or 50 – 60 with UCSF midwifery program reopening after it's transition from MSN to DNP)

Intervention #2: Expand educational capacity for LMs with 2 new programs in Greater Bay Area and LA County
- **Target:** Support ~50 additional LM[2] spots over the next 5 years

Intervention #3: Offer **scholarships** for low-income and underserved students from key shortage areas (e.g., San Joaquin Valley, Northern & Sierra regions) to attend in-state CNM or LM programs
- **Target:** Support ~120 students for duration of their program (~70 CNM and ~50 LM[2])

***For discussion:* What players, funders, and partners would need to be engaged in each intervention?**

1. Includes pipeline, as projected supply 2. Assumes same split of CNMs and LMs as today (60% vs 40%) and CNM and LM FTEs are equivalent

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2

What needs to get done

In nursing, where HCAI funds are limited, focus on high impact interventions in areas of greatest need and providing data to partners to support external funding

Expanding public educational capacity in specific geographies: Education capacity in the public system continues to be a challenge with long waitlists and low acceptance rates, especially at community colleges which are in the best position to promote economic mobility and a diverse student body. However, to increase educational slots, faculty shortages and clinical placement must be addressed in parallel.

Tracking and supporting public clinical placement: Clinical placements are consistently cited as a barrier, driving inequities across the public and private systems. Role, setting and geography are all factors in a system which is hampered by little visibility, no data, and unclear ownership at the State level.

Upskilling is part of the solution: Given surpluses in some roles (e.g., LVN), opportunity to upskill existing nurses to fill RN and Midwife roles, which also addresses important racial and linguistic disparities in Advanced Practice areas. Pathways between Associate and employer-preferred Bachelor's degrees may also be important. Partnerships with unions and employers could be an important unlock in this dimension.

Relocation and local retention to address maldistribution: Both relocation incentives or commitments for recent graduates to stay in shortage areas (e.g., service obligations) and safety net settings will be a component of targeting interventions to specific geographies.

Where possible, interventions should be targeted to decrease racial, linguistic, Medi-Cal and other disparities

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In addition, there are interventions outside of HCAI's scope that may be required to achieve workforce and access goals

For discussion: What other interventions are outside of HCAI's scope but others need to do to move the needle? Who should own them?

1. The Future of Nursing: Leading Change, Advancing Health, 2016

Not exhaustive

Some of these interventions may include:

Financial incentives & support

- Increase **reimbursement rates**
- Improve **compensation for providers**, and competitive benefits (e.g., living wage, childcare)
- Lower **tuition costs** to make nursing education more affordable

Work-life balance & job flexibility

- Reduce **provider : patient ratios** to reduce burnout
- Offer more **part-time** opportunities and **flexible work schedules** (e.g., ability to choose shifts or types of shifts)

Administrative & structural improvements

- Reduce **administrative barriers** (e.g., insurance reimbursement models[1])
- **Standardize pre-requisites** across schools (e.g., leverage the forthcoming HealthImpact pre-requisites report) to ease transferring across programs

Education & professional development

- Develop **clear career pathways** (e.g., LVN to RN) and **stackable credentials**
- Alter **curricular content** for educational and clinical programs (e.g., use of simulation) to provide more clinical opportunities in varied settings (e.g., pediatrics, obstetrics, mental health)

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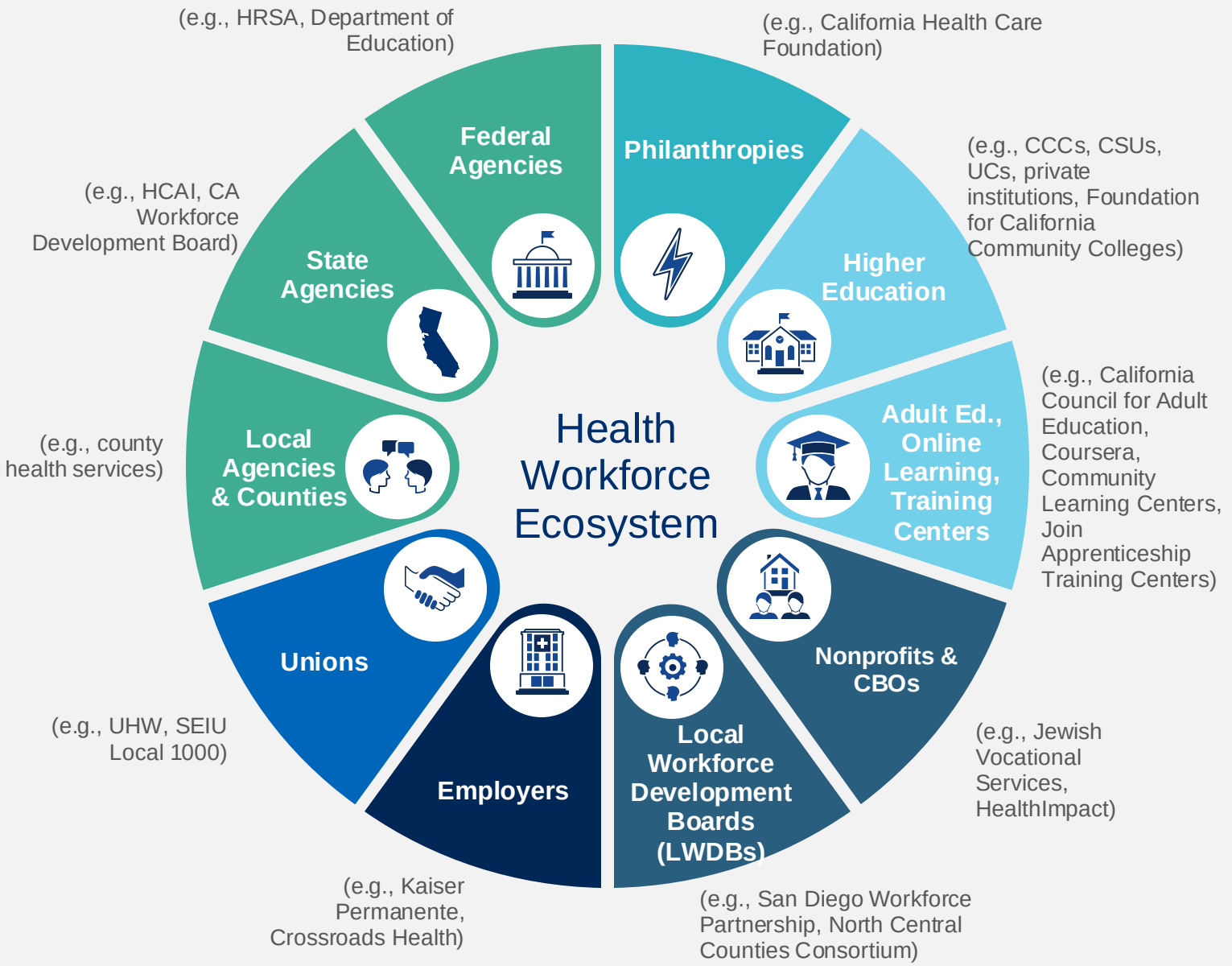

Discussion

What role does each player in the ecosystem need to play to move the needle to address the nursing shortage across California?

- What role should CCCs, CSUs, UCs play in expanding education capacity? What specific barriers can other partners help alleviate (e.g., faculty shortages, space, clinical placement, coordination)?
- How can employers partner with HCAI to generate and share data on nursing shortages and collaborate on shared strategies for retention of nurses?
- Which institutions and funds can be used to support upskilling (e.g., SEIU's LVN-to-RN apprenticeship program)?

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Findings used to provide recommendations for deep-dive nursing interventions that engage all partners, given HCAI's limited funding

Initial funding portfolio is based on HCAI's limited available dollars

We are building a portfolio based on HCAI's available funding to inform how HCAI can best spend its nursing dollars

- *HCAI's limited dollars (<$10M) should target the greatest workforce shortage areas with proven interventions (e.g., education capacity, loan repayment)*

Updated version that is inclusive of all partner needs

We are also developing a recommended funding portfolio for all entities in the nursing workforce ecosystem to collectively address (e.g., specific interventions in specific areas) and forums to collectively discuss path forward (e.g., Council)

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Proposal for how we will use Council as mechanism to bring partners together going forward

We are defining what needs to be shared with partners to enable change, as part of HCAI's influence model. For example:

- *Providing model data on workforce gaps*
- *Sharing demographic overlays with partners, to enable equity focus*
- *Creating feedback loops for specific role/geo-specific strategies*
- *Addressing both demand and supply needs with partners to quickly launch demonstration projects*

HCAI will leverage the Council as its main influence mechanism, by facilitating discussions, determining ownership, and tracking progress against internal goals and broader ecosystem goals. For example:

- *Reporting out on HCAI's program changes and program impact measurement*
- *Facilitating cross-agency discussions and ownership of clinical placement expansion intervention*
- *Using the Council as a forum for HCAI, Council members, and the public to hear and receive updates on key initiatives and commitments to addressing identified gaps*

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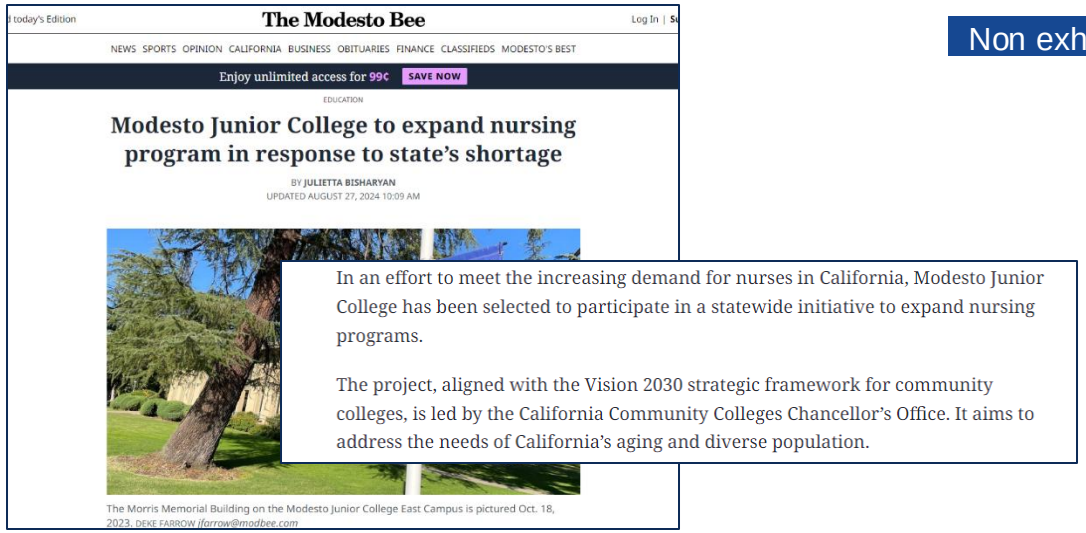
We are starting to work on specific use cases for the modeling results

Use case: a ***practical action*** *(program, funding decision, partnership, etc.)* ***focused on areas of highest need (supply / demand gap, equitable lens)*** *informed by the data and analysis in our model*

For discussion: What are some additional specific opportunities you see for the model results?

Examples of use cases we are starting to work on with partners:

- CCCs leveraging workforce shortage data to understand areas of highest need, for ADN Expansion Demonstration Project, pathways planning, and addressing equity in education
- Organizations using the modeling data to project how changes in workforce supply/demand will impact their long-term strategies (e.g., for their own workforce initiatives)
- Other state agencies seeking recommendations from HCAI on how to allocate their funding (e.g., which interventions, which areas, how many people, what cost), leveraging our data to inform



Non exhaustive

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6

What's coming next

How we are closing out this initial phase of the work

Not exhaustive

Strategy & Implementation:

Providing HCAI with a compendium document with implementation detail on strategy (e.g., roadmaps, tracking tools, change management processes, capabilities required)

*The strategy is a **living document that HCAI will continue to refine** – we will continue to report progress at future council meetings*

Grant-making principles:

Translating the strategy into programmatic implications and considerations for grant making

Key data to inform decisions:

Compiling the data required to make decisions on funding and programming, for HCAI and partners

HCAI's influence model:

Defining HCAI's influence model to enable partners to address workforce shortages in areas HCAI may be unable to (due to scope, limited funding, etc.)

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Next steps

If you would like to share offline feedback on these materials, please email **mancia.ana@bcg.com** with your input by September 20, 2024 at 5pm PT

Our **November Council meeting** will focus on:

- More detail on program implications and principles for grant-making
- Scenario examples that can test impact of various future state assumptions
- Data roadmap