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Department of Health Care Access and Information

California Health Workforce Education and Training Council Annual Report

2020 WEST EL CAMINO AVENUE, SUITE 1222 • SACRAMENTO, CA 95833
PHONE: (916) 326-3600 • EMAIL: HWETCOUNCIL@HCAI.CA.GOV

"A healthier California where all receive equitable, affordable, and quality health care."

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1. Executive Summary

California Health Workforce Education and Training Council

The California Health Workforce Education and Training Council (Council), established under California Health and Safety Code Section 128250, serves as the state's coordinating body for health workforce education and training. Its 18 members bring expertise across health professions, workforce policy, and California's higher education systems, ensuring statewide workforce priorities reflect a wide range of professional and community perspectives.

This is the Council's first annual report. It synthesizes the Council's 2025-2026 discussions, insights, and priorities to communicate key workforce considerations to state leadership, lawmakers, and community partners. The report summarizes workforce issues examined during Council meetings and members' perspectives on priority topics. It does not issue formal recommendations or positions on behalf of members or the organizations they represent.

The report focuses on three priority workforce areas examined this year, behavioral health for older adults, maternal health, and primary care team workforce. For each area, it provides a landscape overview and the key themes that emerged from Council discussion.

Behavioral Health for Older Adults (October 2025 meeting)

- Demand for behavioral health services is rising as one in four Californians will be 65+ by 2040, with needs and growth varying sharply by county.
- The population is growing more diverse, requiring a workforce equipped to deliver culturally and linguistically responsive care, including for LGBTQIA+ older adults.
- The workforce extends well beyond licensed providers to IHSS workers, informal caregivers, peers, and community health workers. Council members discussed the most impactful strategies are upskilling existing workers, broadening roles, improving community responsiveness, and closing data gaps.

Maternal Health (March 2026 meeting)

- Roughly one in ten U.S. births is in California, yet significant racial disparities persist and midwives remain underutilized despite evidence of improved outcomes.

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- Facility closures, including about 40% of freestanding birth centers since 2020 and 46 or more hospital labor and delivery units since 2012, disproportionately affect rural and Latino communities, and nine California counties have no OB-GYNs.
- Council members discussed expanding community-based education pathways, increasing clinical placement capacity, strengthening workforce diversity, improving coordination across professions, and collecting additional data about the workforce to inform planning and resource allocation.

Primary Care Team Workforce (July 2026 meeting)

- Team-based primary care is cost-effective, improves staff experience, and has the potential to improve quality outcomes for patients but team-based primary care providers are unevenly distributed to serve the more than 25% of Californias in federally designated shortage areas.
- The primary care workforce is aging and does not reflect California's racial, ethnic, or linguistic diversity, and training offers few interprofessional opportunities.
- Council members thought it was important to invest in training for the full primary care team, connect workforce investments to outcomes, and use data to target investments.

Looking ahead, the Council will continue to focus on behavioral health, maternal health, nursing, primary care, oral health, and the cross-cutting goal of advancing equity. Each 2027 meeting will explore a priority area in depth.

2. HCAI and the California Health Workforce Education and Training Council Overview

2.1 HCAI and Health Workforce Development

The Department of Health Care Access and Information (HCAI)’s mission is to expand access to quality, equitable, affordable health care for all Californians by supporting high value delivery systems, resilient health care facilities and workforces, and actionable health care information and strategies.

Within this broader mission, HCAI’s Health Workforce Development work supports efforts to strengthen California’s health workforce and address persistent workforce shortages across behavioral health, nursing, maternal health, primary care, and oral health. HCAI’s workforce investments are guided by three priorities: serving

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underserved communities experiencing limited access to health care; ensuring that investments support access to care for Medi-Cal members; and developing a workforce that reflects California's racial and language diversity.

HCAI advances these priorities by administering programs and funding and publishing actionable data about California's health workforce and health professional training programs. This includes supporting organizations that build health workforce pathways, expanding the capacity of education and training programs, providing financial assistance to individuals pursuing health careers, and supporting organizations working to strengthen provider capacity and retention.

2.2 Council Mandate and Role

California Health and Safety Code Section 128250 established the Council to serve as the state's coordinating body for health workforce education and training. Sponsored by HCAI, the Council supports coordination across health professions education and training programs, including efforts to strengthen workforce pathways, align education and training with workforce needs, and improve coordination among educational institutions, health care organizations, and other workforce partners. Through this role, the Council helps inform statewide workforce planning and efforts to develop a health workforce that can meet California's broad and evolving health care needs.

The Council's 18 members bring expertise from across health professions, health workforce policy, and the state's higher education systems to ensure that statewide workforce priorities are shaped by a wide range of professional and community viewpoints.

Membership is defined in statute and includes:

- Six members appointed by the Governor
- Three members appointed by the Speaker of the Assembly
- Three members appointed by the Chairperson of the Senate Committee on Rules
- The Director of the State Department of Health Care Services, or a designee
- The Director of the Department of Health Care Access and Information, or a designee
- The Secretary of Labor and Workforce Development, or a designee
- The President of the University of California, or a designee

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- The Chancellor of the California State University, or a designee
- The Chancellor of the California Community Colleges, or a designee

The Council examines statewide workforce needs, identifies emerging challenges, and shares insights that inform health workforce planning. Through this annual report, the Council aims to share health workforce development considerations with partners throughout the state.

2.3 Council Members and Representation

Council members are appointed through the process identified in statute. Council members are listed below by their appointing authority.

- Governor's Appointments
    - Kevin Grumbach, MD, Family and Community Medicine, University of California, San Francisco
    - Kristina Lawson, JD, Managing Partner, Hanson Bridgett LLP
    - Arrickia McDaniel, EdD, LCSW, MSW, Chancellor of STRIVE University of Community Health and STRIVE Community Health Institute
    - Nader A. Nadershahi, DDS, MBA, EdD, Senior Vice President for Education and Professional Affairs American Dental Association (Chair)
    - Cedric Rutland, MD, CEO, Rutland Medical Group
    - Van Ton-Quinlivan, MBA, CEO Futuro Health
- Assembly Speaker Appointments
    - Sushant Bandarpalle, DO, Chief Medical Officer and Physician, St. John's Community Health
    - Katherine Flores, MD, Family Physician
    - Judith Liu, RN, MSN, United Nurses Association of California Union of Healthcare Professionals
- Senate Rules Committee Appointments
    - Catherine Kennedy, RN, California Nurses Association
    - Kimberly Perris, DNP, MSN, RN, CNL, PHN, DNP Program Director, University of San Francisco School of Nursing and Health Professions

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- Vernita Todd, Vice President and Chief Strategy Officer, San Ysidro Health (Vice Chair)

- State Government Appointments
  - Libby Abbott, MPH, MIA, Deputy Director, Healthcare and Workforce Development, Department of Health Care Access and Information
  - Rehman Attar, MPH, Director of Healthcare and Workforce Development, Representative of the California State University
  - Anthony Cordova, MBA, Vice Chancellor Workforce and Economic Development, California Community College Chancellor's Office
  - Michael Freeman, MBA, Assistant Deputy Director, California Department of Health Care Services
  - Deena Shin McRae, MD, Associate Vice President, University of California Office of the President
  - Abby Snay, M.Ed., Deputy Secretary, Future of Work, California Labor, and Workforce Development Agency

2.4 Meeting Cadence & Public Engagement

Council meetings are held three times a year. At its meetings, the Council reviews statewide health workforce issues, explores data presented by HCAI, and gathers input from Council members. HCAI posts all meeting materials on the HCAI Council webpage so that the public can follow the topics discussed and remain informed about the Council's work. Meeting transcripts and recordings are available upon request.

Members of the public can engage with the Council by giving oral comments during the public comment period at Council meetings and/or submitting written input to HWETCouncil@hcai.ca.gov. Community members, organizations, and workforce partners can share observations or raise issues relevant to the Council's work. Public participation remains an important part of the Council's work.

3. Annual Council Report

In 2025, the Council explored options for taking a more active role in shaping statewide health workforce policy and ultimately aligned on a proposal to issue an annual Council report. Beginning in 2027, the Council will aim to post annual reports on the Council webpage by the month of November, each calendar year.

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The annual report provides a formal structure for synthesizing the Council's previous year of discussions, insights, and priorities. It summarizes the workforce issues examined during Council meetings and members' perspectives on priority topics and potential solutions. The report does not issue formal recommendations or positions on behalf of Council members or the organizations that they represent.

The report provides a structured way to communicate key workforce considerations to state leadership, lawmakers and community partners. Through this process, the Council aims to advance statewide health workforce strategies that are informed by timely, policy-relevant, and evidence-informed insights.

4. 2025-2026 Priority Health Workforce Topics and Insights

The priority health workforce areas reflect presentations and discussions at the October 2025, March 2026, and July 2026 Council meetings.

4.1 Behavioral Health Workforce for Older Adults

The October 15-16, 2025 Council meeting discussed behavioral health workforce needs for older adults. The meeting minutes are available here.

Landscape and Issue Overview

Rosalind de Lisser, PhD, FNP, PMHNP, of the University of California, San Francisco presented a landscape analysis of behavioral health and California's aging adult (65 and older) population. Key insights from this presentation include:

Health workforce needs will vary across counties as the older adult population grows: Older adults are projected to comprise one in four Californians by 2040, compared with one in seven in 2000.[1] Projected population growth varies across counties. The state average for increases in the population of adults 65 and older is 60%. Counties in Northern California are projected to experience little to no growth, while Central Valley counties are expected to see growth of approximately 40%.[2] Southern California counties are projected to experience growth around the state average (60%), while Bay Area counties are expected to see the highest rates of growth in the 70 to 80 percent range.[3]

[1] Public Policy Institute of California (2025). California's Aging Population Anticipating Dramatic Growth in the Number of Older Californians. https://www.ppic.org/publication/californias-aging-population/
[2] Public Policy Institute of California (2025). California's Aging Population Anticipating Dramatic Growth in the Number of Older Californians. https://www.ppic.org/publication/californias-aging-population/
[3] Public Policy Institute of California (2025). California's Aging Population Anticipating Dramatic Growth in the Number of Older Californians. https://www.ppic.org/publication/californias-aging-population/

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Implications of demographic change for workforce diversity: The share of California's older adults who are White non-Hispanic is projected to decline from 68 percent in 2000 to 40 percent in 2040, while the Hispanic share is projected to increase from 15 percent to 30 percent and the Asian share from 11 percent to 21 percent.[4] By 2040, non-White groups combined will outnumber White groups for the first time in California's history. The health workforce will need to meet the changing cultural and linguistic needs of the population. In addition, survey results show disparities in behavioral health access and outcomes for LGBTQIA+ older adults, highlighting the importance of a workforce equipped to provide culturally responsive care.[5] [6]

Behavioral health issues and access among older adults: Behavioral health needs among older adults include depression, substance use disorders, dementia and other neurocognitive disorders, and trauma-related conditions. Reports from the California Health Care Almanac stated that in 2021, one percent of Californian adults, or approximately 70,000 people age 65 and older, met criteria for serious mental illness.[7] Access to behavioral health care can be affected by stigma, ageism, transportation and cost barriers, social isolation, housing instability, and limited availability of culturally and linguistic responsive care.[8]

Behavioral health workforce serving older adults: The workforce serving older adults extends beyond licensed behavioral health providers to include In-Home Support Services (IHSS) providers, informal caregivers, peers, community health workers, and other non-licensed workforce roles. Challenges across workforce roles include shortages, geographic maldistribution, recruitment and retention difficulties, and gaps in geriatric behavioral health training. In addition, an aging workforce will contribute to future workforce gaps.

Broader systems challenges: Challenges outside of HCAI's scope include burnout, compensation, and limited supervision.

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[4] California Department of Aging (2024). Fact Sheet Older Adult Demographics. https://aging.ca.gov/download.ashx?lE0rcNUV0zb4L9ijwWImXw%3D%3D

[5] California Department of Aging (2024). LGBTQIA+ Older Adult Survey Report. https://aging.ca.gov/Survey_of_LGBTQIA/

[6] Center for the Advanced Study of Aging Services, University of California Berkeley (2024). LGBTQ+ Aging Focus Group Project: Aging with Pride and Authenticity: Challenges and Supports for Underrepresented LGBTQIA+ Older Adults. https://casas.berkeley.edu/research/project-spotlight/

[7] California Health Care Foundation, California Health Care Almanac, Mental Health (July 2022). Mental Health in California, 2022: Waiting for Care

[8] Jones, K. F., Beiting, K. J., Ari, M., Lau-Ng, R., Landi, A. J., Kelly, L., ... & Han, B. H. (2023). Age-friendly care for older adults with substance use disorder. The Lancet Healthy Longevity, 4(10), e531-e532 https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(23)00174-5/fulltext

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Panel Discussion

A panel discussion facilitated by Hovik Khosrovian, Senior Policy Advisor at HCAI, discussed behavioral health workforce needs for older adults and strategies to address service and access gaps. This panel included representatives from the California Department of Aging, Self-Help for the Elderly, and Choice in Aging. Panelists highlighted challenges and considerations.

- **Behavioral health workforce for older adults challenges**: Ageism and people choosing not to focus on working with the older adult population are critical barriers. It is difficult to recruit culturally and linguistically diverse providers, engage older adults experiencing isolation and stigma, and sustain community-based services with limited resources.
- **Behavioral health workforce for older adults considerations**: There are opportunities to use the existing aging services network, trusted community organizations, peers, wellness coaches, and other non-clinical roles to identify needs and provide support. Partnerships with community organizations, educational institutions, and government agencies are essential. For the existing workforce, earlier exposure to caring for older adults would help, and creating more opportunities to retrain or expand skills of the existing workforce.

Summary Themes and Council Members' Insights

Following the presentation and the panel discussion, Council members discussed approaches to developing the workforce to meet the behavioral health needs of California's growing older adult population.

- **Expand existing workforce capacity:** Strengthen geriatric workforce capacity by retaining and upskilling existing workers rather than relying only on developing new training programs. Suggestions included incorporating geriatric care into existing professional training, such as interdisciplinary training and team-based care models, and supporting credit for prior learning to accelerate workforce entry for individuals with relevant experience.
- **Broaden workforce roles and training:** There are opportunities to build behavioral health capacity across a broader range of roles and settings. For example, expanding peer and wellness coach roles could better serve older adult populations.
- **Improve workforce responsiveness to community needs:** California needs a workforce that can respond to the cultural and social needs of California's diverse older adult population. Community-based organizations, peer roles, and other

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trusted partners are potential avenues for expanding access to more culturally responsive support.

- **Strengthen data to support workforce development:** Filling in data gaps that could inform workforce development efforts. More complete data is needed about workforce supply and the effectiveness of workforce investments, particularly for roles that may be less visible in traditional workforce data, including IHSS workers.

4.2 Maternal Health Workforce

The Council discussed maternal health workforce needs and challenges on March 4, 2026. The meeting minutes are available here.

Landscape and Issue Overview

Ariana Thompson-Lastad, PhD, of the University of California, San Francisco, presented a landscape analysis of California's maternal health workforce. Key insights from this presentation include:

The current state of births in California: The state accounted for approximately one in ten births in the United States in 2021. Approximately 98 percent of those births occurred in hospitals, while the remaining 2 percent occurred outside hospitals, primarily at home or in freestanding birth centers. Findings reflect that California has lower pregnancy-related death rates compared to the national average, but significant racial disparities persist, with Black individuals experiencing higher rates of maternal morbidity. Birth rates and access to care vary across regions, race and ethnicity, income, and insurance type.[9]

The role of midwives: Midwives are underutilized in the maternal health workforce despite evidence linking midwifery care with improved outcomes. Midwives attend approximately 14 percent of births in California[10] in comparison to approximately 30 to 70 percent of births in comparable wealthy countries.[11] California has approximately three midwives per 1,000 births,[12] compared with 30 to 70 per 1,000 births in comparable countries. [13]

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[9] California Health Care Foundation: Maternity Care in California, 2023: Delivering the Data
[10] California Health Care Foundation: California's Midwife Workforce Snapshot, 2024
[11] American Journal of Obstetrics and Gynecology: Midwifery care during labor and birth in the United States
[12] California Healthcare Foundation: California's Midwife Workforce: Who Midwives Are and Who They Serve
[13] American Journal of Obstetrics & Gynecology: Midwifery care during labor and birth in the United States - American Journal of Obstetrics & Gynecology

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Facility closures: Closures further contribute to geographic access challenges. Since 2020, approximately 40 percent of freestanding birth centers have closed, while more than 46 California hospitals have closed labor and delivery units since 2012. [14] These closures have a disproportionate impact on rural and Latino communities. In Los Angeles County, 16 hospital labor and delivery units closed between 2014 and 2023, and more than 26,500 people sought birth care in emergency departments. [15]

Postpartum care: The United States generally measures postpartum care through a single visit, which most individuals receive. In comparison, other countries use multiple postpartum visits to measure care quality. In California, Medi-Cal and uninsured individuals are less likely to receive their single postpartum visit than those with private insurance. [16]These differences highlight the importance of considering not only whether postpartum care occurs, but also whether the existing system provides sufficient opportunities to identify and address postpartum health needs in just one postpartum visit.

Geographic and workforce distribution challenges: The number of active obstetrician/gynecologists relative to live births, varied across the state. The Greater Bay Area, Orange County, and Sacramento Area were above the state average, while the San Joaquin Valley, Inland Empire, and Northern and Sierra regions were below the state average.[17] Nine California counties: Modoc, Trinity, Glenn, Colusa, Sierra, Yuba, Mono, Alpine, and Mariposa, were identified as having no obstetrician-gynecologists. Half of these counties have midwives, while one or two have family practice physicians providing maternity care. Certified nurse-midwives and family practice physicians are more likely than obstetricians to practice in rural areas and Health Professional Shortage Areas. [18]

Panel Discussion

A panel discussion facilitated by Hovik Khosrovian, Senior Policy Advisor at HCAI, further explored strategies to build and sustain California's maternal health workforce. This panel consisted of participants from the following organizations: California Coalition for Black Birth Justice, University of California San Francisco, Cerro Coso Community College, and Partnership Health Plan. Panelists highlighted challenges and considerations.

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[14] Cal Matters: Why midwives say they can't stay in business in California - CalMatters
[15] The Guardian: As LA maternity wards close, patients are giving birth in ERs:
[16] California Health Care Foundation: Maternity Care in California, 2023: Delivering the Data
[17] California Health Care Foundation: Maternity Care in California, 2023: Delivering the Data
[18] California Health Care Foundation: California's Midwife Workforce Snapshot, 2024

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- **Maternal health workforce challenges**: The concentration of providers in urban areas, and closures of obstetrics units of Critical Access Hospitals pose significant challenges for rural and frontier communities. In addition, recruitment of students, availability of clinical placements and preceptors, and the financial and logistical barriers associated with training are ongoing workforce development challenges.
- **Maternal health workforce development considerations**: Considerations include strengthening maternal workforce pipelines, expanding pathways through community colleges and community-based roles, increasing workforce diversity, strengthening data about maternal health providers, supporting rural and high need communities, and developing strategies that improve coordination across maternal health professions.
- **Broader systems challenges**: Several barriers, particularly reimbursement, facility closures, and broader system level issues, extend beyond HCAI's direct authority but remain important context for maternal health workforce planning.

Summary Themes and Council Members' Insights

Following the presentation and the panel discussion, Council members discussed approaches to developing the workforce to meet the maternal health needs of California's population.

- **Expand workforce pathways through community-based educational programs:** Community colleges and entry level maternal health roles are potential opportunities to strengthen the workforce pipeline. Consider the potential to create pathways from doula roles into nursing and midwifery, to use community colleges to provide training for doulas and lactation consultants, as well as opportunities to develop joint associate and bachelor's degree pathways.
- **Increase training and clinical placement capacity:** Limited clinical placements and preceptors are significant barriers to expanding maternal health training programs. Expanding maternal health workforce programs will require additional strategies to create clinical experiences, particularly in communities where training sites are already limited.
- **Strengthen workforce diversity and culturally responsive care:** To develop a workforce that reflects the communities it serves, community partnerships are essential. Communities can recruit a "home-grown" workforce of individuals who understand local needs and cultural factors. Workforce diversity includes both

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racial diversity and lived experience concordance between providers and the communities they serve.

- **Improve coordination across maternal health professions:** Coordination is needed among doulas, midwives, family physicians, obstetricians, and other maternal health providers. There are opportunities for integrated training and clearer understanding of provider roles to strengthen team-based maternal health care.
- **Strengthen data to support maternal health workforce planning:** Council members identified several areas where additional workforce data could improve planning and resource allocation. HCAI's planned maternal health supply and demand model for 2027 provides an opportunity to address some of these data gaps and better target workforce investments by identifying regions with the most severe workforce gaps.

Address broader system conditions: Reimbursement, facility closures, and systemic racism are broader structural issues affecting maternal health access that extend beyond HCAI's direct authority.

4.3 Primary Care Team Workforce

The Council discussed primary care team workforce needs and challenges at its July 22-23, 2026, meeting. After the minutes are approved at the November 2026 meeting, the link will be available [here].

Landscape and Issue Overview

Diane Rittenhouse, Senior Fellow at Mathematica, and Janet Coffman, Professor of Health Policy at UCSF presented findings from their California Health Care Foundation report about strengthening California's primary care team workforce. With team-based primary care, an interdisciplinary group of people is responsible for the health of a panel of patients.

Primary care team members: Primary care teams consist of clinicians and clinical support staff. Clinicians include physicians, advanced practice providers (nurse practitioners and physician assistants), nurses (registered nurses and licensed vocational nurses), behavioral health clinicians (licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and licensed psychologists), and pharmacists. Clinical support staff are medical assistants and community health workers.

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Advantages of team-based primary care: Team-based care is a cost-effective model that allows qualified team members to share clinical tasks. Team-based care improves both clinician and staff experience and can reduce burnout. Racial, ethnic, and language diversity on primary care teams enhances communication, trust and care quality for patients. Teams promote proactive care and population management. While some team members care for patients during visits, others can respond to patient messages and conduct proactive outreach to address the unmet chronic and preventive service needs of their patients.

Geographic distribution challenges: Primary care team members are unevenly distributed across the state. More than 25% of Californians live in federally designated Primary Care Health Professional Shortage Areas, with regions such as the Inland Empire, Northern/Sierra, and San Joaquin Valley experiencing long-standing and persistent shortfalls.

Workforce demographics: The primary care workforce is aging, and younger clinicians are less likely to enter primary care than in the past. Licensed team members do not reflect California's racial, ethnic, or linguistic diversity. Physicians, pharmacists, and behavioral health clinicians remain disproportionately White and English speaking. People who are Latino/x, Black and Asian are underrepresented in many licensed roles, and linguistic diversity is limited.

Training needs: Training for primary care team members is tailored for specific disciplines without many opportunities for interprofessional learning. In this current practice landscape, many students graduate without exposure to high-functioning, team-based care environments.

Areas for action: Four of the report recommendations are relevant to HCAI: workforce data, supply, education and training, and retention. The report's specific recommendations for HCAI include:

- **Workforce Data**: Collect comprehensive workforce data for all members of the primary care team, including clinical support staff such as community health workers and medical assistants, and information about time spent practicing primary care and rates at which new graduates work in primary care practices.
- **Supply**: Implement evidence-based policies to ensure California has enough primary care team members overall, improve the geographic distribution of primary care team members, and reflect the racial/ethnic and linguistic diversity of California's population.

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- **Education and training**: Ensure that all members of the primary care team receive high-quality education and training in interprofessional, team-based primary care.
- **Retention**: Invest in career ladder programs and upskilling initiatives (e.g. supporting medical assistants to nursing training pathways and expanded clinical and leadership roles for LVNs and RNs).[19]

HCAI's response to the report's recommendations

HCAI discussed how current and planned activities align with the report's recommendations and where there are implementation limitations.

- HCAI is making improvements to licensure surveys, developing a supply and demand model for primary care workforce, and planning updates to workforce reporting and public data tools.
- HCAI currently uses shortage designations, rural workforce incentives, and equity-focused scholarship scoring for grant awards.
- HCAI will incorporate primary care team professions into its primary care supply and demand model.
- HCAI is planning to better target workforce investments, track outcomes, and align primary care pathways. In addition, the California Rural Health Transformation program's investments will expand clinical placements and support preceptors in rural areas, and includes planned interprofessional training, primary care curriculum expectations, and workforce placement tracking.

Panel Discussion

A panel discussion facilitated by Diane Rittenhouse, Senior Fellow at Mathematica, further explored strategies to build and sustain California's primary care team workforce. This panel consisted of participants from the following organizations: Betty Irene Moore School of Nursing at UC Davis, Grove by Sutter Health, and USC Alfred E. Mann School of Pharmacy and Pharmaceutical Sciences. Panelists highlighted primary care team workforce challenges and considerations.

- **Primary care team workforce development challenges**: Physicians and other health professionals are often unprepared for team-based care because it is not consistently integrated into medical education and residency training.

[19] California Health Care Foundation: Strengthening-Californias-Primary-Care-Team-Workforce.pdf

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- **Primary care team workforce development opportunities**: Building trust among professions, developing shared skills, and using simulation to help practitioners understand each team member's role. Integrating pharmacists into team-based care to support high-risk patients.
- **Broader systems challenges outside of HCAI's scope**: Establish infrastructure to sustain team-based models and leverage value-based payment to encourage adoption of team-based care.

Summary Themes and Council Members' Insights

Following the presentation and the panel discussion, Council members discussed approaches to developing the workforce to meet the primary care team workforce needs of California's population.

- **Strengthening the primary care team:** Strengthening primary care requires planning for the full range of professionals involved in care delivery. There are opportunities to strengthen team-based primary care within nursing education, residency programs, and training programs for social workers and other behavioral health professionals. Consider including oral health providers in HCAI's definition of the primary care team. Dental care can serve as an entry point to the broader health system for people who may not otherwise access care.
- **Connecting workforce investments to primary care outcomes:** Outcomes data is essential to understanding whether workforce investments are expanding the intended primary care team workforce and reaching communities with the greatest need. Tracking residency outcomes will show which graduates ultimately enter primary care.
- **Using workforce data to target primary care investments:** Develop data and planning tools to identify gaps in the primary care team workforce at a level useful for policy and resource allocation.
- **Address broader systems challenges:** Issues that extend beyond HCAI's direct authority impact the primary care team workforce. Current payment models can prioritize productivity over interdisciplinary care. Payment needs to be better aligned with team-based and value-based care. Further, enabling health professionals to practice at the top of their license would expand access and capacity.

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5. Look Ahead: Strengthening the Council's Role in Health Workforce Policy

5.1 Strategic Priorities for the Coming Year

The Council's priorities support HCAI's health workforce approach. The Council will continue to focus on HCAI's five workforce areas: behavioral health, maternal health, nursing, primary care, oral health and the cross-cutting goal of furthering equity in HCAI's workforce programs.

5.2 Proposed Agenda Themes

Each Council meeting will explore a different area of health workforce. For 2027, the plan is to focus on primary care in March, behavioral health in July, and maternal health in November. The Council will explore specific questions and issues in these three areas and provide further input on HCAI's workforce development strategies and supply and demand modeling for these areas.

5.3 Meeting Schedule

All Council meetings will be in person at HCAI's office: 2020 West El Camino Avenue, Sacramento, California. Council meetings are for two days. Day One typically includes routine updates and action items. Day Two is when the Council dives deeper into one or more of the priority focus areas.

The 2027 meeting dates are: March 17 and 18, 2027, July 21 and 22, 2027, and November 3 and 4, 2027. Meeting materials will be posted on the Council webpage.

Appendices

- Health Workforce Research Data Center Annual Report to the Legislature – January 2026
- Supply and Demand Modeling for California's Behavioral Health Workforce
- Behavioral Health and the Aging Population Presentation – October 2025 Council Meeting
- Maternal Health and the Maternal Health Workforce Landscape Presentation – March 2026 Council Meeting
- Strengthening California's Primary Care Team Workforce Presentation - July 2026 Council Meeting