



# The Affordable Care Act & Racial and Ethnic Health Equity Series

## Report No. 3 Enhancing and Diversifying the Nation's Health Care Workforce

**Executive Summary**

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Dennis P. Andrulis, PhD, MPH  
Nadia J. Siddiqui, MPH  
Maria R. Cooper, MA  
Lauren R. Jahnke, MPAff

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# Executive Summary

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## I. Introduction

Research to date reveals that the lack of diversity in the health care workforce is a significant challenge to meeting the needs of racially and ethnically diverse populations who experience clear and persistent disparities in health and health care. There is emerging consensus that a health care workforce that is reflective of the patients it serves is essential for high quality and culturally competent care. However, much work still needs to be done to achieve the goal. As recent data confirm, the composition of the health care workforce is not reflective of the changing and diversifying population dynamics and many diverse population groups (e.g., African Americans, Hispanics, and Native Americans) remain significantly under-represented in the health professions.

With the advent of health care reform, renewed opportunities for enhancing and expanding existing programs as well as explicitly addressing workforce diversity have emerged. The ACA includes numerous provisions that reauthorize various programs under Titles VII and VIII of the *Public Health Service Act* as well as authorize several new initiatives to support a diverse and culturally competent workforce. Understanding the status and progress of such provisions in terms of support, funding, and implementation is critical to assuring this priority is fully realized to advance and achieve health equity.

The purpose of this report is to provide a point-in-time status and progress update on the implementation of the ACA's provisions for supporting a more diverse and culturally competent health care workforce. As such, it describes the opportunities presented by the new law, along with challenges, lessons learned, and potential next steps for successfully implementing major provisions of the law critical for advancing diversity and equity in health care. Embedded within this report are emerging programs, best practices, and resources that address workforce diversity, cultural competency training, and related efforts.

## II. Methodology

We identified and monitored 19 provisions which explicitly mention or have significant relevance for advancing racial and ethnic health equity. The provisions were organized into five topic areas:

- A. Increasing supply and diversity in the health professions;
- B. Workforce support for the health care safety net;
- C. Cultural competency education and training;
- D. Health care workforce investment in academic settings; and
- E. Health workforce evaluation and assessment.

For each topic area, we reviewed: peer-reviewed literature and national reports; emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. Findings on progress, opportunities, and challenges identified through our review were synthesized with information and perspectives obtained through a series of key informant interviews with numerous thought leaders, experts, and community advocates in the field.

### III. Implementation Progress

This section describes the implementation progress, opportunities, challenges, and road ahead for 19 provisions in the ACA critical to advancing racial and ethnic health equity. These provisions are discussed in context of the aforementioned five topic areas.

#### A. Increasing Supply and Diversity in the Health Professions

Despite changing population dynamics, many racial and ethnic groups (e.g., African Americans, Hispanics/Latinos, and Native Americans) remain underrepresented in the health professions. The Institute of Medicine's seminal report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, sought to bring attention to this important issue, underscoring that "increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits." Here we summarize the ACA's provisions and progress in addressing diversity across a range of health professions.

- **Physicians and Physician Assistants.** The ACA reauthorizes the Primary Care Training and Enhancement Program to support training in family medicine, general internal medicine, and general pediatrics. The law authorizes \$125 million in funding for FY 2010, along with such sums as necessary for FYs 2011-2014, of which 15% is designated for the Physician Assistant Training Program. Funded for more than the ACA had intended, these programs are training an estimated 889 new physicians and 700 new physician assistants by 2015. A review of funded programs indicates that at least 40% explicitly acknowledge that they will expand their programs to include more racially and ethnically diverse trainees or address cultural competency. The large majority of these programs have created opportunities for primary care residents to serve in underserved communities, either through their own institution or in partnership with health centers, community hospitals, and other community-based health care settings. However, there is widespread acknowledgement that the expansion funded through this provision is only a small portion of what will be needed to adequately meet the nation's primary care workforce needs.
- **Dentists.** A new grants program for training in general, pediatric, and public health dentistry is established by the ACA. Among other criteria, priority for grant awards is given to entities that have a record of training individuals from underrepresented and disadvantaged groups that provide training in "cultural competency and health literacy," and have a record of placing trained professionals in settings experiencing health disparities. While the ACA explicitly authorized \$30 million in FY 2010 and such sums as necessary for FYs 2011-2014, a total of \$71 million has been funded between FYs 2010-2013, with another \$21 million requested for FY 2014. A review of funded programs reveals that many aim to address health disparities by merging didactic learning in public health dentistry with training in community settings, such as health centers, to heighten practical knowledge and application of cultural competency and health literacy principles.
- **Nurses.** The ACA modifies the original Nursing Workforce Diversity Program "to include advanced education preparation, stipends for diploma or associate degree nurses to enter

a bridge or degree completion program, and student scholarships or stipends for accelerated nursing degree program students.” In 2011, HHS awarded \$3.6 million to 11 Nursing Workforce Diversity grantees. A review of grantee programs reveals that, by their very intent, all incorporate a focus on diverse, underrepresented, and disadvantaged nursing students. This goal is achieved through activities such as pipeline programs, improving nursing retention in college, financial stipends to increase graduation rates, and enhancing existing cultural competency and cultural awareness strategies. In 2011, HHS also awarded other grants for enhancing the nursing workforce generally, some of which also address diversity and equity. For example, roughly 40% Nurse Education, Practice, Quality and Retention program grantees explicitly mention that they address health professions diversity or cultural competency.

- ***Mental Health Providers.*** The ACA authorizes grant funding to academic institutions or professional training programs to recruit students into education programs for social work and psychology, programs that are developing or expanding internships or field placement opportunities in child and adolescent mental health, and training programs for paraprofessional child and adolescent mental health workers. Diversity in race, ethnicity, culture, geography, language, religion, socioeconomic status, gender, or sexual orientation is among criteria for eligibility for a grant award. In September 2012, HHS awarded nearly \$10 million to 24 graduate social work and psychology academic institutions. At least 10 grantees cite that they explicitly address racial and ethnic diversity. These grantees describe a number of strategies to enhance training for their students and interns with a specific focus on recognizing and addressing mental health needs of individuals in professional shortage areas.
- ***Long Term Care Providers.*** The law funds a novel program that provides grants to higher education institutions for the training of direct care workers. While there is not explicit language related to diverse populations, this provision holds promise for advancing the health of such communities as a significant percentage of the direct care workforce is made up racially and ethnically diverse individuals. No funding has been appropriated for this provision, to date. Nonetheless, the development of the direct care workforce and related priorities are being addressed under other funded provisions of the ACA. For example, Section 5507 established demonstration projects for six states which are currently being implemented.
- ***Community Health Workers.*** The ACA establishes a novel grants program to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of Community Health Workers (CHW). This provision has not been funded, although opportunities and priorities for community health workers have been funded through other sections of the ACA, such as Community Transformation Grants (Sec 4201). Many community health worker initiatives being implemented with support beyond the ACA serve as models and best practice examples for successful strategies to reach, engage, and serve diverse patients. A common characteristic of these programs which is essential to caring for underserved communities is a close connection to the target population (whether it be through shared race, ethnicity, language or other experiences). There are several challenges that continue to undermine the CHW workforce. These include, for example, limited funding, uncertainty around sustainability

of funded programs, lack of reimbursement for services provided by CHWs, and limited training standards or certification, among others.

## **B. Workforce Support for the Health Care Safety Net**

While the large majority of workforce provisions discussed in this report have implications for the health care safety net, there are at least three that explicitly target programs within public hospitals, community health centers, and other safety net settings. In this section, we discuss the implementation status, progress, and challenges related to these provisions.

- ***National Health Service Corps.*** The ACA reauthorizes the National Health Service Corps (NHSC) as well as increases the amount of funding for the program by authorizing new dedicated funding in the amount of \$1.5 billion for FYs 2011-2015. Through funding from the ACA, the NHSC has grown approximately three times, training a growing proportion of underrepresented minorities and expanding care to underserved communities. Based on self-reported data by nearly 10,000 NHSC clinicians currently providing care, 13% are African American, 10% are Hispanic, 7% are Asian or Pacific Islander, and 2% are American Indian or Alaska Native. And in FY 2012, African American and Hispanic physicians represented 17% and 16% of the NHSC, respectively, nearly three times their representation in the national physician workforce (6.3% and 5.5%, respectively). And more recently, of the nearly 1,000 NHSC scholars in the pipeline, more than half are minorities (26% Hispanic, 19% African American, 12% Asian or Pacific Islander, and 2% American Indian or Alaska Native).
- ***Graduate Medical Education.*** The law authorizes, beginning July 1, 2011, the conversion of unfilled hospital residency positions under the Graduate Medical Education (GME) program to slots for primary care physicians, giving preference for redistributing slots to states with a low resident physician-to-population ratio or with large numbers of people living in primary care health professional shortage areas. In August 2011, excess slots were redirected to 58 hospitals, 24 of which are located in areas where over half the population is Non-White.
- ***Area Health Education Center.*** The law authorizes \$125 million for each FY 2010-2014 for grants to Area Health Education Centers (AHECs) to support community-based training and education. Awards are available for both the development of new health care workforce educational programs as well as to continue or improve upon existing AHECs. Despite being recognized as the only national program to recruit and support diverse and disadvantaged students throughout their health careers pathway, the AHEC program received less than one-fourth of the funding authorized under the ACA over the past four years. This poses significant challenges for a program that is key to fostering a diverse health care workforce.

## **C. Cultural Competency Education and Training**

There is considerable evidence that cultural competency training improves intermediate outcomes such as knowledge, attitudes, and skills of health professionals along with patient-provider interactions and patient satisfaction. Less evidence exists on its link to health outcomes. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come

together in a system, agency, or among professionals that enables effective work in cross-cultural situations. As summarized below, three provisions in the ACA explicitly seek to support and advance cultural competency in health care.

- ***Cultural Competency in Pain Care.*** The ACA authorizes research, treatment, and education to further enhance and improve pain care management. Specifically, the ACA charges NIH to expand its aggressive research through the Pain Consortium, and it also authorizes HRSA to establish a new grants program for training in pain care. An explicit requirement of this program is that grantees include information and education on cultural, linguistic, literacy, geographic, and other barriers to pain care in underserved populations. While the HRSA program has not received funding, the Pain Consortium has made progress as evidenced by its meetings and a report released in 2011, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. The report highlights several aspects of racial and ethnic disparities in pain care. The report also explicitly cites that “enhanced continuing education and training are needed for health care professionals to address gaps in knowledge and competencies related to pain assessment and management, cultural attitudes about pain.”
- ***Cultural Competency in Geriatric and Long Term Care.*** The law authorizes grants for new demonstration projects to develop core training competencies and certification programs for personal or home care aides. In September 2010, HRSA awarded grants to six states (Massachusetts, California, Iowa, Michigan, North Carolina, and Maine) under the Personal and Home Care Aide State Training (PHCAST) Grant Program of the ACA. Grants aim to strengthen the direct care workforce by defining core competencies for direct care workers and supporting training development to further improve the standardization of such competencies. In order to target a diverse population during recruitment, states are also partnering with community colleges, current employers of direct care workers as well as workforce investment boards. All states appear to have made progress toward addressing the required competency of “understanding diversity and cultural competence.”
- ***Model Cultural Competency Curricula.*** The ACA authorizes a grants program for the purpose of the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities and aptitude for working with individuals with disabilities. As of this writing, this provision has not received funding under the ACA. However, this is an important priority for advancing the field of cultural competence.

#### **D. Health Workforce Evaluation and Assessment**

As the ACA’s coverage expansions and novel practice models are implemented, it is critical to gather and learn from concrete workforce data and analysis to make informed and accurate decisions about healthcare workforce needs and challenges, including those related to serving a growing diverse patient population. In this section, we highlight two important provisions that support improved mechanisms to evaluate and assess workforce needs.

- ***National Health Care Workforce Commission.*** The ACA authorizes the establishment of a new entity to coordinate healthcare workforce activities across federal agencies,

evaluate workforce demands and education needs, identify and propose solutions to current and future workforce challenges, and support novel programs to improve health care professions education. While a 15-member Commission was announced in September 2010, Congress has not appropriated funding for this provision as of this writing.

- ***State Health Care Workforce Development Grants.*** The ACA establishes a competitive, HRSA-administered grant program under which 25 states were awarded planning grants and 1 state received an implementation grant. In FY 2010, \$6 million was awarded from the Prevention and Public Health Fund to implement these grants. Such sums as necessary were authorized for the following years and no further funding has been appropriated. The overall goal described by grantees is to gather data and information for planning activities to create a comprehensive plan to address health care workforce shortages. Of 25 grantees, 8 outline explicit goals with a focus on immigrants, diverse, or vulnerable populations, or to reduce health disparities. Virginia, the single implementation grantee, describes goals related to cultural competence.

## **E. Health Care Workforce Investment in Academic Settings**

Initiatives to improve minority enrollment implemented at the college and graduate levels of education have shown promising results in increasing diversity in the health professions. The ACA includes at least three provisions intended to support and strengthen these and other programs at academic settings to ensure the health care workforce is more reflective of the nation's diverse patients and families.

- ***Historically Black Colleges and Universities (HBCUs) & Minority-Serving Institutions.*** The health care reform law amends the Higher Education Act by extending the authority to award funding to HBCUs and other minority-serving institutions through 2019. Mandatory funding for FYs 2008-2019 is available in the amount of \$255 million. Questions remain as to whether the increased funding from the ACA is sufficient to alleviate concerns around sustainability of minority-serving institutions. Distributed among more than 100 universities and colleges, the annual funding authorized through the law is relatively modest. Since HBCUs are critical for the educational achievements of many African Americans from college through post-graduate studies, they are an important component of ensuring a diverse healthcare workforce. Despite this promise, however, recent studies suggest that HBCUs are not playing a large enough role in educating African American health professionals. While HBCUs saw a modest increase in the graduation of African American practitioners between 2000 and 2008, this increase did not keep pace with growing need or with graduation of African Americans from comparable programs at White institutions.
- ***Centers of Excellence (COEs).*** The ACA authorizes \$50 million for each FY 2010-2015 for COEs, a federal program to enhance training opportunities for minority students and faculty administered by HRSA and originally authorized under Title VII of the *Public Health Service Act*. Over the past four years, COEs have received less than half of the funding authorized by the ACA. A review of grantees between FYs 2010-2012 reveals that 18 explicitly target Hispanics or Latinos; 4 target African Americans; 5 target Native Americans; and 12 target minorities in general (i.e., more than one racial/ethnic group). A programmatic review revealed that several institutions are adopting common strategies

and practices to train and prepare a diverse health care workforce. For example, to recruit, train, and retain minority students, many programs are increasing the pool of qualified applicants through pipeline and outreach programs designed to inspire students in diverse settings early on in their education to pursue health professions careers. Several programs are also offering cultural competency training through diverse clinical experiences in community health settings and are also committed to increasing diversity among faculty members.

- ***Health Care Professions Training for Diversity.*** The law reauthorizes two key programs for health care professions training among underrepresented minorities. First, the ACA reauthorizes the Scholarships for Disadvantaged Students (SDS) program, allocating \$51 million in FY 2010, and such sums as necessary for FYs 2011-2014. This program funds scholarships for disadvantaged students who commit to working in medically underserved areas. In FY 2010, this program received \$49 million, with appropriations declining each year to \$44 million in FY 2013. Secondly, the ACA reauthorizes the Health Careers Opportunity Program (HCOP), allocating \$60 million in FY 2010 with such sums as necessary for FYs 2011-2014. The goal of HCOP is to support individuals from disadvantaged backgrounds in entering and graduating from health professions programs. In FY 2010, HCOP received just over one-third of authorized funding (i.e., \$22 million), with funding declining each year to just \$14 million in FY 2013. Despite studies that show the benefits of tailored enrollment and retention programs for minority students, programs such as SDS and HCOP have been declining in support over the years. Though the ACA showed significant promise in changing this trend by authorizing the highest level of funding since 2005 for HCOP, for example, actual appropriations were far less.

#### **IV. Renewed Opportunities and Remaining Challenges for the Health Care Workforce**

Among other equity objectives, the ACA is committed to supporting and expanding the nation's health care workforce, including enhancing efforts to ensure providers are more representative of the populations they serve, are located in underserved areas, and possess skills to provide culturally and linguistically competent care. The ACA reauthorizes and expands a number of programs originally authorized under Titles VII and VIII of the *Public Health Service Act*, giving preference to, in many cases, underrepresented minorities and services provided in traditionally underserved, diverse communities. It also authorizes a series of novel workforce initiatives which offer the potential for further strengthening the health care workforce. Despite this momentum, these efforts may not be sufficient to match increases in demand expected from the growth in newly insured populations following the operation of health insurance exchanges and state expansions in Medicaid. Thus, while over 19 million racially and ethnically diverse enrollees may be eligible to become newly insured through the exchanges and Medicaid, lack of funding may jeopardize, if not prevent, programs from achieving their goals. Three prominent concerns and challenges exist to addressing workforce needs and diversity in an era of reform.

***Continued Workforce Shortages.*** Significant shortages are expected across the range of health professions—including doctors, nurses, dentists, and others—potentially posing “one of the biggest threats” to the overall success of health care reform. The implementation of the ACA is projected to increase the number of insured by 30 million, over half of whom will be racially and

ethnically diverse individuals. This increase, along with an aging population and general population growth, will boost the demand for medical services. In particular, steep increases in demand for primary care are expected, along with an insufficient supply of providers to match this increase in many regions of the country.

***Limited and Declining Funding for Workforce Diversity Initiatives.*** Funding continues to be an overarching challenge for supporting the health care workforce, generally, and particularly to advance diversity and cultural competency. Among the 19 provisions reviewed in this report, the six explicitly focused on enhancing primary care capacity—such as increasing the number of primary care physicians, physician assistants, and the National Health Service Corps—have seen the greatest level of federal support and commitment. The other nearly dozen provisions have either been severely under-funded or have not received any funding to date. Among critical programs supported in intent by the ACA, but with declining funding are the Centers for Excellence, Scholarships for Disadvantaged Students, and the Health Careers Opportunity program. Minority-serving institutions have also only modestly been supported by the ACA despite the fact that they train a large proportion of minorities in the health professions and generally do not differ in performance of training from other academic institutions.

***Reluctance to Pursue Diversity and Cultural Competency as a Priority.*** Despite considerable progress in addressing health disparities, promoting a diverse and culturally competent health care workforce largely remains a “tough sell”—politically, institutionally, and within the health care system. Reasons are varied and range from diversity and cultural competency not being a priority to limited data and evidence linking such efforts to better outcomes, and a narrow mindset on what diversity essentially means or encompasses. As one key informant noted, “...things that are not a priority, like cultural competency, get put on at the very end...it’s not in the ‘urgent’ category.” Some suggested that the reason cultural competency efforts have not made it to the forefront of priorities is that they are still trying to figure out how to implement broader provisions around delivery and payment reform: “It’s evident that no one understands what is happening broadly. There is no discussion of diversity and cultural competency because they’re still struggling with what broader change means.”

## **V. Moving Forward: Ensuring Diversity and Cultural Competency in the Health Care Workforce**

We identify at least six areas of priority in working to ensure the nation’s workforce is adequate in supply and skill to serve a growing insured, racially and ethnically diverse, and aging population. These priority areas build on common themes we identified through a synthesis of research, policy review, grant opportunities, grantee programs, and interviews around the implementation of the ACA, but also reflect longstanding challenges, needs and roles.

***Expanding scope of practice.*** While the expansion of insurance coverage created through the ACA will open doors to care for millions, great concern remains around the capacity of health care settings and systems to meet the demand for services, especially for diverse, low-income, and other vulnerable populations. As health professionals’ capacity is at the center of this concern, provider organizations and policymakers are seeking ways to expand the pool of qualified practitioners. With the uncertainty around support for many of the ACA’s workforce diversity provisions, expanding scope of practice may offer new opportunities for improving provider capacity and diversity and, in turn improving access for historically underserved populations.

Scope of practice laws establish the legal framework by which medical services are delivered. These laws vary by state. Many states and advocates are looking to scope of practice laws to reassess the role that providers such as advanced practice nurses and physician assistants can play to fill shortages in primary care physicians. Emerging studies show that these providers can generally provide 80% of the care that primary care physicians currently provide and that their care is “as safe and effective as care provided by doctors.”

***Encouraging interdisciplinary team-based care.*** Many of the ACA’s provisions are intended to promote patient-centered care, care coordination, and recognition of health-related circumstances beyond the clinical encounter that may significantly affect treatment adherence and outcomes. Culture and language-specific concerns, community characteristics such as child care, safety, and access to healthy foods, all contribute to the ability to deliver services efficiently and effectively. To integrate these and other priorities into treatment plans, many health care providers are testing and implementing new models of care delivery. One such model is the interdisciplinary team-based approach which involves health professionals beyond physicians—including for example, nurses, social workers, mental health professionals, and others—to coordinate care and other patient services. There are a range of team-based approaches to care, and many of which are part of the Patient-Centered Medical Home model of care. Community health workers, in particular, are seen as important players in team-based care and studies show they contribute to improved access to care, culturally competent chronic disease management, and cost-effectiveness. Team-based approaches which utilize social workers and nurse-practitioners, working alongside primary care physicians have also shown promise particularly in the care of diverse and vulnerable geriatric populations.

***Integrating the Enhanced CLAS Standards into Workforce Programs.*** The release of the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS) in 2013 comes at a pivotal time in efforts to redress longstanding disparities and advance health equity. The CLAS standards are intended to serve as a set of guiding principles for health care organizations in serving diverse populations and were developed, in their original form in 2000, to direct cultural and linguistic competency in health care. The CLAS standards align closely with the ACA’s provisions around workforce and systems capacity including developing a culturally competent workforce, enhancing diversity, and integrating equity priorities into leadership and governance. Examples of the synergy between the ACA and CLAS standards include provisions around workforce support and diversity—e.g., tailoring CLAS Standards 1 and 4 to inform and guide primary care providers, nurses, dental and mental health providers, pain care providers and community health workers on providing culturally and linguistically appropriate care. Standard 3 addresses recruitment of a diverse workforce, an essential goal to achieving health equity that is also underscored in the ACA. Standard 13 describes community partnerships to enhance cultural and linguistic appropriateness of care, a collaboration that many ACA grantees are pursuing in training and education programs. These standards also offer clear opportunity to incorporate elements of culture and language into workforce evaluation, impact, and assessment of ACA-funded programs.

***Evaluating health care workforce diversity needs, capacity, and outcomes.*** With the numbers of insured projected to grow exponentially as the ACA marketplaces and state Medicaid expansions roll out, understanding community, state, and national workforce capacity needs—including creating a more diverse health care workforce—will be especially critical for meeting new demands for services, for reaching historically underserved populations, and ultimately, for

eliminating disparities in access to and quality of care. To this end, evaluating national, state and local strategies to improve workforce diversity across the country as well as those within various disciplines offers the opportunity to determine progress in advancing related goals around: meeting service needs and capacity; recruitment and retention of a diverse workforce; and the effectiveness of cultural competency training and education.

***Enhancing Support for Health Professions Schools and Initiatives Committed to Diversity and Equity.*** Medical and health professions schools, urban and minority-serving universities, community colleges, and health professional societies stand to play an important and central role in attracting and training a diverse health care workforce to meet growing need and demand expected in 2014. Several institutions—such as the Association of American Medical Colleges (AAMC) and urban universities— are beginning to take a leadership role in addressing this priority, while others do not have the support that could reinforce their important role—such as HBCUs and other minority-serving institutions. In all, there is a need to garner more widespread awareness and support for institutions committed to diversity and equity, especially given federal funding through the ACA and otherwise for many efforts is significantly compromised.

***Leveraging Resources Provided through the ACA with Philanthropic Support.*** Given the many financial and ideological challenges to advancing health equity across states and communities, advancing workforce diversity and cultural competency will require supplemental support from other funding avenues—both federally and beyond, including the private sector. Well-funded programs, particularly those with mandatory funding in the ACA, may offer some opportunity. For example, the Patient-Centered Outcomes Research Institute authorized through 2019, may offer an avenue to test the efficacy of cultural competency or other specific workforce diversity initiatives. The private sector may also fill gaps in support for such efforts. In fact, in many communities, national, state, and local philanthropies and foundations are beginning to fill an important void to support the health care workforce, particularly where sufficient support from the ACA and other federal sources has not occurred.

## **VI. Conclusion**

The ACA's numerous provisions reaffirm many existing workforce efforts and intend to advance new initiatives—although not funded or underfunded in some cases—such as creating a national workforce commission, promoting cultural competence education, and supporting underrepresented minorities in health professions. At its core, this emphasis seems to acknowledge the formidable challenges that lie ahead in redressing limitations and disparities of the past affecting access to timely, high quality health care, and assuring that the intent of the new law to truly enfranchise new populations is fulfilled. The related demand for a high quality, diverse workforce will only grow, but will require significant resources and political will. What remains much less clear in moving into the fifth year of ACA implementation is whether the resources and political will to support a broad spectrum of critical programs and actions will be sufficient to meet service goals and people's need