AGENDA ITEM 15

UPDATE ON THE OCCUPATIONAL THERAPY WORKFORCE STUDY CONDUCTED BY THE CALIFORNIA COMMUNITY COLLEGES CHANCELLOR'S OFFICE AND THE AB 2105 REPORT ABOUT APPRENTICESHIPS AND ALTERNATIVE MODELS.

2019 California Occupational Therapy Assistant Workforce Survey

Executive Summary

TBD

Introduction

TBD

About the Survey

In collaboration with the California Board of Occupational Therapy, the California Community College Centers of Excellence conducted the 2019 California Occupational Therapy Assistant Workforce Survey, the only state-level survey specifically focused on the California Occupational Therapy Assistant (OTA) workforce. This survey generates information on the supply of OTAs in California, information that is critical for planning for well-prepared and well-educated OTAs in sufficient numbers to meet the healthcare needs of the state.

In total, over 550 OTAs, representing 16% of all active licensees, completed the survey. Their responses provide insight into the demographic composition of OTAs in California, their education, licensure, job characteristics such as work tasks, scheduling, and compensation, and the future of the OTA profession, including retirement and potential policy changes.[1]

In the report to follow, statements representing the survey responses should be assessed with a degree of caution as the sample may not reflect the universe of OTAs.

Workforce Demographics

To better understand OTA workforce needs, this study compiled information from: (1) a survey of OTAs with active licenses in California, (2) community college training programs, and (3) available labor market data.

In this section, the demographics of the current OTA workforce (licensed OTAs) and the future OTA workforce (community college students in OTA programs) are examined.

OTAs in CA in 2019
3,500 OTA active licenses
2,609 OTAs employed

Size of the OTA Workforce

In 2019, occupational employment data estimates that there are approximately 2,600 OTAs employed in California.[2] Over the same period, according to state licensure data, an estimated 3,500

[1] As of July 2019, the total number of active occupational therapy assistant licensees was 3,500. In July 2019, all 3,500 OTAs with an active license received a letter inviting them to complete an online survey in exchange for a $15 gift card. Participants could submit their responses online until the survey closed in August 2019.

[2] Emsi data, 2019 current workforce

individuals held an active OTA license in the state.[3] This could mean that approximately 900 OTAs are licensed but were not employed as OTAs in California in 2019.

Experience working as OTAs in California

Based on survey responses, a quarter of respondents (25%) were new licensees, having only had their license for up to two years, while 39% have held a license between three and 10 years and 36% have held a license for a decade or more.

Exhibit 1: Years with License

Years with License	#	%
0-2 years	138	25%
3-5 years	127	23%
6-10 years	91	16%
11-20 years	103	18%
21 or more years	100	18%
Totals	559	100%

Demographics

Gender

Information from the OTA survey indicates that females represent a considerably larger proportion of OTAs (82%) than male OTAs (17%) and that a small number of OTAs (1%) are transgender women. This percentage is consistent with data reported by the California Board of Occupational Therapy (79% female)[4].

Exhibit 2: Gender Distribution of OTAs

	#	%
Female	459	82%
Male	96	17%
Transgender Female	3	1%
Total	**559**	**100%**

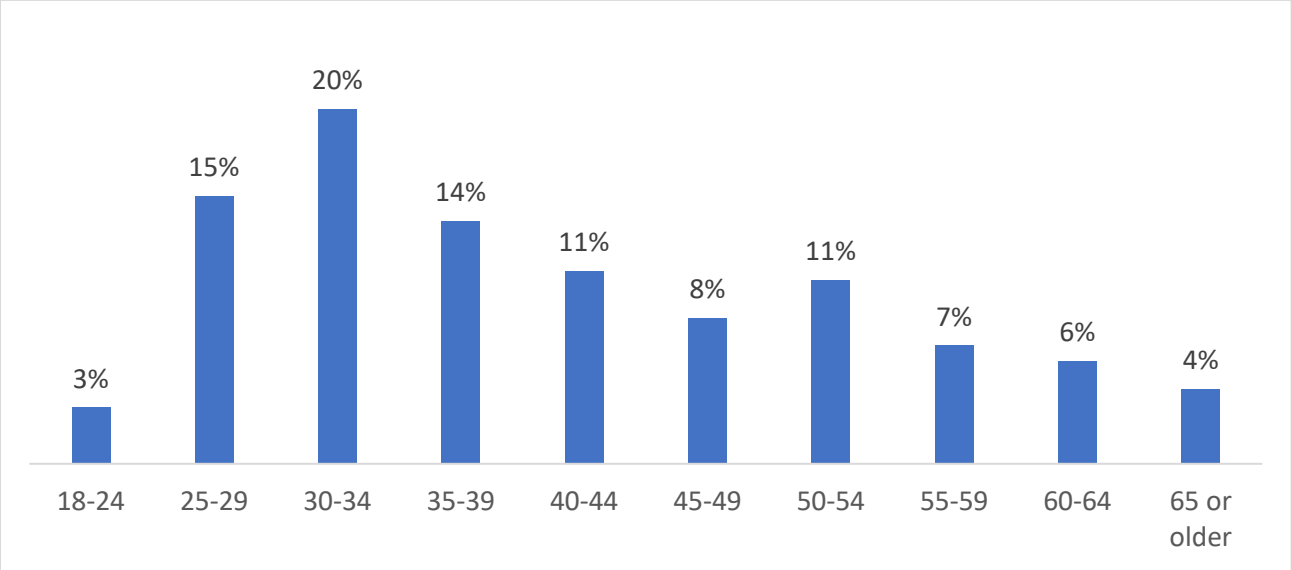
The trend toward more females working as OTAs is mirrored in the current pipeline of students in OTA training programs. In the community college system, 81% of students in the 2018-2019 academic year were female and 17% were male. This gender composition was also consistent with data on the previous three academic years.

[3] License count as of July 2019. Source: California Board of Occupational Therapy.
[4] 2019 data

Age

The age of survey respondents was about equally split with 52% of respondents under the age of 40 and 47% of respondents over age 40. Overall, the population of licensed OTAs average 42 years old. The age group with the greatest number of licensed OTAs is 30-34 year-olds, while the smallest proportions of OTAs are the youngest and the oldest age groups (see Exhibit 3).

Exhibit 3: Age Distribution



As a point of comparison, community college students represent future OTAs that will mostly increase the number in younger OTA age cohorts. Nearly half (46%) of students enrolled in OTA programs in community colleges are between the ages of 25 and 34. The proportion of students just out of high school (ages 20-24) is 19%.

Race/Ethnicity

In the existing workforce, whites comprised 55% of OTA survey respondents while underrepresented minority groups accounted for approximately 45% of respondents (Exhibit 4). In comparison, Census data on the demographic composition of California details that the overall population is led by Hispanic/Latino residents (39%), followed by 37% White (non-Hispanic), Asian (15%), Black/African American (7%) and Other/Two or more races (6%).

Based on these two sets of data, it would seem the OTA workforce is comprised of a higher concentration of White (non-Hispanic) workers than found in the general population. The largest difference in underrepresented minority groups is the share of Hispanic/Latino OTAs (12%) compared to the state's population (39%).[5]

When comparing race/ethnicity across age groups, OTAs over the age of 40 were significantly more likely to be white than respondents under age 40. This suggests that diversification is

[5] Source: US Census Bureau, 2018.

underway, with racial and ethnic minorities becoming better represented in younger age groups. If this trend holds true, it follows that as OTAs retire, the OTA workforce overall should be more racially/ethnically diverse.

The pipeline of students in OTA training programs also seems likely to contribute toward the further diversification of future workers. Students enrolled in OTA training programs during the 2018-19 school year showed the racial and ethnic makeup is majority white (32%), approximately 30% Hispanic, 13% Asian and the remaining 25% other groups.

Exhibit 4: Race/Ethnicity of Surveyed OTAs and California Population

	OTAs		California
	#	%	%
White (non-Hispanic)	305	55%	37%
Asian	106	19%	15%
Hispanic/Latino	68	12%	39%
Black/African American	28	5%	7%
Other	22	4%	2%
Two or more races	30	5%	4%
Totals	559	100%	104%

Note. For the race question, respondents were asked to select all that apply. The responses were subsequently recoded to ensure that the race categories were mutually exclusive. Respondents selecting multiple race categories were reclassified into 'Two or more races' category. For the California data, those selecting 'Two or more races' are counted separately than the other race/ethnicity categories.

Employment and Compensation

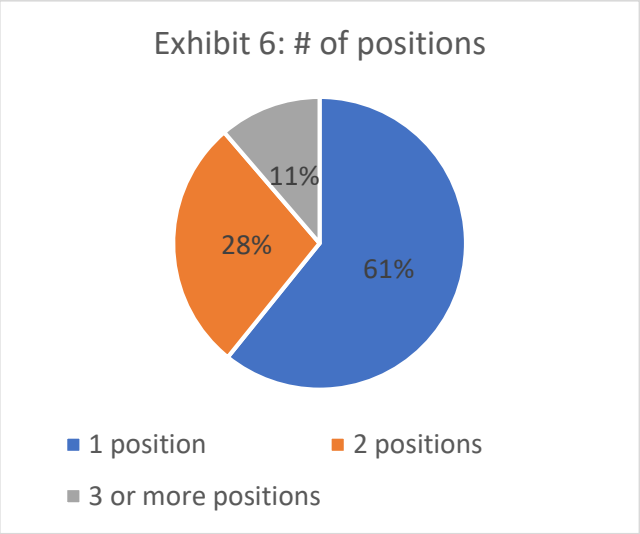
The survey wanted to understand the extent to which licensed OTAs are working in their field, their employment status, and their earnings. Overall, licensed OTAs are employed in their profession and a significant amount hold multiple OTA positions.

Data collected from survey respondents revealed that 91% of OTA licensees were actively employed in occupational therapy (see Exhibit 5), and of those, 70% worked full time. While most OTAs (61%) reported being employed in one position, it is common to hold multiple OTA positions (39%), see Exhibit 6. This practice makes up for insufficient hours, helps to build savings, and makes up for low wages, according to the findings of this study.

Respondents were also asked how long they have been employed in their current occupational therapy position. In their primary job, most OTAs have two to five years of experience with their current employer, with an additional 26% having six or more years of experience.

Exhibit 5: Current Employment Status

	#	%
Employed in Occupational Therapy only	440	79%
Employed in Occupational Therapy and another field	65	12%
Employed in another field only	13	2%
Unemployed	36	6%
Retired	5	1%
Total	559	100%



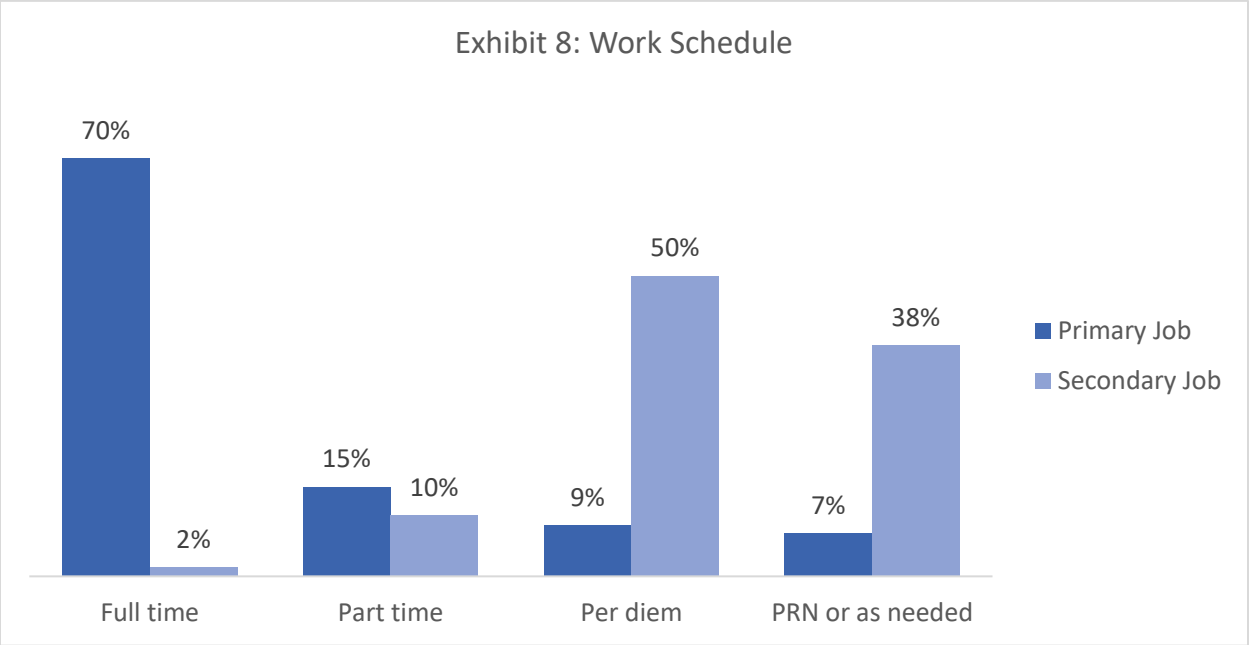
**Note: Respondents were asked to select all that apply*

In the year prior to the survey, one-fifth (21%) of OTAs were working in a part-time or temporary position when they would have preferred a full-time position. Nearly half (47%) of surveyed OTAs reported they have taken on additional work in the past year (Exhibit 7). While taking on additional work within the profession was common, few respondents haven taken on work outside the profession. Most have taken on additional OTA work (39%), while fewer (8%) have taken on work outside the profession.

Exhibit 7: Underemployment

	#	%
Took additional OTA work in the last year	197	39%
Worked PT but preferred FT	107	21%
Worked outside the profession for additional income	39	8%

**Note: respondents were asked to select all that apply*



Scheduling

Survey findings reveal that a significant number of OTAs take on secondary jobs. Those with two OTA jobs were asked about how those positions are scheduled. According to responses, 70% of OTAs are scheduled full time while 16% are scheduled either per diem or PRN or as needed (Exhibit 8). These trends are reversed for OTAs who have a second occupational therapy position. In the secondary job, 88% of OTAs are schedule as per diem or PRN or as needed while only 2% are schedule full-time.

Earnings

The average reported income for OTAs was $51,200 for those with one job and $65,900 for respondents holding two OTA jobs. These figures are consistent with earnings for California's OTA workforce. According to occupational employment data, the median annual income for OTAs is $71,656 with the lowest 10% earning $47,902 and the highest 90% earning $91,936.[6] Survey findings show that 87% of surveyed OTAs receive an hourly wage at their primary work location, while 13 % are compensated by salary.

Exhibit 9: Reported Earnings

	#	%
Less than $30,000	67	13%
$30,000-$49,999	90	18%
$50,000-$59,999	72	14%
$60,000-$69,999	91	18%
$70,000-$79,999	78	15%
$80,000-$99,999	44	9%
$100,000 or more	24	5%

[6] Source: Economic Modeling Specialists, Inc. 2020, Q4.

Prefer not to say	39	8%
Totals	505	100%

Survey findings also indicate more years of experience is correlated with higher earnings. Respondents who had been licensed as an OTA for less than two years had significantly lower median earnings ($40,700) than OTAs licensed 3-10 years ($61,500) or OTAs licensed more than 10 years ($61,800). There is an increase in salary as the number of years licensed increases. However, there is not as significant salary increases between OTAs licensed 3-10 years and those OTAs licensed for more than 10 years, suggesting that earnings seem to plateau after 3 years of experience.

Exhibit 11: Income by Number of Years with an OTA License

	0-2 Years		3-10 Years		More than 10 Years	
	#	%	#	%	#	%
Less than $30,000	37	29.8%	18	8.7%	13	7.3%
$30,000-$49,999	23	19.0%	38	18.4%	29	16.3%
$50,000-$59,999	19	15.7%	28	13.6%	25	14.0%
$60,000-$69,999	9	7.4%	45	21.8%	37	20.8%
$70,000-$79,999	6	5.0%	38	18.4%	34	19.1%
$80,000-$99,999	9	7.4%	18	8.7%	17	9.6%
$100,000 or more	1	0.8%	13	6.3%	10	5.6%
Prefer not to say	18	14.9%	8	3.9%	13	7.3%
Total	121	100.0%	206	100.0%	178	100.0%

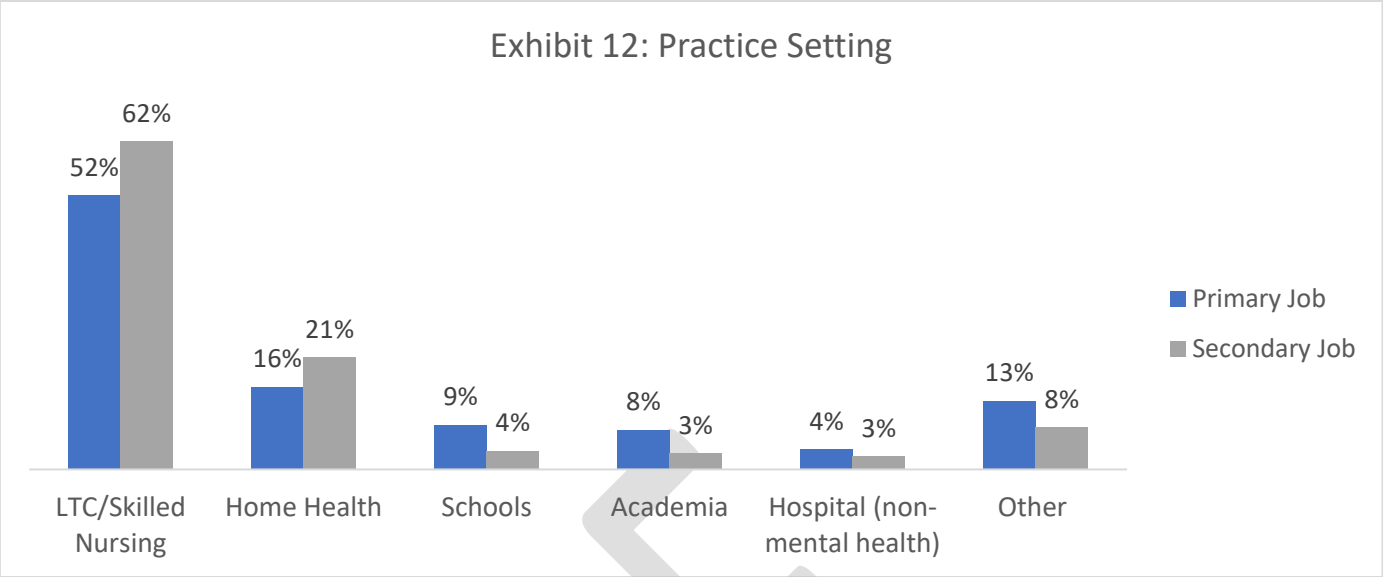
Work Environment

In addition to understanding employment status and compensation, the survey also wanted to identify where OTAs are employed, what tasks they complete on the job, and other work environment factors.

Industry Employers

Traditional labor market data indicates Ambulatory Health Care Services, Nursing and Residential Care Facilities, and Hospitals as the largest industry employers of the position. Data from a 2015 national AOTA Salary and Workforce survey confirm that the majority of OTAs work in a Long-Term Care or Skilled Nursing facility (56%), followed by schools (15%) and hospitals (11%) (AOTA 2015).

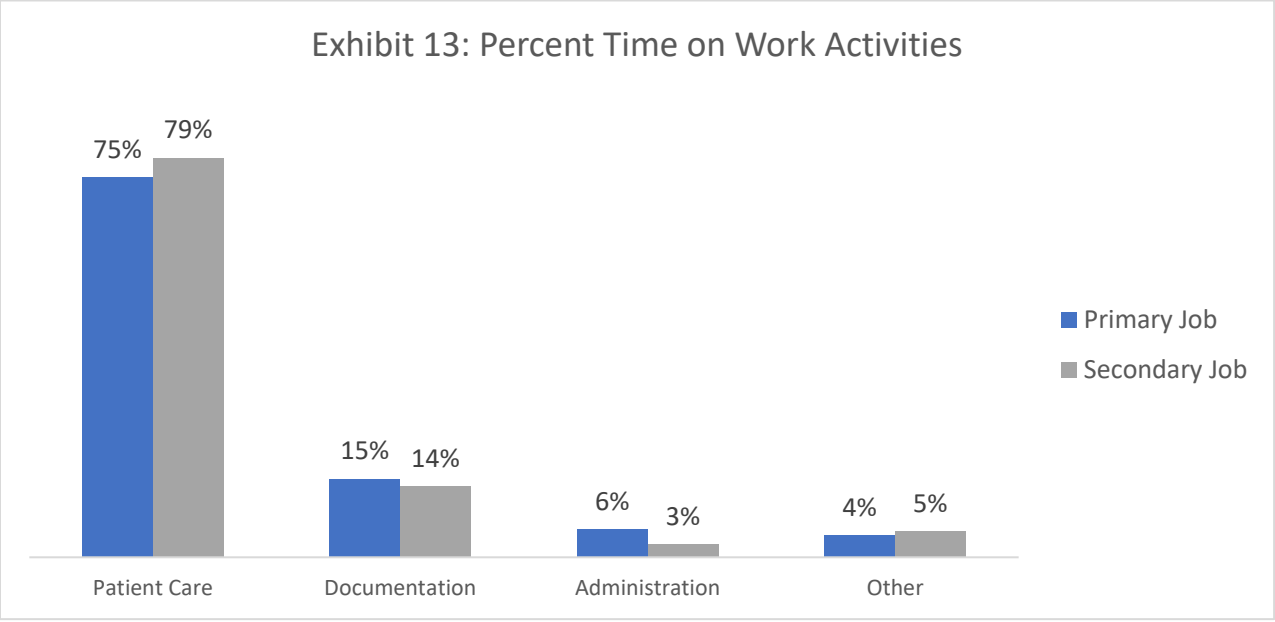
Similarly, according to survey responses, 52% of the OTA sample is employed in Long-Term Care or Skilled Nursing facilities (a subset of hospital establishments), 16% in home health settings and 9% in a traditional hospital setting (Exhibit 12). Nearly one-fifth (17%) of OTAs are currently working in schools.



Work Activities

Occupational Therapy Assistants generally work in healthcare settings (hospitals, care facilities) where they report spending the majority of their time on patient care in both their primary and secondary jobs (Exhibit 13). The patient care task means that at least 60% of their time is spent in that activity.

Other OTA work tasks include 15% time on documentation and to a much lesser degree, administration.



Prior work experience and education

Work Experience

Based on information from the current workforce, OTAs obtain work experience primarily in other health professions (including LVN, CMT, and CHW) prior to obtaining a license (43%), as shown in Exhibit 14. Nearly one-fifth were employed as a certified nurse assistant (18%) and another 10% were previously employed as rehabilitation aides. Only four percent of current OTAs were employed in a position somewhat outside of the traditional health care arena (4% of respondents worked as a personal trainer).

Exhibit 14: Employment in Health Field Prior to OTA License

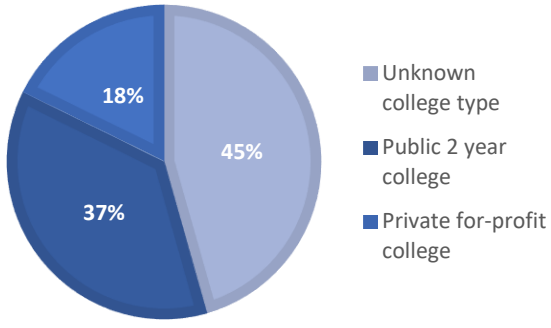
	#	%
Other Health Profession	67	43%
Certified Nurse Assistant	28	18%
Rehabilitation Aide	16	10%
Physical Therapy Aide	10	6%
Other Nursing	8	5%
Medical Billing or Records	8	5%
Behavior Therapist	7	5%
Caregiver	6	4%
Personal Trainer	6	4%
Totals	156	100%

College Experience

Type of College Attended

37% of surveyed OTAs attend public two-year colleges, while 18% attended private for-profit colleges and the remaining attend an unknown college type (46%).

Exhibit 15: Public and Private College Attendance



The majority of OTAs licensed in California also completed their OTA education in California (69%), while 27% completed their OTA education at a college outside California and 3% completed an online program. None of the surveyed OTAs completed their OTA education abroad, suggesting that California employers rely mostly on OTAs educated in California and to a lesser extent other states.

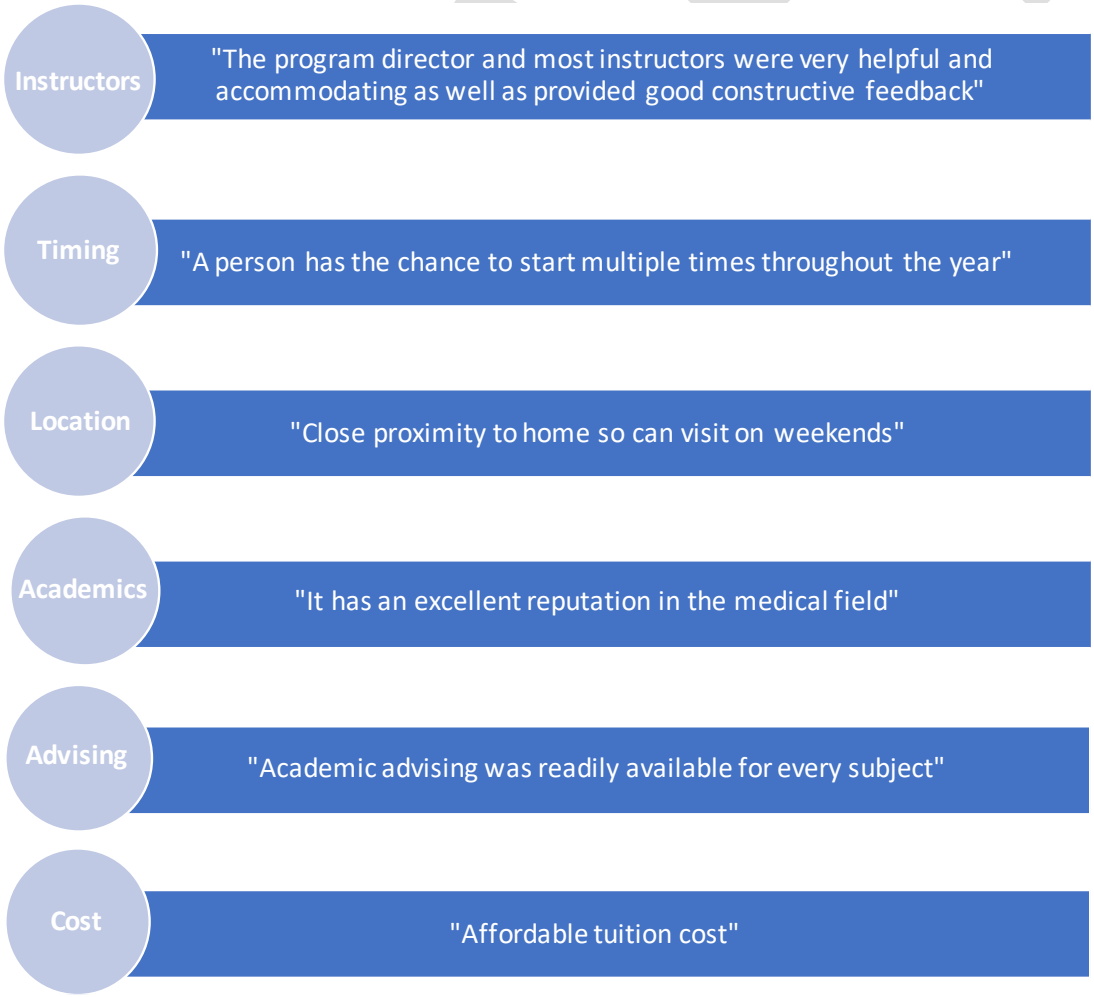
Surveyed OTAs were asked how likely they would be to recommend the college they attended to a friend (Exhibit

16). Overall, OTAs reported a positive college experience with 78% extremely or somewhat likely to recommend the college they attended to a friend.

Exhibit 16: Likelihood of Recommending College to a Friend

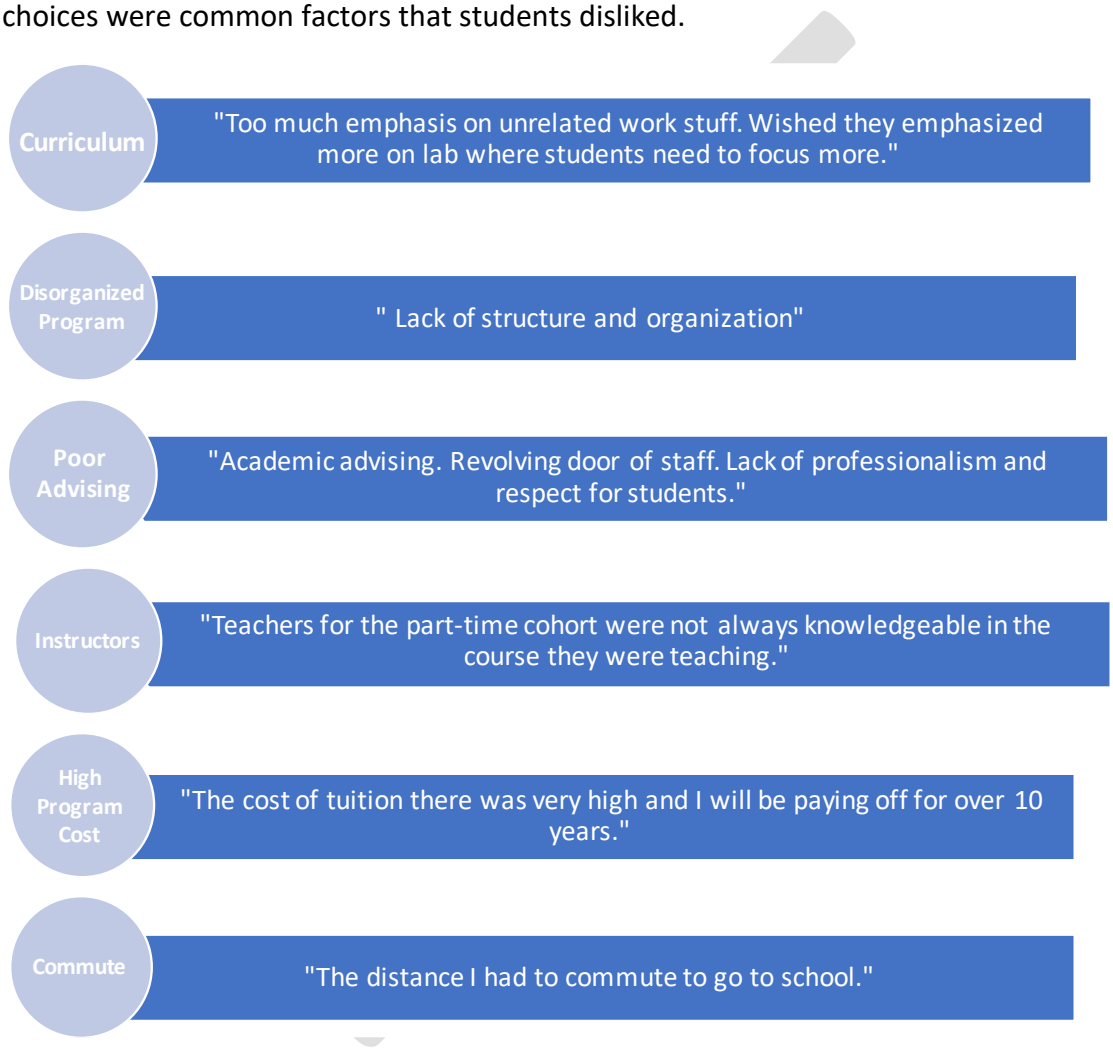
	#	%
Extremely/Somewhat Likely	438	78%
Neither likely nor unlikely	75	13%
Extremely/Somewhat Unlikely	46	8%
Totals	559	100%

OTA respondents completed an open-ended question asking them to reflect on what they liked about the college where they completed the majority of their OTA coursework. Qualitative data analysis of the open-ended responses reveals that students most appreciate competent instructors, flexible timing, convenient location, positive reputation of the academics at the



college, quality advising, and low cost. The figure below displays positive aspects of the colleges that were most commonly referenced along with a key quote that reflects a typical response.

In addition, respondents were asked about the qualities of the college that they disliked. Instructors, advising, location, and cost were common themes when students reflected on both positive and negative aspects of their college. Respondents frequently referenced poorly-trained instructors, high cost, long commute times, and limited or misleading advising. In addition, students also took issue with poor program organization and irrelevant curriculum choices were common factors that students disliked.



Education Debt

The cost of education was one component of OTA education that respondents indicated as a negative of their experience. Over half (58%) of responding OTAs used student loans to pay for education expenses (OTA or non-OTA), including over a quarter (25%) of respondents who took out significant debt ($30,000 more) to finance their education. Exhibit 17 displays the detail of student debt accumulation by respondents.

Exhibit 17: Student Loan Debt

	#	%
No Debt	237	42%
Under $5,000	18	3%
$5,000 - $9,999	27	5%
$10,000 - $14,999	31	6%
$15,000 - $19,999	29	5%
$20,000 - $24,999	31	6%
$25,000 - $29,999	37	7%
$30,000 or more	141	25%
I don't know	8	1%
Totals	559	100%

The amount of debt students carried was correlated with the type of institution they attended for their OTA coursework (Exhibit 18). Overall, students who attended private colleges were significantly more likely than public college attendees to have any education-related debt. Of the students who attended private colleges, the majority (78%) took out $30,000 or more in loans compared to just 16% of students who attended public colleges.

Exhibit 18: Student Loan Debt by College Type

	Attended Public College		Attended Private College	
	#	%	#	%
Under $5,000	8	15%	1	1%
$5,000 - $9,999	12	22%	0	0%
$10,000 -$14,999	6	10.9%	0	0%
$15,000 -$19,999	6	11%	2	2%
$20,000 -$24,999	5	9%	3	3%
$25,000 -$29,999	7	13%	13	15%
$30,000 or more	9	16%	69	78%
I don't know	2	4%	1	1%
Totals	55	100%	89	100%

Education attainment

When asked to indicate their highest level of education, 56% of survey respondents indicated they obtained an associate degree, while 45% hold a bachelor's degree or higher (Exhibit 19). These figures are significantly different than the national data on education attainment for OTAs which indicate 82% hold Associate degrees and 18% a bachelor's degree or higher.[7]

Exhibit 19: Educational Attainment

	#	%
Associate degree	310	56%
Bachelor's degree	225	40%
Master's or Doctoral degree	24	4%
Totals	559	100%

Additionally, according to survey responses, associate degree holders were more likely than those with a bachelor's degree or higher to hold a degree in a health field. Nearly all (96%) of associate degree holders indicated that their field of study was in a health field, compared to only 37% of bachelor's degree holders. This may suggest that students are earning bachelor's degrees in other fields first and then moving into the occupational therapy field.

Older OTAs were more likely to report an associate degree as their highest degree earned (60%) as compared to 51% for OTAs under 40. A baccalaureate is significantly more common for younger OTAs, with 45% of respondents under 40 holding a bachelor's degree compared with 35% for those over 40. This indicates that the workforce is becoming increasingly educated as younger OTAs enter the profession with higher levels of education than their older counterparts.

Responses on OTA education attainment by the number of years licensed supports this conclusion. The longer an OTA has been licensed the lower the level of education attainment (see Exhibit 20). OTAs with more than 10 years of experience are significantly less likely to have a bachelor's degree compared to OTAs with 0-2 years of experience (30% and 48% respectively).

Exhibit 20: Educational Attainment by Years Licensed

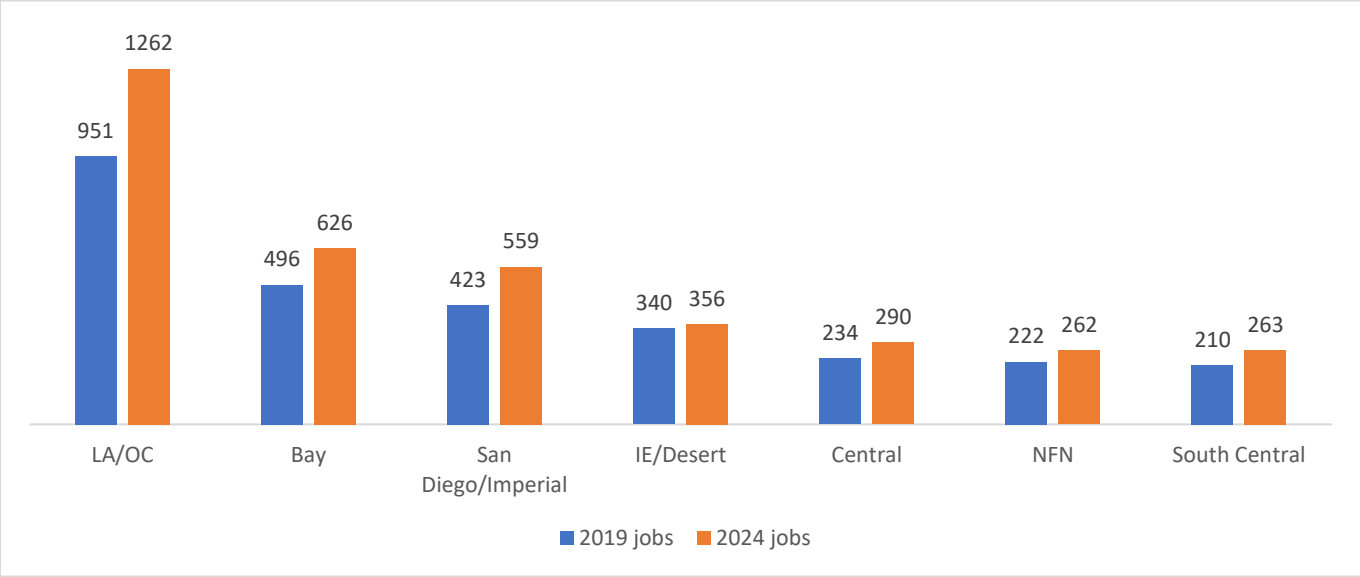
	0-2 Years		3-10 Years		More than 10 years	
	#	%	#	%	#	%
Associate degree	71	51%	107	49%	132	65%
Bachelor's degree	66	48%	98	45%	61	30%
Master's or Doctoral degree	1	1%	13	6%	10	5%
Totals	138	100%	218	100%	203	100%

[7] ONet Online https://www.onetonline.org/link/summary/31-2011.00#Education

Future employment demand

According to occupational projection data, there is an estimated need of as many as 500 OTAs per year through 2024. The greatest need will be in the Los Angeles/Orange county region which is expected to have job growth of 311 positions over the next five years (Exhibit 19). The Los Angeles/Orange County and San Diego/Imperial regions are expected to have the largest percentage growth of OTA positions by the year 2024; 33% and 32%, respectively.

Exhibit 21: OTA jobs by region, 2019-2024



Expected Retirement Age

In addition to the growth of new jobs for OTA, retirements of OTAs are also important for understanding future workforce needs. Only half (51%) of current OTAs expect to retire at age 65 or earlier (Exhibit 22). Many expect to delay retirement, with most (45%) retiring before age 75, and a few (5%) expecting to delay retirement significantly or not retire at all (4%). While it appears that OTAs will be working further into retirement age, only a small percentage plan to work through their mid-70s and later.

Exhibit 22: Expected Retirement Age

	#	%
Age 55 or younger	34	7%
56-65	221	44%
66-75	205	41%
76 or older	24	5%
I do not intend to retire	21	4%
Totals	505	100%

The projected retirement of OTAs varies significantly by their age, see Exhibit 23. Survey respondents under age 40 were significantly more likely than those over age 40 to suggest retiring earlier (58% and 42%, respectively). It is possible that as OTAs approach retirement age, they adjust their retirement plans and expect to work more years.

Exhibit 23: Expected Retirement Age by Age of Respondents

	Age: Under 40		Age: 40+	
	#	%	#	%
Age 55 or younger	26	10%	8	3%
56-65	129	48%	92	39%
66-75	89	33%	116	49%
76 or older	14	5%	10	4%
I do not intend to retire	11	4%	10	4%
Totals	269	100%	236	100%

Plans for the Future

Changes in the healthcare environment are especially relevant to OTAs, where there have been calls for higher levels of occupational therapy education. In the future, 46% of surveyed OTAs expect to pursue additional years of education. With additional years of education, OTAs could advance into a career as an Occupational Therapist.

Current OTAs under the age of 40 report they plan to pursue additional educational opportunities at a rate significantly higher (62%) than their older counterparts (28%).

Exhibit 24: Plan to Pursue Future Educational Opportunities

	Under age 40		Over age 40	
	#	%	#	%
Yes	166	62%	65	28%
No	103	38%	171	73%
Totals	269	100%	236	100%

In order to prepare education institutions for the pipeline of OTAS, the survey asked respondents to consider hypothetical education pathways. First, they were asked their level of interest in pursuing a bachelor's degree in occupational therapy, and second, their interest in completing a bridge program from OTA to OT. Responses are detailed in Exhibit 25.

Results indicate twice as many students would definitely be interested in an OTA to OT bridge program as compared to students considering a bachelor's degree in OT. Nearly two thirds (60%) of respondents were definitely or probably interested in an OTA to OT bridge, if one were

available, as compared to just over a third (37%) of responding OTAs who were definitely or probably interested in a bachelor's degree in OT.

Exhibit 25: Interest in Pursuing Education Pathways

	BA in OT		OTA to OT Bridge	
	#	%	#	%
Definitely yes	112	22%	207	41%
Probably yes	72	14%	96	19%
Might or might not	115	23%	109	22%
Probably not	111	22%	50	10%
Definitely not	95	19%	43	9%
Totals	505	100%	505	100%

Newly licensed OTAs expressed significantly more interest in pursuing an OTA to OT bridge program as compared to experienced licensees (74% and 53% respectively), see Exhibit 26. There are no significant differences by years licensed for respondents who are unsure about pursuing an OTA education pathway.

Exhibit 26: Interest in Pursuing Education Pathways, by years of license

	0-2 Years	10+ Years
Definitely/Probably Yes	74%	53%
Might or might not	18%	21%
Definitely/Probably Not	7%	26%
Totals	100%	100%

The potential for continued education varies according to the type of college current OTAs attended. Those who attended private colleges for the majority of their OTA coursework were significantly more likely than those who attended public colleges to want to earn a bachelor's degree in occupational therapy (49% and 30% respectively), see Exhibit 27. Respondents who attended public colleges were more unlikely (45%) to pursue a bachelor's degree than those who attended private colleges (30%).

Exhibit 27: Interest in Pursuing a BA in OT by College Type

	Alumni of: Public	Private
Definitely/Probably Yes	30%	49%

Might or might not	25%	21%
Definitely/Probably Not	45%	30%
Totals	100%	100%

The Association of Occupational Therapist Assistants (AOTA) has recently called to increase the education requirement for OTAs. Our data indicate that most (59%) OTAs are in support of this requirement. However, associate degree holders are significantly less likely (53%) to support this change as compared to OTAs with a bachelor's degree or higher (67%). The same is true for older OTAs, who are significantly less likely (53%) than OTAs under 40 (64%) to support this requirement.

Overall, when asked about the possibility of obtaining a bachelor's degree in occupational therapy, 36% definitely or probably would. However, this number is significantly higher (44%) for those whose highest level of education is an associate degree, as compared to those with a bachelor's degree or higher (27%). More OTAs (60%) would definitely or probably be interested in completing an OTA to OT bridge program, if one were available.

Community College Training and Education

The California Community Colleges Chancellor's Office (CCCCO) pulls from a statewide data system known as LaunchBoard, which aggregates data on community colleges progress, employment and earnings outcomes for both Career Technical Education (CTE) and non-CTE pathways. In the California Community College system there are 446 students (2016-2017 data) taking courses in Occupational Therapy Technology (OT) according to the CCCCO LaunchBoard.

The number of students enrolled in OT programs has been relatively consistent from the 2015-2016 year to the 2018-2019 year, about 450 students. There were 292 FTES (Full-Time Equivalent Students) in 2017, 340 in 2018 and 350 in 2019. Over the last three academic years, approximately 14% of students are enrolled in OT programs on a full-time basis while about 80% attend part-time.

The California Community Colleges offers training and education programs to prepare future OTAs at five colleges (Sacramento, Santa Ana, Grossmont, Mt San Antonio, Monterey Peninsula). In the last three years, these programs have collectively conferred awards to 270 students.

Future of OTA Workforce

Recent guidance from the American Occupational Therapy Association (AOTA) concluded that occupational therapy assistants may enter the profession at the associate or bachelor's level. However, they have recently considered changing the education requirement for OTAs from an associate degree to a bachelor's degree. This study asked if respondents would support a requirement for bachelor's degree for new OTAs. Overall, there is support for a hypothetical bachelor's degree requirement by 2027.

Based on survey responses, 59% of OTAs definitely or probably would support this new requirement, while 21% would definitely or probably not support it. These findings exceed estimates reported in a recent study by an AOTA Special Task Force, which sampled 840 OTA students. They found 9% of respondents supported bachelor's degree entry level only. OATA survey respondents were more likely to report dual entry levels at the associate or baccalaureate level (38%) or associate degree entry only (43%).

Exhibit 28: Support for New BA Requirement

	#	%
Definitely would	176	35%
Probably would	122	24%
Might or might not	99	20%
Probably would not	55	11%
Definitely would not	53	11%
Totals	505	100 %

The range of OTAs who are in support of a bachelor's degree requirement for employment is expansive. Only 9% of respondents to an AOTA survey and 59% of OTAs in California.

This survey also wanted to understand how the existing workforce perceived the added benefit of obtaining a bachelor's degree. When asked, nearly one-third (29%) of respondents did not see an added benefit while another third (33%) thought it would lead to more well-rounded OTAs, and an additional 20% thought it would lead to a better quality of care.

Exhibit 29: Benefit of a OTA Bachelor's Degree

	#	%
More well rounded	164	33%
Better quality of care	101	20%
Additional coursework to support cultural competence	48	10%
Other skills	28	6%
Reading comprehension and writing skills	15	3%
Math skills	1	0%
I don't see a benefit to the added degree requirement	148	29%
Totals	505	100%

Supply/Demand Summary

TBD

Conclusion and Recommendations

Overall, the findings from this survey provide a profile of the typical OTA in California. The typical OTA works 31-40 hours a week in a Long-Term Care/Skilled Nursing facility, working with elderly clients. They hold the title of "Occupational Therapy Assistant" and have been with their current employer for less than 5 years.

The survey also revealed some striking differences between primary and secondary jobs for the 39% of OTAs who work more than one occupational therapy job. Compared to their primary job, respondents' secondary jobs were more likely to be scheduled for fewer hours, with lower compensation, located in LTC/Skilled Nursing or Home Health, and scheduled by the day. In their secondary jobs, OTAs are much less likely to receive employer-sponsored benefits and are more likely to focus on patient care.

In their secondary jobs, the survey estimates that 21% work in Home Health, compared to just 8% percent that do their primary work in a home health facility and the vast majority (82%) work with elderly clients in their secondary job, which is nearly 20% more than those who work with elderly clients in their primary jobs (64%). Finally, the typical OTA is new in their secondary practice setting; 44% have 0-2 years of experience compared to 31% at their primary job.

The Occupational Therapy Assistant Workforce

Demographics

Race/ethnicity by age

Results show that racial groups are balanced between OTAs under 40 years old and OTAs over 40 years old, with two notable exceptions. Older OTAs are significantly more likely than younger OTAs to be white. In contrast, younger OTAs are significantly more likely than older OTAs to be Asian. In other words, white OTAs that responded to the survey are more likely to be over age 40 as opposed to younger than 40. Asian OTA respondents are more likely to be under 40 as compared to over 40. This indicates some increase in the diversity of the OTA population.

Table X: OTAs Race/Ethnicity by Age

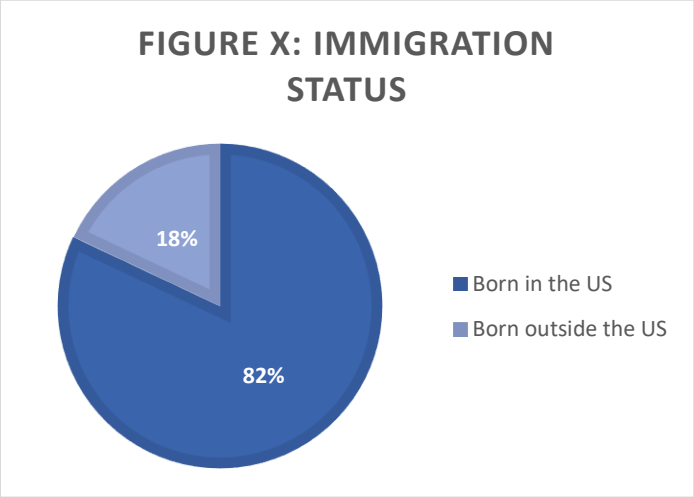
	Under 40		Over 40	
	#	%	#	%
White	141	48.0%	164	62.0%
Asian	76	26.0%	30	11.0%
Hispanic/Latino	38	13.0%	30	11.0%
Black/African American	15	5.0%	13	5.0%
Other	8	3.0%	14	5.0%
Two or more races	18	6.0%	12	5.0%
Totals	296	100.0%	263	100.0%

Taken together with trends by age, data on the racial ethnic background of OTAs by years licensed suggests that the diversity of OTAs is increasing. We observe a decline in the proportion of white OTAs, who make up 65.5% of experienced licensees, 52.8% of OTAs who have held a license for 3-10 years, and 41.3% of newly-licensed OTAs. We see a steady increase in the share of Asian OTAs as the number of years licensed decreases. While Asian OTAs make up 8.9% of respondents who have been licensed more than 10 years, they make up a third (31.2%) of respondents who are newly licensed. Other non-white racial-ethnic groups such as Hispanic/Latino, Black/African American, and Two or more races have seen small increases over time that are not statistically significant.

Table X: Race/Ethnicity by Years Licensed

	0-2 Years		3-10 Years		More than 10 years	
	#	%	#	%	#	%
White	57	41.3%	115	52.8%	133	65.5%
Asian	43	31.2%	45	20.6%	18	8.9%

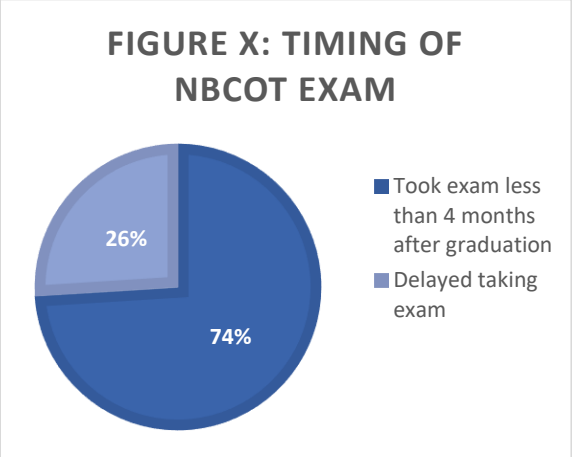
Hispanic/Latino	17	12.3%	28	12.8%	23	11.3%
Black/African American	8	5.8%	9	4.1%	11	5.4%
Other	5	3.6%	8	3.7%	9	4.4%
Two or more races	8	5.8%	13	6.0%	9	4.4%
Total Respondents	138	100.0%	218	100.0%	203	100.0%



Immigration

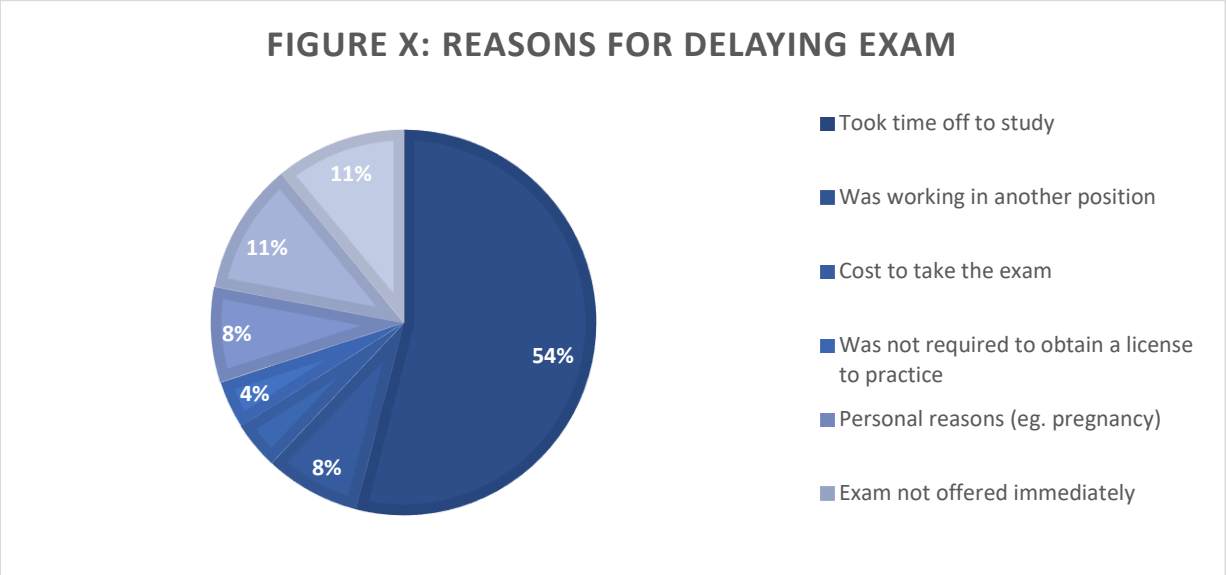
Approximately 82.5% of surveyed OTAs were born in the US and 17.5% were born outside the US.

OTA Licensure



National Licensing Exam

Respondents were asked if they delayed their licensing exam after finishing their OTA program and fieldwork. Most respondents (26.1%) did not delay their licensing exam, and for those who did, most (54.1%) delayed the exam to take time to study and approximately 11.0% did so because the exam was not offered immediately. There is little evidence that students are delaying the exam for financial reasons. The vast majority of respondents (89.3%) passed their licensing exam in one attempt.



Employment

Unemployment

For those respondents that reported they were unemployed (n=36), they were asked to select the reasons for their unemployment. "Difficulty findings my desired Occupational Therapy Assistant position" was the most frequently selected reason for being unemployed, selected by 44.4% of respondents, and "taking care of home and family" was selected by 42% of unemployed respondents. Respondents who selected "other" indicated that relocation, health issues, maternity leave, or time between jobs were additional reasons for unemployment among OTAs.

Table X: Reasons for Unemployment

	#	%
Difficulty finding my desired Occupational Therapy Assistant position	16	44.4%
Taking care of home and family	15	41.7%
Other	10	27.8%
Available jobs provide an inadequate salary	3	8.3%
School	3	8.3%
Disabled	1	2.8%

**Note: Respondents were asked to select all that apply.*

Hours Worked

In a typical week in all OTA positions, 39% of respondents worked 31-35 hours per week and 16% of respondents worked 36-40 hours per week. It was more common for OTAs to work part-time than to work more than full time. While 29% of respondents worked less than 30 hours per week, only 16% worked more than 40 hours per week. The survey results indicate that most OTAs work slightly less than full time, with 39% of responding OTAs working 31-35 hours

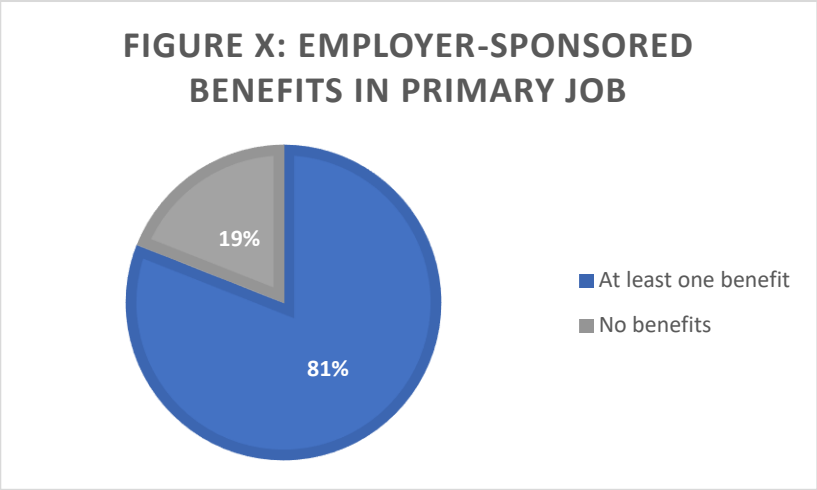
in a typical week across all positions. The second most frequently selected category was 36-40 hours (15.6%).

Table X: Hours Worked per Week

	#	%
20 or fewer hours per week	72	14.3%
21-30 hours per week	74	14.7%
31-35 hours per week	197	39.0%
36-40 hours per week	83	16.4%
41-50 hours per week	59	11.7%
51 or more hours per week	20	4.0%
Totals	505	100.0%

Earnings and Benefits

Employer Benefits



Most OTA respondents receive at least one employer-sponsored benefit in their primary job (81.0%), while one in five (19.0%) receive no benefits in their primary job.

Table X: Employer-Sponsored Benefits in Primary Job

	#	%
Paid vacation	353	69.9%
Paid sick leave	326	64.6%
Health insurance	324	64.2%
Unemployment insurance, disability insurance, and workers compensation	206	40.8%
Employer-provided pension	94	18.6%
Signing/retention bonus	22	4.4%

**Note: Respondents were asked to select all that apply*

Practice Setting and Work Activities

Employer Tenure

Respondents had fewer years of experience with their current employer in their second job. Nearly a quarter (23.2%) have one or two years of experience while 23.2% have two to five years of experience. Those who have a secondary job have half as many years of experience than OTAs in their primary job.

Table X: Employer Tenure

	Primary Job		Secondary Job	
	#	%	#	%
Less than 6 months	77	15.2%	54	27.3%
6 months - 11 months	60	11.9%	27	13.6%
1 year - up to 2 years	93	18.4%	46	23.2%
2 years - 5 years	146	28.9%	46	23.2%
6 years or more	129	25.5%	25	12.6%
Total	505	100.0%	198	100.0%

In the last year, over a quarter (26.5%) of OTAs have switched employers while 14.5% have switched practice settings. For this group of OTA respondents, it was nearly twice as common to switch employers as it was to switch practice settings.

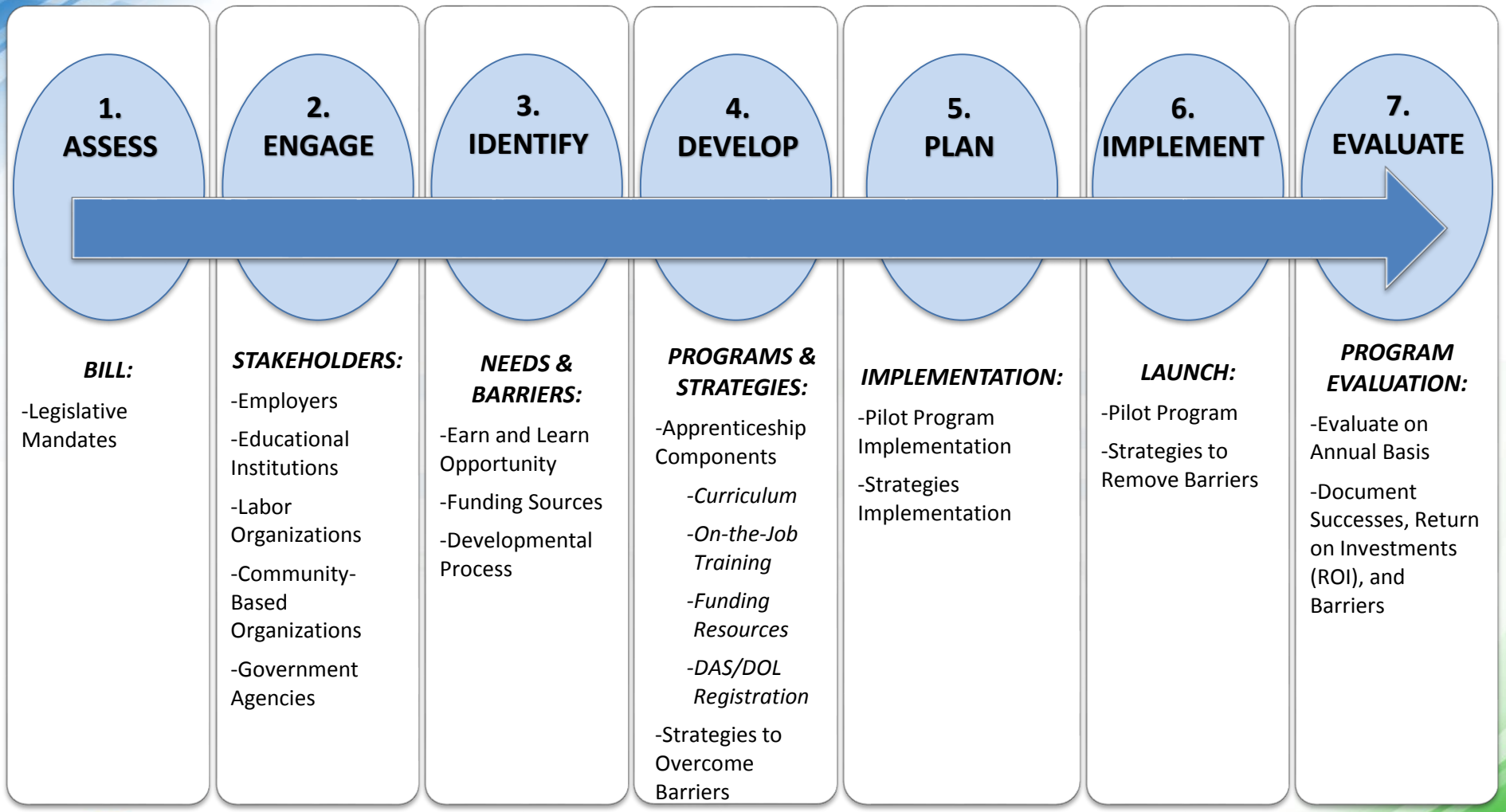
Table X: Employee Turnover

	#	%
Switched employers	134	26.5%
Switched practice settings	73	14.5%

Table X: Characteristics of Primary and Secondary Job

	Primary Job	Secondary Job
Hours worked	31 hours	9 hours
Practice setting	LTC/Skilled Nursing	LTC/Skilled Nursing
Over two years of experience in setting	69%	56%
Patient population	Elderly	Elderly
Over two years of experience with employer	55%	36%
Earnings	$51,200	$14,800
Scheduling	Full-time	Per Diem
At least one benefit	81%	25%
Percent of work time on patient care	75%	79%
Total respondents	505	198

AB 2105 Pilot Program Development Process



STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

A.Bui rev. 07.30.18

BARRIERS AND RECOMMENDATIONS TO FACILITATING EARN AND LEARN TRAINING PROGRAMS IN ALLIED HEALTH PROFESSIONS

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

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Acronyms and Helpful Links

Below are the most commonly used acronyms and helpful links referenced throughout the report.

AAMA American Association of Medical Assistants (**www.aama-ntl.org**)

ABHES Accrediting Bureau of Health Education Schools (**www.abhes.org**)

BBS Board of Behavioral Sciences (**www.bbs.ca.gov**)

BRN Board of Registered Nursing (**www.rn.ca.gov**)

BVNPT Board of Vocational Nurses and Psychiatric Technicians (**www.bvnpt.ca.gov**)

CAAHEP Commission on Accreditation of Allied Health Education Programs (**www.caahep.org**)

CAI California Apprenticeship Initiative (**https://foundationccc.org/What-We-Do/Workforce-Development/Workforce-Services/California-Apprenticeship-Initiative**)

CBHPC California Behavioral Health Planning Counsel (**www.dhcs.ca.gov/services/MH/Pages/CBHPC-PlanningCouncilWelcome.aspx**)

CCCCO California Community Colleges Chancellor's Office (**www.cccco.edu**)

CDPH California Department of Public Health (**www.cdph.ca.gov**)

CHW Community Health Worker

CLS Clinical Laboratory Scientist

CNA Certified Nurse Assistant

CTE Career Technical Education

CVIR Cardiovascular and Interventional Radiology

CWDB California Workforce Development Board (**https://cwdb.ca.gov**)

DAS Division of Apprenticeship Standards (**www.dir.ca.gov/das/das.html**)

DCA Department of Consumer Affairs (**www.dca.ca.gov**)

DHCS Department of Health Care Services (**www.dhcs.ca.gov**)

DIR Department of Industrial Relations (**www.dir.ca.gov**)

DOL U.S. Department of Labor (**www.dol.gov**)

ETP Employment Training Panel (**https://etp.ca.gov**)

H-CAP Health Career Advancement Program (**https://hcapinc.org**)

HPEF Health Professions Education Foundation (**https://oshpd.ca.gov/loans-scholarships-grants/hpef**)

HWI Healthcare Workforce Initiative (**https://ca-hwi.org**)

IACA Interagency Council on Apprenticeship (**www.dir.ca.gov/das/iaca/iaca.html**)

JRCERT Joint Review Commission on Education in Radiologic Technology (**www.jrcert.org**)

JVS	Jewish Vocational Services (**www.jvscareers.org**)
LCSW	Licensed Clinical Social Worker
LEA	Local Education Agency
LMFT	Licensed Marriage and Family Therapist
LPCC	Licensed Professional Clinical Counselor
MA	Medical Assistant
MAERB	Medical Assisting Education Review Board (**www.maerb.org**)
MHSA	Mental Health Services Act (**https://mhsoac.ca.gov/about-us/prop63mhsa/act**)
MHSOAC	Mental Health Services Oversight & Accountability Commission (**www.mhsoac.ca.gov**)
OSHPD	Office of Statewide Health Planning and Development (**https://oshpd.ca.gov**)
PAB	Physician Assistant Board (**https://pab.ca.gov**)
RCB	Respiratory Care Board of California (**www.rcb.ca.gov**)
TPRU	Training Program Review Unit (**www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/TPRU.aspx**)
WET	Workforce Education and Training Programs (**https://oshpd.ca.gov/loans-scholarships-grants/grants/wet**)
WIOA	Workforce Innovation & Opportunity Act (**www.doleta.gov/wioa**)
YED	Youth Employment and Development

Background

In 2016, Assembly Member Freddie Rodriguez authored AB 2105 (Chapter 410), which the Legislature passed and Governor Edmund G. Brown Jr. signed. AB 2105 required DCA to carry out a stakeholder process to update policies and remove barriers to facilitate the development of earn and learn training programs, which include apprenticeships in the allied health professions. The stakeholder process was to conclude by January 1, 2020. This report is a summary of the efforts by the Department of Consumer Affairs (DCA) to bring stakeholders together to identify specific barriers and potential solutions.

Earn and learn training programs are models that allow a person to receive compensation while also receiving the necessary training to learn the skills for a specific occupation.[1] Apprenticeship, one of the highest standards of earn and learn, is a paid on-the-job training and education model and, in order to be registered at either the federal or state level, must have a number of components, which add rigor and standards.[2] Allied health professions are generally considered to be a broad range of professions that are specially trained but are not physicians, dentists, or nurses.

Assembly Bill 2105, and preceding legislation, AB 1797 (Rodriguez, Chapter 157, Statutes of 2014), were aimed at increasing the number of earn and learn job training opportunities in the health care industry. Under AB 1797, the California Workforce Development Board (CWDB), in conjunction with the Division of Apprenticeship Standards (DAS), issued a report, *Expanding Earn and Learn Models in the California Health Care Industry*, which identified opportunities and barriers to expanding apprenticeship in health care. While DCA has not traditionally played a significant role in workforce development issues in the past, AB 2105 provided an opportunity for DCA to lead a stakeholder process aimed at addressing workforce needs in allied health professions.

The intent of these pieces of legislation was to address and mitigate future workforce shortages in allied health professions while also addressing the need for developing a workforce in the health care industry that reflects the communities they serve. While there is no single solution that will solve the allied health workforce shortage, studies conducted by several groups spanning at least a decade suggest that investing in earn and learn job training programs, where participants earn a wage while completing necessary training, may narrow the workforce gap and increase diversity within the health care industry.[3]

The mission and priority of DCA and its entities is ensuring the protection of California consumers through the licensure and regulation of professions, including many in the health care industry. Under DCA, there are 19 licensing boards that regulate health care professions. However, there are several professions in the health care industry that are not under the authority of DCA and its entities, such as certified nurse assistants and radiology technicians, and some that may not require any formal licensure by the state, such as medical assistants and medical coders (see Table 1). While there are barriers to implementing earn and learn training programs in the health care industry, there are no direct, specific prohibitions in DCA entities' laws or regulations limiting the creation of these programs.

[1] AB 1797 Report (**https://www.dca.ca.gov/consumers/earn_and_learn.pdf**)

[2] Components of a Registered Apprenticeship Program include structured on-the-job learning, incremental wage gains, and classroom instruction.

[3] AB 1797 Report

However, there are indirect barriers that have been identified as limiting the ability to create earn and learn training programs.

TABLE 1. HEALTH CARE LICENSING PROGRAMS

DCA HEALTH CARE LICENSING PROGRAMS		
Acupuncture Board	California State Board of Optometry	Board of Registered Nursing
Board of Behavioral Sciences	Osteopathic Medical Board of California	Respiratory Care Board of California
Board of Chiropractic Examiners	California State Board of Pharmacy	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Dental Board of California	Physical Therapy Board of California	Board of Vocational Nursing and Psychiatric Technicians
Dental Hygiene Board of California	Podiatric Medical Board of California	
Medical Board of California	Physician Assistant Board	
Naturopathic Medicine Committee	Board of Psychology	
California Board of Occupational Therapy		
CDPH LICENSING PROGRAMS		
Licensing and Certification Program		
Laboratory Field Services		
Radiologic Health Branch		

While apprenticeship models have been successful in the building/construction trade sectors, the health care industry has been slow to adopt the same models for several reasons. The scope of work performed in a patient care setting is inherently different than the scope performed in a building/construction trade setting. Additionally, health care employers, educational institutions, and community partners face significant challenges with developing sustainable training programs with the finite resources available. The apprenticeship barriers could be attributed to low Medi-Cal reimbursement rates, lack of a culture built around apprenticeship that is found in other industries as well as several other factors including staff (preceptor) time and administrative costs including the cost of documenting and reporting required for state apprenticeship programs, which are viewed by some stakeholders as onerous. This further makes it difficult for health care employers to budget for training programs, including payment of wages for students. Other industries that use earn and learn/apprenticeship models have established and accepted working relationships with unions and employee groups that allow them, through a council structure, to jointly discuss and plan for workforce needs. This does not appear to be as developed within the health care sector.

In April 2018, DCA convened a Planning Committee (Committee) to provide technical assistance and guidance with this effort. The Committee was comprised of subject matter experts representing health care employers, education, labor unions, community-based organizations, and government agencies. The Committee identified four key areas of focus and developed subcommittees to identify and address barriers specific to Medical Assisting, Mental Health, and Specialty Imaging. A subcommittee on Nursing was also established and was tasked with researching and compiling information on existing earn and learn training programs. DCA held a statewide webinar on October 2, 2018 to review its efforts to date and the role of the subcommittees going forward.

The subcommittees, comprised of subject matter experts in the specific focus areas, met from October 2018 through April 2019 to complete a rubric. The subcommittees were tasked with identifying and addressing barriers to the development of earn and learn job training programs in health care within the following categories:

- **STATUTORY BARRIERS**
- **REGULATORY BARRIERS**
- **ACCREDITATION**
- **FINANCING**
- **CULTURAL**
- **EDUCATION STRUCTURE**

The four subcommittees were developed based on stakeholder input, employer need, and where there was the greatest opportunity for earn and learn job training program development. While the four areas of focus are not reflective of all allied health professions, or needs across the various regions, the intent of DCA and the Planning Committee was to provide a framework that could possibly be replicated for other health professions. Between the Planning Committee and subcommittees, DCA held over two dozen stakeholder meetings between April 2018 and April 2019. The final Planning Committee meeting was held on September 17, 2019. This report is a culmination of the discussions and work conducted by DCA and the stakeholders.

Key Findings and Recommendations

The barriers and recommendations listed below are cross-cutting themes emerging from DCA's stakeholder process that included numerous Planning Committee and subcommittee meeting discussions as well as interviews, research, and analysis. The Planning Committee and DCA did not conduct a fiscal or implementation assessment of each recommendation.

1. **Prohibitions on Payment by Program Accrediting Entities.** Licensure boards enforce minimum qualifications for the professionals they regulate. It is through the enforcement of education, experience, and exam requirements that the boards approve qualified individuals to provide services. Education requirements are set forth in statutes and regulations although some boards do not evaluate training program content.

   In some professions, some national accreditation entities are empowered to assess and approve educational programs. Accreditation is given to programs that are deemed to have met the standards by these accrediting entities. Through its deliberations, stakeholders identified some instances[1] where accrediting entities prohibit the payment of wages for students completing hours of training. These prohibitions are not within the authority of DCA to unilaterally remove. These prohibitions may also be the result of cultural resistance to earn and learn training models.

   Recommendation: Work with program accrediting entities to remove prohibitions on the payment of money to students and provide educational outreach to them about the value of earn and learn training models. Should accrediting entities refuse, further review may be required.

2. **Lack of Demographic and Workforce Data.** Stakeholders identified that a lack of available demographic and workforce data necessary to recognize needs and opportunities hinders the evaluation as to whether current investments are achieving intended outcomes, such as insuring the workforce reflects California's population.

   Almost all of DCA healing arts boards collect demographic data, but it is a voluntary request from licensees as only seven of the boards have mandates to collect this data. Additionally, data collection requirements are not standardized among the seven boards.

   Business and Professions Code sections 2717, 2852.5, 3518.1, 3770.1, and 4506 require the Board of Registered Nursing (BRN), Board of Vocational Nursing and Psychiatric Technicians (BVNPT), Physician Assistants Board (PAB), and Respiratory Care Board (RCB), to collect data on applicants and licensees in the following fields: Race/Ethnicity, Gender, Languages Spoken, Educational Background, Classification of Primary Practice Site, and Location of Practice. Race/Ethnicity is optional, but all other information is mandatory for applicants to provide.

   Recommendation: Using existing statutory authority from these boards as a model, require all healing arts boards under DCA and the California Department of Public Health (CDPH) to collect demographic and workforce data at initial licensure and at renewal.

3. **Registered Apprenticeship Requirements Are Not Aligned with Allied Health Training Programs.** While federal and state apprenticeship standards allow for competency-

[1] One example is the Commission on Accreditation for Respiratory Care (CoARC), which has standards that prohibit students from being employees or being paid for educational clinical work.

based programs, and competency-based programs appear to be a better fit for health professions, programs must still have 2,000 hours of on-the-job training. Credit for work and education related to skill attainment can be applied to meet the 2,000 hours; however, apprentices receiving credit must be in a state-registered program a minimum of six months. Entry level allied health training programs require less than 2,000 hours and often less than 1,000 hours of on-the-job training. This makes these programs ineligible for state apprentice registration under the time-based and competency-based models; however, these programs could be registered into a pre-apprenticeship program if there is a linkage agreement with a state-registered apprenticeship program.

Recommendation: Evaluate the requirements to increase the flexibility for apprenticeship programs in allied health professions. Determine possible workarounds that could be applied in the health professions. The Division of Apprenticeship Standards (DAS) could leverage the new Interagency Council on Apprenticeship (IACA) health subcommittee to help address these issues.

4. **Lack of Knowledge About Registered Apprenticeship for the California Health Care Industry.** Stakeholders experienced challenges with engaging other parties who were not familiar with earn and learn models. While there are materials available on a federal level, there is a lack of information applicable to the health care sector on apprenticeship and earn and learn programs in California. Additionally, there is no clearly delineated process for registering apprenticeships in the health care industry. Stakeholders have reported that is it unclear where they have to go for each step in the process of creating an earn and learn training program.

   Recommendation: Develop a comprehensive health-centric employer guide/toolkit for the California Registered Apprenticeship Process through the DAS, including how to work with the DAS, the list of steps necessary for the creation of an apprenticeship program, the value that registering an apprenticeship provides, and accessing funding to support program development and implementation. This effort could also include mapping and streamlining the process for establishing a registered apprenticeship program and developing an information portal for sharing contacts, program information, educational resources, and best practices.

5. **Lack of Coordinated Effort.** There was general consensus among the stakeholders that not having a single entity responsible for earn and learn training programs in the health care industry or a single point of contact is a barrier to easily accessing resources and information. State agencies and nongovernmental organizations fill various roles in the development of successful programs and the removal of barriers. Further, there have been several initiatives throughout the state focused on expanding earn and learn programs in the health care industry with little to no coordination among all groups. Coordinating resources would result in greater progress in expanding earn and learn programs in the California health care industry.

   Recommendation: Establish a workgroup that will serve as the centralized task force on earn and learn job training programs including pre-apprenticeship, apprenticeship, youth employment, subsidized employment, and on-the-job training in health care. Develop a collaboration between state and regional entities, the Office of Statewide Health Planning and Development (OSHPD), Community Colleges Health Sector navigators, Department of Health Care Services (DHCS), DCA, CDPH, and the Labor Agency to address the barriers across training, education, and health entities in the state. The IACA may provide an effective starting point for addressing this issue.

6. **Lack of Available Data on the Economic Benefit of Earn and Learn Job Training Programs in Health Care in California.** Empirical research on the economic benefit of earn and learn job training programs, specifically for apprenticeship programs, has been conducted largely in the building trades sector. Employers and educational institutions may be reluctant to commit to an earn and learn job training model because of the concern on the cost/benefit ratio. The costs of developing and implementing a program are generally easier to measure than the benefits, and research for health care earn and learn training programs in California is inadequate. Employers are not able to easily

identify a return on the investment of an earn and learn training program in health care settings.

Recommendation: Identify and gather data to study the economic benefits and value of earn and learn training programs for health care employers and programs sponsors in California. This may require additional time as data may not be easily accessible.

7. **Funding.** Not-for-profit health care employers, educational institutions, and partners face significant challenges with developing sustainable training programs with the finite resources available. Some employers attribute this to low Medi-Cal reimbursement rates as well as several other factors including staff (preceptor) time and administrative costs including the cost to fulfill documenting and what they perceive to be onerous reporting requirements for state apprenticeship programs. This further makes it difficult for health care employers to budget for training programs including payment of wages for students fulfilling their clinical placement requirements.

   State investments in earn and learn training programs include various funding structures. One model is the Employment Training Program (ETP), which not-for-profit health care employers cannot access since they do not contribute to this funding source. Other existing programs, such as those managed by OSHPD, are grant-based programs that expend funds from on-going funding sources, such as Proposition 63 funds.[2] Employers, educational institutions, and partners struggle to create ongoing programs using their own resources after grant dollars have been exhausted.

   Further complicating the funding predicament is that state/federal registration does not guarantee Related Supplement Instruction (RSI) funds through the California Apprenticeship Initiative (CAI) grants or other Workforce Innovation and Opportunity Act (WIOA) funding. Since CAI grants are derived from Proposition 98 funds, public universities are not eligible for CAI grants as they are not Local Education Agencies (LEAs). Given that some health professions require at least a four-year or master's-level degree, creating a complimentary program for California State University (CSU) and the University of California (UC) could help sustain programs.

   Similar to finding No. 5, stakeholders have also expressed that not having a single entity that oversees funding programs makes it difficult for program sponsors to understand how to fund an earn and learn program and locate contacts and resources. Further, individuals completing education or training outside of the traditional classroom setting are not eligible for financial aid (e.g., clinical laboratory scientist who must complete one year of post-baccalaureate training through an employer).

   Recommendations: Explore the potential of developing a sustainable funding structure for earn and learn training programs using existing models, such as the programs administered by OSHPD via funding collected by licensing boards at initial licensure and renewal.[3]

   Consider applying the ETP model to nonprofit health providers using their public benefit funds to fund workforce training that draws workers from the community and diversifies the workforce.

   Explore the potential for a CAI model for CSUs and UCs.

8. **Difficulty Finding Clinical Practicum Sites and Program Sponsors.** There is a reluctance to develop earn and learn job training programs, mostly due to already impacted programs and decreased clinical sites required for licensure. Unforeseen bottlenecks could make addressing workforce shortages difficult.

   Recommendations: Consider innovative training models, such as increased use of simulation for clinical training and telehealth for supervision.

[2] Proposition 63 in 2004 established a state personal income tax surcharge of 1% on taxpayers with annual taxable incomes of more than $1 million. Funds resulting from the surcharge are used to expand county mental health programs. (Legislative Analyst's Office, **https://lao.ca.gov/ballot/2004/63_11_2004.htm**)

[3] The Licensed Mental Health Services Provider Education Program, Steven M. Thompson Physician Corps Loan Repayment Program, and Bachelor of Science Nursing Loan Repayment Program are examples of OSHPD programs funded by licensees of boards under DCA.

For program sponsors struggling to find qualified preceptors, identify incentives to increase participation (e.g., granting continuing education credit for licensees that serve as preceptors[4]).

Utilize information reported via implementation of SB 1348 (Pan, Chapter 901, Statutes of 2018), which requires the California Community Colleges Chancellor's Office and the Bureau of Private Postsecondary Education to gather metrics on allied health clinical programs, to further refine how to address this issue.

9. **Educational Structure.** It is difficult to develop career pathways from high school through graduate degree programs when there are overlapping requirements that may require repeating coursework to move between or within professions. This may also be reflected in licensure requirements. For example, the lack of common prerequisites at the post-secondary level for all health care programs have also been identified as a barrier to earn and learn job training program development. Curriculum design and implementing changes can be an extremely lengthy and multi-layered process. There is not a clear earn and learn process that will allow community colleges' health programs to quickly adapt to industry needs.

   Additionally, the wage disparity between instructors and working health care professionals makes it difficult for educational institutions to recruit and retain instructors, which creates a bottleneck in developing more programs and the ability to grow existing programs.

   Recommendation: Support and expand existing programs, such as the Health Workforce Initiative (HWI) within the California Community Colleges Chancellor's Office, in efforts to align nursing programs and develop a common curriculum for statewide adoption. Model the HWI process for other allied health training programs. Support stackable credentials though the creation of pathways for health care workers.

[4] The California Board of Occupational Therapy offers continuing education credit (known as professional development units or PDUs) for licensees that supervise students.

Further Efforts

EFFORTS TO ADDRESS LICENSURE BARRIERS AND WORKFORCE DEVELOPMENT

By 2020, California is projected to need nearly half a million health care workers to meet the health care services demand. Increased demand for services will account for 250,000 new health care jobs. Retirement of existing workers will account for 200,000 jobs[1]. This growth is projected across all areas of the health care workforce with employment in the allied health workforce, expected to make up roughly 40% of the projected workforce needs.[2] The allied health occupations provide a path to the middle class and will be one of the fastest growing occupational groups, growing at a rate of 23.6%.[3]

Earn and learn job training models, such as apprenticeship, youth employment, subsidized employment, and on-the-job training programs, can provide opportunities for low-income students from underrepresented communities to gain entry into the health care industry and advance into career paths leading to high-paying and high-demand health care professions. Studies on the long-term care workforce, such as the one conducted by the University of California, San Francisco (UCSF), found an inverse relationship between racial/ethnic diversity and educational attainment—as the level of educational attainment increased, the share of employed nonwhite health care workers in long-term care decreased. The study further found that financial assistance for those wishing to pursue additional education[4] was needed for the expansion of earn and learn job training models.

As the state continues to make investments in workforce development in the health care industry, regulatory entities, such as DCA and CDPH, have proactively undertaken initiatives to streamline processes to expeditiously license qualified applicants to allow timely entrance into the California workforce and to try to remove artificial barriers to licensure.

- The California Board of Occupational Therapy appointed an ad hoc committee to explore the development of a pilot apprenticeship program to address the shortage of facilities accepting clinical/fieldwork placements for students seeking to become occupational therapy assistants.
- The Board of Registered Nursing (BRN) established a Nurse Education and Workforce Advisory Committee (NEWAC) to advise the BRN members and staff on issues affecting the nursing workforce in California. BRN also conducts multiple surveys annually to gather additional data on nursing education and the workforce.[5]
- The Board of Behavioral Sciences (BBS) through legislation reduced the total required supervised experience hours from 3,200 to 3,000 for licensed clinical social workers (LCSW).[6]
    - BBS, through legislation, increased opportunities for associates (LCSWs, licensed marriage and family therapists, and licensed

[1] **https://www.ppic.org/content/pubs/report/R_914SMR.pdf**
[2] AB 1797 Report
[3] **https://www.bls.gov/opub/mlr/2017/article/projections-overview-and-highlights-2016-26.htm**
[4] **https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/REPORT-2018.HWRC_diversity_.4-18.pdf**
[5] **https://www.rn.ca.gov/consumers/advcommittees.shtml#nwa**
[6] **https://www.bbs.ca.gov/pdf/legupdate_18.pdf**

professional clinical counselors) to gain supervised work experience hours toward licensure by allowing triadic supervision (one supervisor to two associates).

- BBS has worked to streamline processes and remove barriers for applicants who hold a license in another jurisdiction of the United States as a marriage and family therapist, clinical social worker, or professional clinical counselor.[7]

- The Dental Hygiene Board of California recently obtained additional staffing to explore alternate pathways to licensure. While the costs and feasibility are yet to be determined, the expectation is that alternative pathways may grant the flexibility to establish nontraditional training programs.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

DCA is not the only entity that regulates health care professionals in the state. CDPH also regulates health care professionals in California and has implemented a number of initiatives to streamline its licensing processes.

- **Training Program Review Unit (TPRU):** CDPH established the TPRU mailbox, which allows all applications to be immediately received into the unit and reduce delays in receiving applications by mail or fax.
- **Templates:** CDPH developed template policies and procedures that cut application processing times by half.
- **Process Improvements:** CDPH streamlined instructor application approvals, reducing processing times by 30%.

The stakeholder process has yielded increased collaboration between DCA and CDPH. The professions within the nursing field are currently regulated by multiple agencies—BRN and BVNPT under DCA and the Licensing and Certification Program under CDPH. Through the efforts working on this project, these three entities have increased communication and collaboration in enforcement activities to better protect consumers.

DIVISION OF APPRENTICESHIP STANDARDS

In February 2019, the Division of Apprenticeship Standards (DAS) began holding its first meetings of the Interagency Council on Apprenticeship (IACA). The IACA was established in the Shelley-Maloney Apprentice Labor Standards Act with the passage of SB 235 (O'Donnell, Chapter 704, Statutes of 2018). The committee provides guidance to the administrator of apprenticeship and chief of DAS on apprenticeship programs, standards, and agreements in nonbuilding trades industries.

THE FIVE SUBCOMMITTEES UNDER THE INTERAGENCY COUNCIL ON APPRENTICESHIP ARE:

- Health Care
- Information Technology
- Civil Service
- Advanced Manufacturing
- Pre-Apprenticeship and Equal Employment Opportunity

Ongoing, the Health Care subcommittee may provide a valuable venue for exploring some of the potential solutions identified in this report.

APPROVED APPRENTICESHIP STANDARDS

MONTH	APPRENTICESHIP NAME	OCCUPATIONS
January 2019	OPENTECH LA Apprenticeship Committee	Health Information Technology Specialist, Computer Support Specialist, Computer Programmer, Information Technology Project Manager, Clinical Laboratory Scientist, Medical Laboratory Technician, Information Security Analyst, Microbiology Quality Control Technician, and Chemistry Quality Control
February 2019	Strong Workforce Apprenticeship Group Health Care Apprenticeship Program	Certified Nurse Assistant, Medical Laboratory Technician
June 2019	Shirley Ware Education Center (Kaiser Permanente and Dignity Health)	Hospital Coder, Medical Assistant, Ambulatory Coder, Central Sterile Processing Technician, Surgical Technologist
July 2019	Allied Health West (UAC)	Medical Assistant
July 2019	Rightvarsity Technology Workforce Immersion Program	Application Developer, Helpdesk Technician, IT Project Manager, Information Assurance Specialist, E-Commerce Specialist, Health IT Specialist, Health Information Management Business Analyst, Health Information Data Analyst, and Clinical Documentation Improvement Specialist
July 2019	Martinez Adult Education (MAE) Optical Assistant Training Program	Optical Assistant
August 2019	CCHCS LVN to RN Apprenticeship Expansion Program Joint Apprenticeship Committee	Registered Nurse

[7] SB 679 **http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB679**

OPPORTUNITY FOR FURTHER RESEARCH

- Hospital employers have shared during this process that there is a tremendous need for clinical laboratory scientists (CLSs). CLSs assist physicians with determining treatment plans by performing a variety of diagnostic assessments. The California Hospital Association found CLSs to be one of the top three occupations having the highest retirement eligibility figures. A shortage of CLSs will significantly impact physicians' ability to diagnose and treat patients quickly and efficiently.

  CLSs require a bachelor's degree and one year of post-baccalaureate training, which stakeholders have expressed may meet registered apprenticeship requirements. This is an area of high demand and also high opportunity for potential earn and learn job training program development.
- Surveys should be conducted of regional workforce development boards and registered apprenticeship programs in health care that are approved by DAS. This effort may yield additional perspectives on barriers or difficulties in establishing earn and learn training programs in health care. Regularly assessing these groups will provide continuous improvement to the process of developing earn and learn training programs.

Subcommittees

The AB 2105 Planning Committee identified four specific areas of focus in the allied health professions to review, gather barriers, and identify possible solutions. These four subcommittees were identified as areas of need by the Planning Committee and where time and effort would be best utilized.

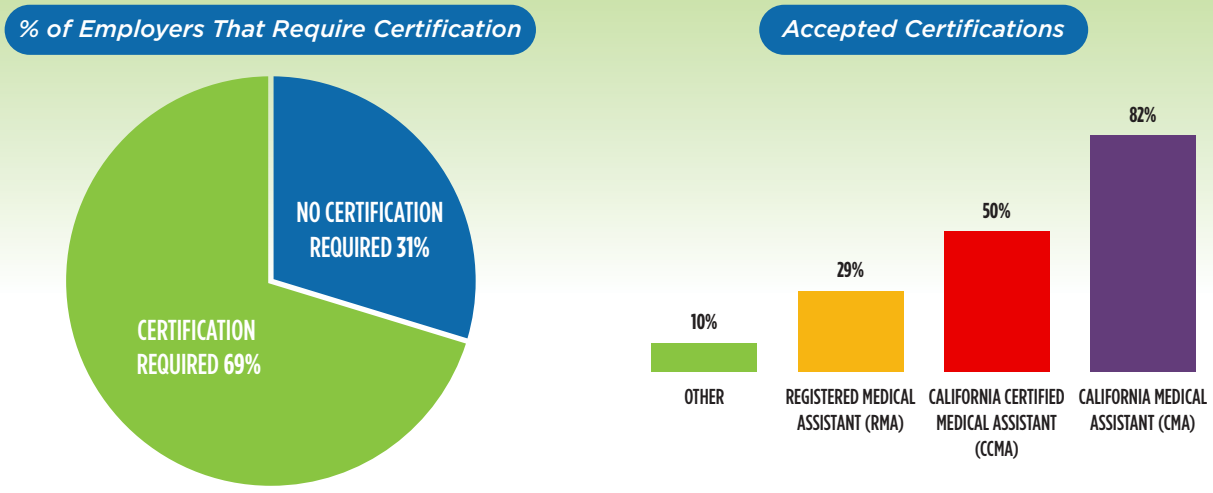
- Medical Assistants
- Specialty Imaging
- Mental Health
- Nursing

The rubrics included in this section are working documents that reflect the issues and ideas discussed during those meetings with the relevant stakeholders. The potential solutions have not been fully vetted for fiscal or implementation impacts.

MEDICAL ASSISTANTS

Medical assistants (MAs) are unlicensed individuals who perform noninvasive routine technical support services under the supervision of a licensed physician and surgeon, podiatrist, physician assistant, nurse practitioner, or nurse midwife in a medical office or clinic setting.[1] The MA's employer and/or supervising physician's or podiatrist's malpractice insurance carrier may require that the MA be certified by a national or private association. So long as the MA will not be training other MAs, such a certification may come from a national or private association and is not required to come from one of the board-approved MA-certifying organizations. Only MAs who will train other MAs must be certified by one of four certifying organizations approved by the Medical Board of California.[2]

FIGURE 1



Source: Centers of Excellence, Health Workforce Initiative, and California Hospital Association 2014 survey
http://coeccc.net/reports/834da18a-9103-4965-b1f9-d0e3e9265d61

[1] Figure 1. Certification requirements
[2] **http://www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Medical_Assistants/Medical_Assistants_FAQ.aspx**

FIGURE 2

CALIFORNIA (2016–2026)			
ESTIMATED EMPLOYMENT	PROJECTED EMPLOYMENT	CHANGE	JOB OPENINGS
84,800	109,600	24,800	127,200

Source: Medical Assistants in Santa Clara County
https://www.labormarketinfo.edd.ca.gov/OccGuides/Detail.aspx?Soccode=319092&Geography=0604000085

Jobs for MAs will increase by 29.2%, or 24,800 jobs between 2016 and 2026, making medical assistants one of the fastest growing occupations in California. Employment growth is expected because of the increase in the number of group practices, clinics, and other health care facilities that need greater numbers of support personnel, particularly the flexible MA who can handle both administrative and clinical duties.[3]

Hospitals, community clinics, and public health systems have reported a high demand for MAs. Hospitals and public health systems in the Bay Area, particularly, face difficulty retaining MAs due to the relatively low wages and high cost of living. Moreover, community clinics experience difficulty with retaining MAs who are often likely to leave the community clinics for the higher-paying hospital setting.

The Career Ladder Mapping Project effort[4] identified MAs as one of the points in which individuals can enter the health care workforce and then advance into various roles, providing a path to the middle class. See Figure 3.

Medical assistants who pursue further education and training usually advance to licensed vocational nurse and registered nurse occupations.

While MA earn and learn programs exist, stakeholders have expressed concerns with sustainability. Further, efforts to expand or scale existing programs have been slow. The following rubric reflect the barriers identified and possible solutions discussed during the Medical Assistant subcommittee meetings.

[3] **https://www.labormarketinfo.edd.ca.gov/OccGuides/Detail.aspx?Soccode=319092&Geography=0604000085**

[4] The Career Ladder Mapping Project was an effort to address workforce shortage in health care and was led by Service Employees International Union (SEIU) Local 250 and Kaiser Permanente, Northern California.

FIGURE 3

Career Ladder Pathways

Kaiser Permanente Labor Management Partnership Career Ladder Workgroup & The Shirley Ware Education Center 9/02 Appendix A

Source: **https://www.careerladdersproject.org/docs/The-Career-Ladder-Mapping-Project.pdf**

	MEDICAL ASSISTANTS			
	IDENTIFY BARRIER	**RECOMMENDATION 1**	**RECOMMENDATION 2**	**KEY STAKEHOLDERS**
STATUTORY BARRIERS	Most training programs do not meet the required 2,000-hour training requirement per section 3077 of the Labor Code for state registration.	DAS to provide guidance on how to comply with the hour requirement.		DAS
REGULATORY BARRIERS	Title 8 CCR section 212.2 requires apprenticeship programs comply with all applicable federal and state law and regulations (including the 2,000-hour requirement) to be eligible for DAS approval.	DAS to provide guidance on how to comply with the hour requirement.		DAS
ACCREDITATION	CAAHEP and MAERB 2015 standards adopted by AAMA requires students to complete 160 unpaid, supervised hours. **https://www.caahep.org/CAAHEP/media/CAAHEP-Documents/MedicalAssistingStandards.pdf**	Have DCA request the accrediting bodies allow for apprenticeships/ earn and learn programs.		DCA, accrediting bodies, DAS
FINANCING	1. Reimbursement is a barrier to paying students. 2. Employer incentives are not aligned with training and educating the workforce. Good employees tend to leave. 3. Financial cost of training—wages, classroom hours, backfill, administration costs, etc. 4. K-12 schools cannot pay students because it counts as a public gift. 5. Need sustainable funding not just grant dollars.	Include reimbursement of students/trainees as an allowable cost toward hospital's/clinic's community benefit program.	Increase community college reimbursement for allied health programs to defer the cost of trainees. Increase the availability of California Apprenticeship Innovation grants.	Legislature, DCA, community colleges, industry
CULTURAL	1. There are cultural barriers between apprenticeship and how employers think about training and educating their workforce. 2. Employers do not want to take on the malpractice/liability. 3. There is a misconception that students who are trained using an apprenticeship model are not equipped with the correct courses and/or skills needed in the field. 4. No employer consensus on training/ certification. Hard for education providers to hit a moving target.	Utilize potential education campaigns and work with DAS to put out health care-focused materials that walk through how to set up and sustain a program.	Industry to partner with community colleges to create pathways focused on earn and learn health care program that meet industry short/long term need.	DAS, education institutions, industry
EDUCATION STRUCTURE	There are examples of medical assistant earn and learn programs. However, they still have issues: 1. Curriculum designs/changes can be an extremely lengthy and multi-layered process. 2. The entry level education does not prepare the workforce for employer needs. 3. Hard to create an earn and learn pathway because of tension between nonpaid students waiting to get in and paid students.	Allow apprenticeship programs that meet industry need to adjust curriculum through an expedited process.	Allow for online completion of didactic courses to allow for flexibility and the ability to spread the cohort over multiple employers across the state.	

SPECIALTY IMAGING

While the initial scope of this subcommittee was to focus on "specialty imaging," the group later took a broader approach and encompassed the broader "imaging" profession in its discussions.

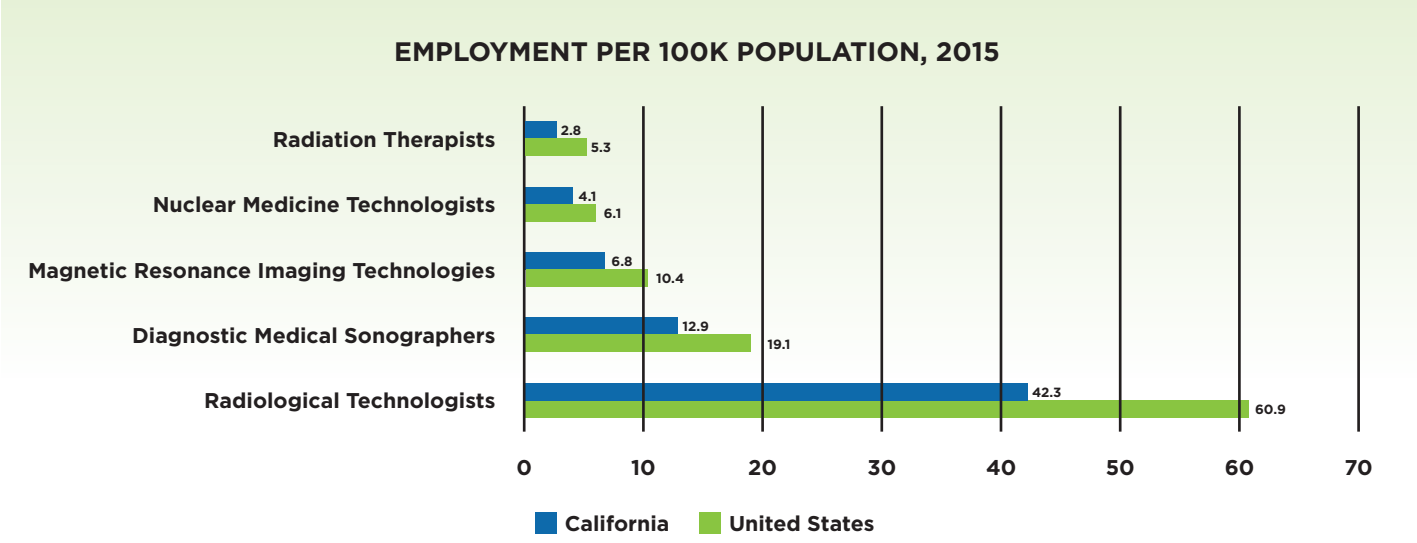
The imaging workforce is comprised of several professions including a number of specialties. Imaging professionals, such as radiological technologists ("rad tech") and diagnostic sonographers, who provide vital services, use X-rays, MRIs, and ultrasound equipment to help health care providers view inside the human body and perform these functions in inpatient and ambulatory settings. Health care employers report that the need is for specialty imaging modalities, such as cardiovascular and interventional radiology (CVIR).[5] The growing and aging population and the increased demand for diagnostic imaging will result in continued job growth.[6]

To help alleviate the imagining professional shortage, industry leaders will need to establish industry baselines for what is considered a well-trained industry professional. Employers have reported that students coming out of the training programs are not trained to desired levels. Once the baseline is identified, the professional imaging industry will be able to set standards that may open earn and lean programs to a wider demographic of applicants.

Further barriers exist because there is a misalignment of incentives and goals as employers are not incentivized to deal with their own needs. Businesses have to spend a lot of money on training the imagining professionals. Once they are trained, they tend to leave for better and higher paying jobs. For employers to invest in training pathways that open opportunities for all regardless of socio-economic background, employers need to see a return on their investment.

Figures 4 and 5 show the changes in the professional imaging employment levels from 2012 to 2015 and, as they show, a shortage was already starting to develop in the industry. In reviewing the data below, the amount of imaging professionals were already not meeting demand. With the expansion of population, there is more of a need for earn and learn programs to become more accessible to potential imagining professionals.

FIGURE 4[7]



[5] www.calhospital.org/sites/main/files/file-attachments/FINAL.Critical_Roles.Feb_.9.2011.pdf
[6] www.labormarketinfo.edd.ca.gov/OccGuides/Detail.aspx?Soccode=292037&Geography=0604000000
[7] www.chcf.org/wp-content/uploads/2017/12/PDF-AlmanacQRG_2017ImagingPros.pdf

FIGURE 5

EMPLOYMENT CHANGES FROM 2012 TO 2015			
CALIFORNIA	**2012**	**2015**	**CHANGE**
Radiation Therapists	1,320	1,100	-16.7%
Nuclear Medicine Technologists	1,550	1,600	+3.2%
MRI Technologists	1,920	2,650	+38.0%
Diagnostic Medical Sonographers	5,180	5,060	-2.3%
Radiologic Technologists	14,820	16,540	+11.6
UNITED STATES	**2012**	**2015**	**CHANGE**
Radiation Therapists			
Nuclear Medicine Technologists	20,480	19,740	-3.6%
MRI Technologists			
Diagnostic Medical Sonographers	57,700	61,250	+6.2%
Radiologic Technologists			

Source: U.S. Bureau of Labor Statistics

The following rubric reflects the barriers identified and possible solutions discussed during the Specialty Imaging subcommittee meetings.

	SPECIALTY IMAGING			
	IDENTIFY BARRIER	**RECOMMENDATION 1**	**RECOMMENDATION 2**	**KEY STAKEHOLDERS**
STATUTORY BARRIERS	Most training programs do not meet the required 2,000-hour training requirement per the Labor Code for state registration.	There does not seem to be an issue for rad techs because the hour requirement is close to the traditional training requirements.	For the imaging specialties that do not require 2,000 hours, a competency-based equivalent should be developed to satisfy the hour requirement.	CDPH, DAS
REGULATORY BARRIERS	Title 8 CCR section 212.2 requires apprenticeship programs comply with all applicable federal and state law and regulations (including the 2,000-hour requirement) to be eligible for DAS approval.	DAS to provide guidance on how to comply with the hour requirement.		DAS

	SPECIALTY IMAGING (CONT.)			
	IDENTIFY BARRIER	**RECOMMENDATION 1**	**RECOMMENDATION 2**	**KEY STAKEHOLDERS**
ACCREDITATION	Joint Review Commission on Education in Radiologic Technology (JRCERT) has taken the position that students who received wages for their clinical hours would be construed as employees by JRCERT, thus rendering it "inconsistent with JRCERT accreditation policies and standards." (Standard 1.3) (**https://sccrcolleges.org/images/jcordova/Thurmond_Letter_3-22-17.pdf**) Accrediting Bureau of Health Education Schools (ABHES) is used as an institutional accreditor for some "freestanding" allied health education schools. ABHES also has specific programmatic standards for some occupations, which it does not programmatically accredit but which may be included within an institution's grant of accreditation. The standards for diagnostic medical sonography and radiologic technology/radiography include language that forbids remuneration for training hours: **DIAGNOSTIC MEDICAL SONOGRAPHY** CH VIII Program Evaluation Standards for Diagnostic Medical Sonography DMS.A.2.(c) Supervision: "Students may not replace existing staff or be compensated while participating in externships and this fact is made known to the student. The student is clearly in addition to the staff/team and not a substitution." **RADIOLOGIC TECHNOLOGY/RADIOLOGY** CH VIII Standards for Radiologic Technology/ Radiography RT.A.3.(a) Assignment and Administration: "... Students may not replace existing clinical site personnel and may not receive compensation while participating in the clinical experience. Admissions or other clinical experience preparatory documents (e.g., clinical agreement) must include these disclosure requirements. Under no circumstances may a student be considered an employee or serve as a staff substitution. Rather, students serve in a capacity to experience relevant processes and procedures in order to learn and master the required skills of the profession."	Request for JRCERT to update their standards to recognize/allow for an earn and learn pathway. Petition ABHES to update language to accommodate earn and learn pathway.	Mandate that all accrediting bodies for allied health must recognize/ allow for an earn and learn pathway. This mandate would not require a training program to have an earn and learn pathway.	CDPH, JRCERT, Legislature, industry, education institutions

	SPECIALTY IMAGING (CONT.)			
	IDENTIFY BARRIER	**RECOMMENDATION 1**	**RECOMMENDATION 2**	**KEY STAKEHOLDERS**
FINANCING	1. Reimbursement is a barrier to paying students. 2. Employer incentives are not aligned with training and educating the workforce. Employers are not incentivized to deal with their own needs. It costs $100,000 to cross train and once employees become specialized, they tend to leave. 3. Financial cost of training—wages, classroom hours, backfill, administration costs, etc. 4. Nonprofit organizations do not qualify for Employment Training Panel (ETP) funds.	Include reimbursement of students/ trainees as an allowable cost toward hospital's community benefit program. Focus on post-licensure occupations because the employer burden of wages is less of a concern because these individuals are likely to be already working and earning a salary.	Increase community college reimbursement for allied health programs to defer the cost of trainees. Increase the availability of California Apprenticeship Innovation grants. ETP has adopted several initiatives in the past to serve nonprofit organizations. Work with ETP to establish such an alternative funding program.	Legislature, CDPH, community colleges, industry, CSU, other clinical site providers
CULTURAL	1. There are cultural barriers between apprenticeship and how employers think about training and educating their workforce. 2. Employers do not want to take on the malpractice/liability. 3. There is a misconception that students who are trained using an apprenticeship model are not equipped with the correct courses and/or skills needed in the field. 4. There is a history of hospital-based programs that current education programs believe were not up to today's standards.	Potential education campaigns and work with DAS to put out health care focused materials.	Industry could partner with community colleges to create pathways focused on earn and learn health care program that meet industry short/long term needs.	DAS, education institutions, industry
EDUCATION STRUCTURE	Wisconsin has a time-based registered federal apprenticeship for MRI techs, approved in 2006: **www.doleta.gov/OA/bul06/bulletin_2006-26-MRI-CT_Tech-Medical_Coder-Mammogram.pdf** The Indiana Air National Guard has an approved diagnostic imaging apprenticeship (military only) from 2004: **https://doleta.gov/OA/bul04/Bul2004-19%20Occ-New%20Apprenticeable%20Occupations%20Military%20Only.pdf** 1. Curriculum designs/changes can be a lengthy and multi-layered process. 2. Employers felt that a disconnected workforce needed more connectivity between entry level rad techs and more advanced specialties. 3. Entry level education providers do not prepare the workforce for current employer needs. In particular, the current educational need does not meet the requirements for specialties, such as pharmacology.	1.1 Allow apprenticeship programs that meet industry need to adjust curriculum through an expedited process. 1.2 Work with industry to create a pre-licensure program to advance certification curriculum. 1.3 Provide didactic training.	Allow for online completion of didactic courses to allow for flexibility and the ability to spread the cohort over multiple employers across the state.	Community colleges, training programs, CSU, industry

MENTAL HEALTH

Between 2011-2015, only 37.2% of California adults who had a mental illness received mental health treatment in the last year. The Office of Statewide Health Planning and Development (OSHPD) further found that the percentage of California adults with a mental illness and the percentage of California adolescents with major depression who received treatment within the past year were lower than the percentages in the U.S. overall.[8]

A report issued by the Health Center at UCSF entitled *California's Current and Future Behavioral Health Workforce* highlights the need for an adequate supply of behavioral health workers who are distributed equitably across the state and reflect the demographic of the state's population. Stakeholders across the various sectors of mental health agree there is a need to establish academic ladders that will provide opportunities for individuals with certificates or degrees to pursue education and training leading to licensure through a workplace-based training program.

The Mental Health subcommittee focused on the following mental health/behavioral health professionals and discussed how apprenticeship can be leveraged to build a career ladder to get individuals from entry level professions into the fully licensed mental/behavioral health professions.

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Educational Psychologist (LEP)

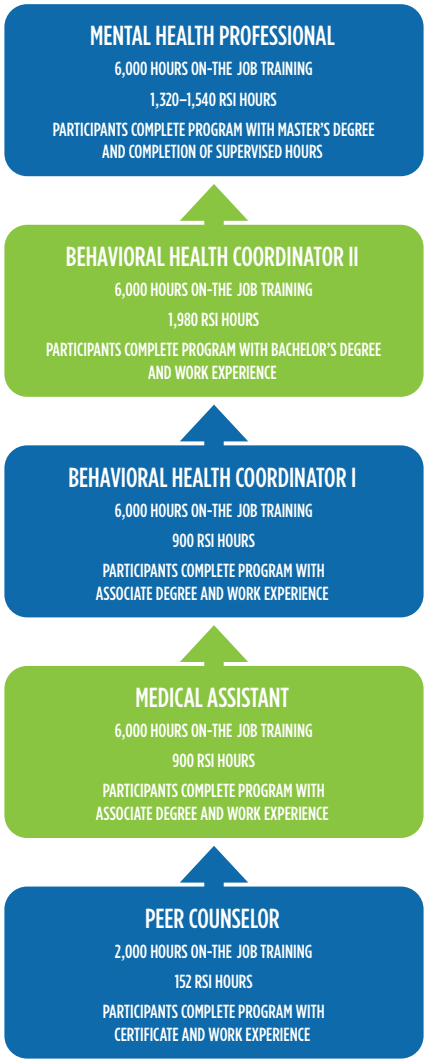
The above professionals are licensed by BBS. Each discipline requires either a qualifying master's or doctorate degree, 3,000 hours of supervised experience (gained as an employee or volunteer), the passage of an examination, and licensure application approval.

Data suggests that based on current service utilization patterns, by 2028, California will have 11% fewer psychologists, LMFTs, LPCCs, and LCSWs than needed.[9] The mental health workforce shortage is shared across the United States due in part to the aging workforce.

As states explore strategies to fill the need, new training models emerge. Washington recently developed innovative apprenticeship programs that serve as a workplace-based career pathway program, taking individuals from entry level peer counselors to fully licensed clinical social workers or marriage and family therapists. See Figures 6 and 7.

Career pathway earn and learn programs such as this, if developed in California, can serve to increase the number of diverse, competent licensed and nonlicensed professionals, expand the capacity of California's current mental health workforce, and provide greater access to care. Moreover, career pathway programs can lead to economic self-sufficiency.

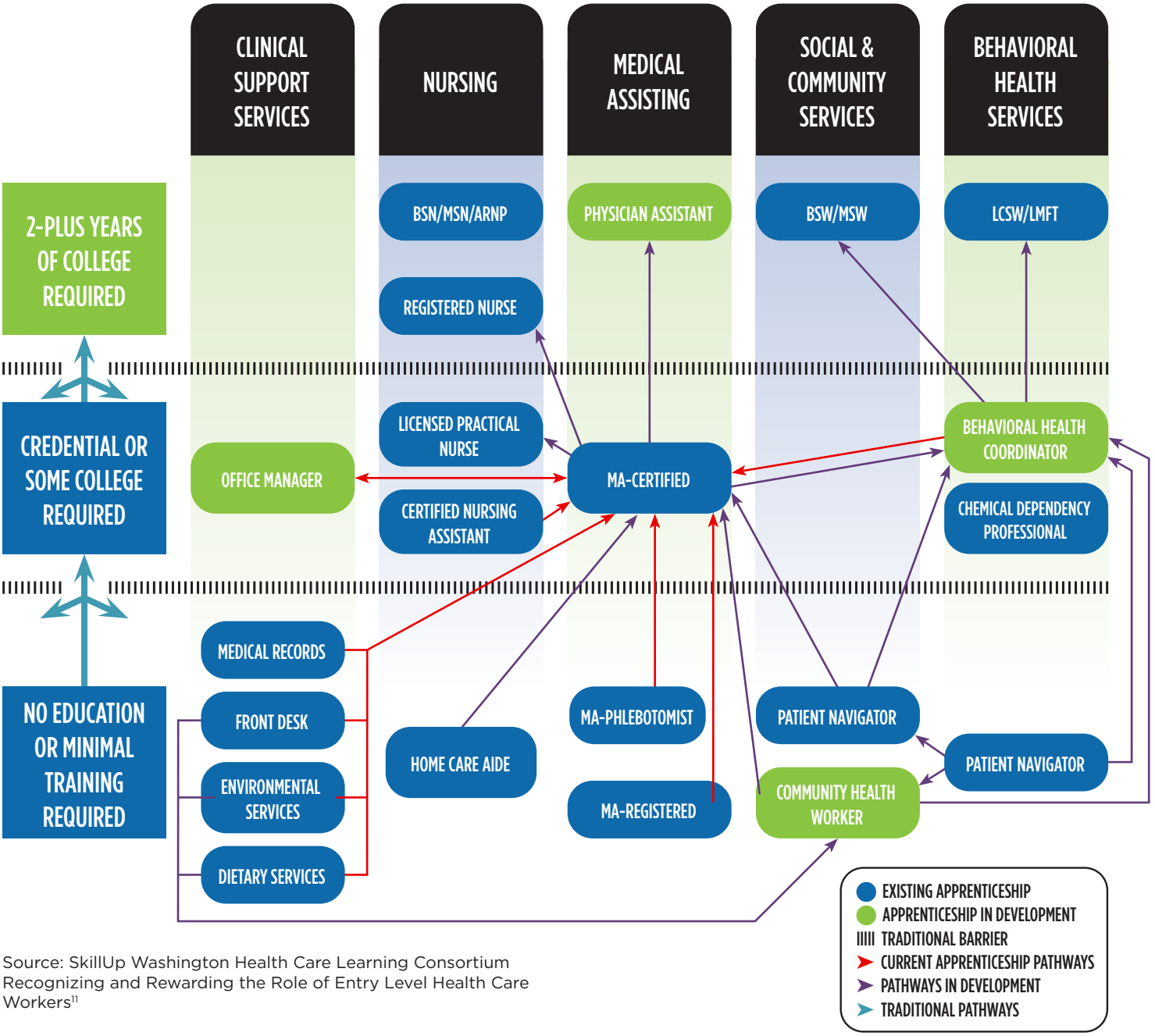
FIGURE 6



Source: Great Rivers Behavioral Health Organization Apprenticeship Program Standards

[8] **OSHPD WET Report**
[9] **https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce**

FIGURE 7



Source: SkillUp Washington Health Care Learning Consortium Recognizing and Rewarding the Role of Entry Level Health Care Workers[11]

[11] SkillUp Washington report

The following rubric reflects the barriers identified and possible solutions discussed during the Mental Health subcommittee meetings.

	MENTAL HEALTH			
	IDENTIFY BARRIER	**RECOMMENDATIONS**	**IMPLEMENTATION**	**KEY STAKEHOLDERS**
STATUTORY BARRIERS	Lack of a clear pathway between certificated or other unlicensed mental health occupations and board licensed occupations. Perceived lack of recognition by licensure boards of skills acquired through alternative means of obtaining experience. Lack of statutory recognition of practice levels below master's level, such as peer counselor, behavior tech, autism tech, bachelor's level social workers by the state is a barrier. It has led in some cases to private certification of nonlicensed personnel that makes it difficult to develop standards of practice and a set of articulated skills that lead to licensure through a career pathway under DCA or other state agency.	Develop an articulated path between paraprofessions and licensure-based occupations in order to create a defined career pathway. Explore other states licensure of the behavioral health occupations below the master's level. Develop a database on mental health paraprofessions that includes certification requirements including education and experience. Explore the feasibility of state licensure and the requirements for meeting licensure for practice levels below a master's degree.	Create a workgroup to articulate possible career pathways, identify core principals of each discipline, identifying models for career pathways. Task the workgroup with examining each of these barriers and, working with education and licensure groups and representatives from competency-based models, develop a strategy for entry into licensure from a variety of pathways. Involve the licensure boards in determining basic requirements for certification of paraprofessions that could lead to board licensure.	DAS, DCA, Legislature, DOL, MHSOAC, OSHPD, DHCS, community colleges, professional organizations
REGULATORY BARRIERS	Title 8 CCR section 212.2 requires apprenticeship programs comply with all applicable federal and state law and regulations (including the 2,000-hour requirement) to be eligible for DAS approval. Regulations may not recognize entry level classifications, i.e., peer counselor, behavior tech, autism tech, that can potentially be a pathway to master's level mental health professions.	Work with DAS to provide guidance on how to comply with the 2,000-hour requirement, especially with regards the use of competency-based approach. Convene a workgroup of key stakeholders to determine what regulatory changes would be required to create career pathways in the mental health field.	Define as broadly as possible what would count for inclusion of 2,000 hours. Create possible recommendations on the advisability or inadvisability of regulation of entry and mid-level classifications by existing boards or state agencies.	DAS, DOL, CCCCO, other state agencies
ACCREDITATION	None identified.			

	MENTAL HEALTH (CONT.)			
	IDENTIFY BARRIER	RECOMMENDATIONS	IMPLEMENTATION	KEY STAKEHOLDERS
FINANCING	New funding sources have been developed (Mental Health Loan Assumption Program, stipends) but awareness is limited. OSHPD collaborated with public mental health stakeholders to develop the 2020-2025 Mental Health Services Act Workforce Education and Training (MHSA WET) Plan, which was approved by the California Behavioral Health Planning Council (CBHPC) in January 2019. The approved plan can support stipends for individuals working toward licensure in the allied mental health professions who choose to work within the publicly funded mental health system. However, this is only one of many approved activities to be implemented with funding allocated in the FY 2019-20 budget process. Additional funding of the WET plan is not guaranteed.* Few if any loan assumption, loan forgiveness, stipend, or scholarship programs for associate's and bachelor's degree programs in the social sciences.	Create partnerships that provide outreach regarding loan repayment and scholarship programs through OSHPD and other opportunities through statewide funding resources. Work through local workforce development boards to publicize financing opportunities. Work with local education agencies and graduate programs to place interns in schools due to the change through State Plan Amendment 15-021 that will now allow interns to be reimbursed by Medi-Cal under the LEA Billing Option Program. Explore the feasibility for a program similar to CAI for four-year institutions and determine a funding source. Consider developing loan assumption, forgiveness, stipend, and scholarship programs for associate and bachelor's degree programs in the social sciences.	Develop partnerships (community colleges) that publicize loan repayment opportunities and other financing programs to underserved populations. Work with local workforce boards to publicize financing opportunities. Work with MSHOAC to develop guidelines for local workforce development to meet shortages. Counties conduct specific outreach to those with schools, community colleges, and four-year institutions as a part of the county MHSA stakeholder process. LEAs to be part of the stakeholder process. Some counties contract with school districts to provide mental health services, including services funded through Proposition 63. Best practices from these collaborations should be collected and disseminated to encourage new partnerships. Create an enhanced Medi-Cal rate for those providing licensed supervision of interns. Determine what would be needed to extend the CAI program to other sectors and who would be interested in discussing feasibility.	OSHPD, California Behavioral Health Planning Council, County Behavioral Health Directors, LEAs, DHCS, DCA, CSU/UC, DOF, labor organizations
CULTURAL	Lack of data on demographics. Lack of incentives for people to enter the profession and understanding of stigma.	Require boards to collect and report demographic data on licensees based on current authority for some DCA boards. Require educational institutions and programs to report demographic data on students as a part of accreditation of the institutions. Consider caseload ratios, compensation increases, including bilingual stipends, and remove barriers to college education.	Obtain the necessary statutory or regulatory authority.	Legislature, DCA, educational institutions and programs, diversity-based organizations

*The fiscal agent must be a CCC or K-12 local educational agency, but a four-year institution can be a partner in the apprenticeship.

	MENTAL HEALTH (CONT.)			
	IDENTIFY BARRIER	RECOMMENDATIONS	IMPLEMENTATION	KEY STAKEHOLDERS
EDUCATION STRUCTURE	Lack of career ladders within behavioral health professions. Development of pipeline programs for professionals.	Develop a career ladder that starts from high school and continues to graduate degree education. Increase the number of educational institutions and programs in underrepresented areas and determine funding sources.	Consider certification/ licensure through CDPH, DHCS, or community colleges. Use entry level programs such as medical assistants, psychiatric technicians, peer specialists, and substance abuse counselors as pathway to graduate programs. Encourage four-year psychology degree students to enter training programs for professional mental health licensure. Use recent reports from OSHPD to inform policy. Create outreach programs within educational institutions to encourage entry into mental health programs.	OSHPD, MSHOAC, CDPH, DHCS, California Behavioral Health Planning Council
OTHER	Difficulty finding high quality supervision/program sponsors. Lack of information among those in the mental health field about apprenticeship models.	Develop online repository of earn and learn partners and placements for internships and link to relevant public agency websites. Consider innovative models such as tele-supervision or roving supervision for oversight of interns in field placements. Establish formal communication between DAS IACA, mental health groups, and state agencies such as DCA, OSHPD, and DHCS.	Look at possible funding sources to incentivize licensees to become intern supervisors. Identify incentives for public and private entities to provide licensed supervision and oversite for clinical training. Consider creating incentives for supervision by counting hours toward meeting continuing education requirements. Implement provisions of SPA 15-021 that will allow interns within school districts to bill for their services.	Mental Health Services Oversight and Accountability Commission, County Behavioral Health Directors Association, DAS, DHCS, DCA, LEAs

NURSING

The Nursing subcommittee was tasked with identifying existing health care earn and learn programs in this field and gathering information regarding their focus and structures. The subcommittee worked to develop a list of existing programs that could serve as exemplars and where interested parties can glean information. While many of the programs are not registered apprenticeship programs, they demonstrate that employers—such as Sutter Health; Kaiser Permanente; Cedars-Sinai Hospital; One Community Health; educational institutions, including Fairfax High School, Valley High School, and San Joaquin Delta College; and partners, which include Jewish Vocational Service (JVS)—are engaging and working to develop paid training programs in health care that serve to narrow the skills and workforce gap and increase diversity in the workforce. These programs have yielded significant positive outcomes, such as 93% of the Cedars-Sinai Youth Employment and Development Program participants (more than half being Hispanic, Latino, Black, or Asian) going on to pursue work at the hospital after program completion. Information available on each program is provided below.

It is important to recognize all of the stakeholders who have made significant investments to provide opportunities to low-income and underserved communities and have made investments to help sustain and expand existing programs.

CEDARS-SINAI YOUTH EMPLOYMENT & DEVELOPMENT (YED) HEALTH CAREERS ACADEMY PROGRAM

Program Sponsor: Cedars-Sinai Hospital

Target Participants: Junior and senior Fairfax High School students with diverse socioeconomic and academic experiences.

Program Focus: Engage juniors and seniors at Fairfax High School in health care careers and introduce them to the workforce through experiential learning and working in the health care field.

Duration: Two-year program

Paid/Unpaid: Paid

Description: The YED program was developed to address the following problems: low rates of Fairfax High School students who pursue higher education, workforce shortages and lack of diversity in the health care field among underprivileged and at-risk youth, and economic and social disparities affecting Fairfax High School students and their families. The program is designed with three components: (1) school-based learning/health academy; (2) work-based learning; and, (3) mentoring.

Participant Demographic:

59% Hispanic or Latino
17% Black/African American
13% Asian
5% White
5% Other
72% Female
28% Male

Participant Outcomes:

77% Pursued higher education in a health care-related field of study
93% Pursued work at Cedars-Sinai Hospital
80% Pursued work at another health care setting
65% Became involved in health care in another way (e.g. volunteer work, internship)

VALLEY HIGH SCHOOL COMMUNITY HEALTH WORKER HEALTHTECH ACADEMY

Program Sponsor: Elk Grove Unified School District

Target Participants: Valley High School HealthTECH Academy students

Program Focus: Inspire students representing medically underserved areas and populations to pursue careers in health care; meet the Sacramento region's need for trained community health workers (CHWs); and, to provide transferable skills to students who wish to pursue careers in nursing, medicine, pharmacy, etc.

Duration: Four-year program (two-year internship)

Paid/Unpaid: Paid

Description: Students who are on track to meet CHW requirements can apply to participate in the HealthTECH paid internship. Interns currently serve at One Community Health and WellSpace Health. Students who are selected for internships receive additional training to build their counseling and health education skills and knowledge. Students receive CHW certification after completion of specified courses along with a minimum of 50 hours of field work experience and passage of a comprehensive CHW certification exam. The HealthTECH academy has articulation agreements with Sacramento City College's CHW program earning 1/5 nontransferrable units toward the CHW certificate at SCC, CSU Sacramento credit/dual enrollment credits for Communication Studies 5, and future articulation with California Northstate University.

JVS NURSING REFRESHER

Program Sponsor: Jewish Vocational Services (JVS)

Target Participants: Foreign trained and disconnected nurses.

Program Focus: Address the needs of trained nurses who are either disconnected from the health care workforce or who are foreign trained and new to the U.S. job market.

Paid/Unpaid: Paid

Description: In partnership with City College of San Francisco, JVS trains two cohorts of licensed vocational nurses each year. JVS provides classroom instruction, skills labs, clinical rotations at area facilities, job search services, retention support, and connections to Bay Area hospitals and other health care employers in need of culturally competent staff.

Program Outcomes: JVS has offered 14 cohorts of the Nurse Refresher Program and have placed 162 participants in jobs earning wages of $38/hour.

JVS MEDICAL ASSISTANT REFRESHER

Program Sponsor: Jewish Vocational Services

Target Participants: Applicants must have an accredited MA certification, a high school diploma or equivalent, proof of valid authorization to work in the U.S., among other requirements.

Program Focus: Enables MAs to refresh their skills in customer service and patient-centered communication while further developing their clinical and job readiness skills.

Duration: Five-week classroom learning and six weeks to three months clinical.

Paid/Unpaid: Paid

Description: In partnership with several employers including Sutter Pacific Medical Foundation, North East Medical Services, Kaiser Permanente, and La Clinica de la Raza and Lifelong Medical Care, JVS provides five weeks of classroom training that includes reviewing the MA scope of practice, vital signs, pharmacology, medication concepts and calculations, medication administration, EKG, medical terminology, cultural awareness, in-flow training, and Epic EHR training. The classroom training is followed by six weeks to three months of clinical training with the employer partner.

Program Outcomes: JVS has offered six cohorts of the MA Refresher Program and have placed 82 participants in jobs that average wages between $22.17 and $25.84/hour.

JVS MEDICAL ADMINISTRATIVE ASSISTANT TRAINING PROGRAM (EXCEL)

Program Sponsor: Jewish Vocational Services

Target Participants: CalWORKS recipients.

Duration: 8-10 weeks classroom learning and four months paid internship

Paid/Unpaid: Paid

Description: In partnership with UCSF and the San Francisco Human Services Agency, JVS trains two cohorts annually to become medical administrative assistants in San Francisco. The program consists of 8-10 weeks of classroom training and a four-month paid internship. Participants typically obtain employment as medical administrative assistants, medical receptionists, and patient service representatives post internship.

Program Outcomes: JVS has offered 16 cohorts of EXCEL since 2010 and have placed 287 participants (CalWORKS recipients) in jobs that average $20.98 - $25.52/hour.

JVS DENTAL ASSISTING PROGRAM

Program Sponsor: Jewish Vocational Services

Target Participants: Applicants must be 18 years of age or older, authorized to work in the U.S., have a high school diploma or GED, be a Bay Area resident, be low-income or unemployed, among other requirements.

Duration: Three months

Paid/Unpaid: Paid

Description: In partnership with San Francisco State University and multiple dental clinics, JVS provides over 90 hours of hard-skills instruction consisting of basic dental assistant training, 60 hours of health care related soft skills training, and 160 hours of paid externships over the three-month program.

Program Outcomes: JVS will be launching its second cohort as a regional partnership across Alameda and Contra Costa counties. JVS is also in conversations to replicate the program in San Francisco with multiple partners.

KAISER RESIDENCY PROGRAM

Program Sponsor: Kaiser Permanente

Target Participants: Newly licensed registered nurses as they transition to professional practice.

Program Focus: Provides an opportunity for experienced nurses to pass on their knowledge and help to build the next generation of professional, competent, and caring nurses. Designed to help Kaiser medical centers fill current and future nursing positions in specialty care areas.

Duration: 16-week course for labor and delivery, six-month course for perioperative nurses

Paid/Unpaid: Paid

Description: The program began with a 16-week course for labor and delivery nurses and a six-month course for perioperative nurses. A third course was added for newly licensed medical/surgical nurses, and a fourth will be added for critical care nurses. Training courses typically include a mix of newly licensed nurses and experienced registered nurses who spend three to four days a week in clinical training, working alongside an experienced nurse preceptor at the Kaiser Permanente Medical Center where they are hired. The courses also include classroom time led by Kaiser Permanente nurse educators. Nurse residents and fellows also attend a monthly, 12-month professional development program that focuses on leadership, quality outcomes, and the professional role of the registered nurse. Nurses go on to complete an evidence-based practice project at their medical center.

SAN JOAQUIN DELTA COLLEGE NURSE EXTERN PROGRAM

Program Sponsor: St. Joseph's Medical Center

Target Participants: Nursing program students with certified nurse assistant certification.

Program Focus: Designed to give the student college credit for on-the-job experience.

Paid/Unpaid: Paid

Description: Under the direction of a registered nurse, the student nurse provides basic nursing care and implements selected aspects of the patient plan of care.

WISCONSIN'S DEPARTMENT OF WORKFORCE DEVELOPMENT YOUTH APPRENTICESHIP PROGRAM

Program Sponsor: Multiple employers

Target Participants: High school students.

Program Focus: Provides opportunities for high school students who want hands on learning in an occupational area at a worksite along with classroom instruction.

Duration: One or two-year elective program

Paid/Unpaid: Paid

Description: Wisconsin's Youth Apprenticeship (YA) program is part of a statewide School-to-Work initiative. It integrates school-based and work-based learning to instruct students in employability and occupational skills defined by Wisconsin industries. Students are simultaneously enrolled in academic classes to meet high school graduation requirements, in a youth apprenticeship related instruction class, and are employed by a participating employer under the supervision of a skilled mentor. Students may participate in a number of programs including medical office, ambulatory/support services, dental assistant, medical assistant, nursing assistant, and pharmacy technician.

Program Outcomes: Over 3,000 juniors and seniors across Wisconsin participate in the Youth Apprenticeship program.

Appendix A: List of AB 2105 Stakeholders

The following is a list of the organizations that were represented and participated in this stakeholder process under AB 2105 (Rodriguez, 2016). The Department of Consumer Affairs is grateful for the assistance, large and small, provided by these organizations and their representatives.

EDUCATIONAL ENTITIES

Butte College
California Community Colleges Chancellor's Office
California State University, Northridge
East Los Angeles College
Foothill Community College
Folsom Lake College
Glendale College
Oakmont High School
Napa Valley College
San Joaquin Delta College
UC Davis Health
Valley High School Health TECH Academy
Ventura College

NONGOVERNMENTAL ORGANIZATIONS

California Association of Health Facilities
California Association of School Psychologists
California Hospital Association
California Institute for Behavioral Health Solutions
California Primary Care Association
Cedars-Sinai Hospital
County Behavioral Health Directors Association
Dignity Health
Healthcare Career Advancement Program
HR Dowden & Associates
Jewish Vocational Services
Jobs for the Future
John Muir Hospital
Kaiser Permanente
National Association of Social Workers - California Chapter
Quality Care Health Foundation
Service Employees International Union – United Healthcare Workers
Steinberg Institute
Sutter Health

PUBLIC AGENCIES

California Acupuncture Board
California Board of Behavioral Sciences
California Board of Occupational Therapy
California Board of Psychology
California Board of Registered Nursing
California Veterinary Medical Board
California Board of Vocational Nursing and Psychiatric Technicians
California Department of Health Care Services
California Department of Public Health
California Labor and Workforce Development Agency
California Workforce Development Board
Division of Apprenticeship Standards
Health Workforce Commission
Little Hoover Commission
Medical Board of California
Mental Health Services Oversight and Accountability Commission
Office of Statewide Health Planning and Development
United States Department of Labor

STATE OF CALIFORNIA

dca

DEPARTMENT OF CONSUMER AFFAIRS

Revised: 7/20 PDE_19-274

SB-1348 Postsecondary education: allied health professional clinical programs: reporting. (2017-2018)

Date Published: 09/28/2018 09:00 PM

Senate Bill No. 1348

CHAPTER 901

An act to amend Section 94934 of, and to add Section 88826.5 to, the Education Code, relating to postsecondary education.

[Approved by Governor September 28, 2018. Filed with Secretary of State September 28, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1348, Pan. Postsecondary education: allied health professional clinical programs: reporting.

Existing law establishes the California State University, under the administration of the Trustees of the California State University; the University of California, under the administration of the Regents of the University of California; the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges; and independent institutions of higher education as the 4 segments of postsecondary education in this state.

Existing law establishes the Strong Workforce Program, which provides funding to career technical education regional consortia made up of community college districts. Existing law requires the Office of the California Community Colleges to report to the Legislature specified data relating to the program.

This bill would require, beginning in 2019 and in each year thereafter, the chancellor to also report, for each community college program that offers a certificate or degree related to allied health professionals, specified information, including the number of students participating in the clinical training and the license number or employer identification number of each clinical training site, delineated by program and occupation, with multiyear implementation for the reporting.

Existing law, the California Private Postsecondary Education Act of 2009, requires an institution that is subject to the act's provisions to submit an annual report to the Bureau for Private Postsecondary Education under penalty of perjury, signed by a responsible corporate officer, by July 1 of each year, or another date designated by the bureau, that includes specified information for educational programs offered in the reporting period.

This bill would, by 2019, and in each year thereafter, require each institution approved by the bureau, offering a certificate or degree related to allied health professionals that requires clinical training, to annually report specified information, including the number of students participating in the clinical training, and the license or employer identification number of each clinical training site, delineated by program and occupation, with multiyear implementation for the reporting. By expanding the crime of perjury, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 88826.5 is added to the Education Code, to read:

88826.5. (a) Beginning in July 1, 2019, and in each year thereafter, for each community college program that offers certificates or degrees related to allied health professionals, the chancellor shall provide a report to the Legislature, with comparative clinical placement delineated by program and occupation. The report shall include both of the following:

(1) The number of students participating at each clinical training site. This shall include information about proficiency in languages other than English.

(2) The license number of each clinical training site. If the license number is not available, the report shall include the employer identification number of the clinical training site.

(b) The collection and reporting of findings pursuant to subdivision (a) will be implemented over multiple years, and collected by the chancellor's office as follows:

(1) Beginning in the 2019–20 academic year, the chancellor's office shall collect from colleges, and report on, the following allied healthcare professional degrees and certificates:

(A) Licensed Vocational Nurse.

(B) Medical Assistant.

(C) Occupational Therapy Aide.

(D) Radiologic Technologist.

(E) Respiratory Care Therapist.

(F) Pharmacy Technician and Technologist.

(G) Surgical Technician and Technologist.

(2) Beginning in the 2020–21 academic year, the chancellor's office shall collect from colleges, and report on, the following allied healthcare professional degrees and certificates:

(A) Cardiovascular Technologist.

(B) Certified Nurse Assistant.

(C) Dialysis Technician.

(D) Diagnostic Medical Sonographer.

(E) Medical Lab Technician.

(F) Orthopedic Assistant.

(G) Physical Therapy Aide and Assistant.

(H) Psychiatric Technologist.

(I) Radiologic Therapist.

(J) Speech Language Pathology Aide.

(3) Beginning in the 2021–22 academic year, and in each academic year thereafter, the chancellor's office shall collect from colleges, and report on, all certificates or degrees related to allied health professionals that require clinical training.

(c) Any disclosure under this section shall be in compliance with state and federal privacy laws.

(d) For the purposes of this section, "allied health professional" has the same meaning as in Section 295p of Title 42 of the United States Code.

SEC. 2. Section 94934 of the Education Code is amended to read:

94934. (a) As part of the compliance program, an institution shall submit an annual report to the bureau, under penalty of perjury, signed by a responsible corporate officer, by July 1 of each year, or another date designated by the bureau, and it shall include the following information for educational programs offered in the reporting period:

(1) The total number of students enrolled by level of degree or for a diploma.

(2) The number of degrees, by level, and diplomas awarded.

(3) The degree levels and diplomas offered.

(4) The School Performance Fact Sheet, as required pursuant to Section 94910.

(5) The school catalog, as required pursuant to Section 94909.

(6) The total charges for each educational program by period of attendance.

(7) A statement indicating whether the institution is, or is not, current in remitting Student Tuition Recovery Fund assessments.

(8) A statement indicating whether an accrediting agency has taken any final disciplinary action against the institution.

(9) Additional information deemed by the bureau to be reasonably required to ascertain compliance with this chapter.

(b) The bureau, by January 1, 2011, shall prescribe the annual report's format and method of delivery.

(c) (1) By July 1, 2019, or another date designated by the bureau, and in each year thereafter, each institution approved to operate by the bureau, that offers specified certificates or degrees related to allied health professionals that require clinical training, shall include in the report submitted pursuant to subdivision (a) clinical placement data delineated by program and occupation. The report shall include all of the following:

(A) The number of students participating at each clinical training site. This shall include information about proficiency in languages other than English.

(B) Whether any donation, money, compensation, or exchange of consideration was offered or provided to the business, nonprofit, or other organization, clinic, hospital, or other location where the student was placed and, if so, the amount.

(C) The license number of each clinical training site. If the license number is not available, the report shall include the employer identification number of the clinical training site.

(2) The collection and reporting of findings pursuant to paragraph (1) will be implemented over multiple years, and collected by the bureau as follows:

(A) By the 2019–20 fiscal year, or another date designated by the bureau, each institution approved to operate by the bureau shall include in the report submitted pursuant to subdivision (a), the following allied healthcare professional degrees and certificates:

(i) Licensed Vocational Nurse.

(ii) Medical Assistant.

(iii) Occupational Therapy Aide.

(iv) Radiologic Technologist.

(v) Respiratory Care Therapist.

(vi) Pharmacy Technician and Technologist.

(vii) Surgical Technician and Technologist.

(B) By the 2020–21 fiscal year, or another date designated by the bureau, each institution approved to operate by the bureau shall include in the report submitted pursuant to subdivision (a), the following allied healthcare professional degrees and certificates:

(i) Cardiovascular Technologist.

(ii) Certified Nurse Assistant.

(iii) Dialysis Technician.

(iv) Diagnostic Medical Sonographer.

(v) Medical Lab Technician.

(vi) Orthopedic Assistant.

(vii) Physical Therapy Aide and Assistant.

(viii) Psychiatric Technologist.

(ix) Radiologic Therapist.

(x) Speech Language Pathology Aide.

(C) By the 2021–22 fiscal year, and in each fiscal year thereafter, each institution approved to operate by the bureau shall include in the report submitted pursuant to subdivision (a), all certificates or degrees related to allied health professionals that require clinical training.

(D) Any disclosure under this section shall be in compliance with state and federal privacy laws.

(E) For the purposes of this subdivision, "allied health professional" has the same meaning as in Section 295p of Title 42 of the United States Code.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Occupational Therapy Assistants (OTAs)

Occupational Therapy Assistants (OTAs) assist occupational therapists in providing occupational therapy treatments and procedures. May, in accordance with state laws, assist in development of treatment plans, carry out routine functions, direct activity programs, and document the progress of treatments. Generally requires formal training.

In California, the Board of Occupational Therapy (CBOT) is responsible for licensing occupational therapy assistants.

OTA Workforce in California

Jobs

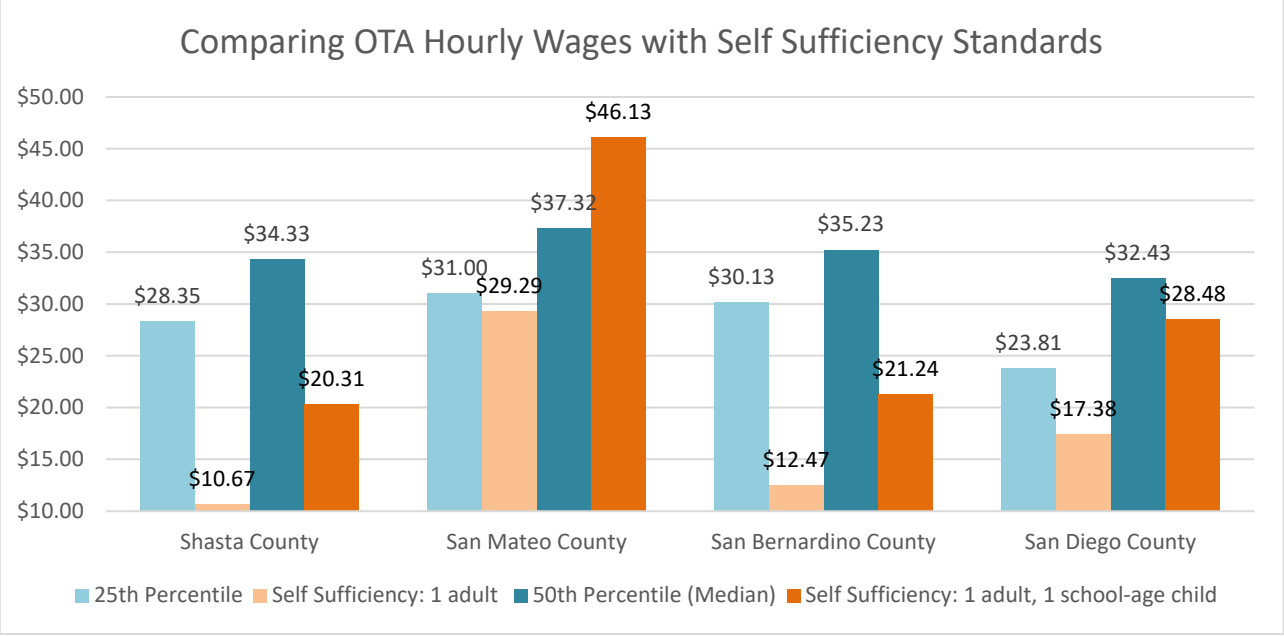
In 2019, it is estimated there were about 2,900 OTAs employed across California. Looking forward to 2024, occupational projections indicate significant new job growth of 29% or more than 830 jobs; additionally, each year about 11% of current workers are expected to change occupations altogether – creating approximately 1,740 replacement jobs during the 5-year period. Annually, the new job growth and the replacement needs create as many as 500 opportunities for new professionals.

Wages

Wages are subject to variability based on location, years of experience, and employer. However, assuming a full-time schedule of 40 hours per week, an OTA in California could reasonably expect to earn between $59,200 and $71,650 annually. This range represents estimates of earnings at the 25th and 50th percentile (median).

Using the same wage range, the hourly wages for four representative counties within California are shown below and compared to county-level self sufficiency standard or living wage estimates. This illustrates the difference in cost of living and wages earned across California.

As shown in the chart, earnings within the 25th-50th percentile wage range for OTAs in three of the four counties (Shasta, San Bernardino, and San Diego counties) exceed the self sufficiency standard to support a single adult and the standard for one adult and one school-age child. However, in San Mateo County, an individual would need to overcome an income gap of about $7.00 per hour to meet the one adult, one school-age child standard.



Licensing

Occupational therapy assistant programs offered through California community colleges focus on cohort-based instruction leading to an associate-degree accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association (AOTA). Graduates of these programs are eligible to sit for the national certification examination administered by the National Board for Certification in Occupational Therapy (NBCOT). After successful completion of this exam, the student will be a Certified Occupational Therapy Assistant (COTA). In addition, California requires licensure to practice; however, the California license is based on the results of the NBCOT Certification Examination. According to CBOT, an estimated 3,500 individuals held an active California OTA license in 2019.

Educating the Future OTA Workforce through California Community College Programs

OTA Programs at California Community Colleges

During the 2018-19 program year, there were three active OTA programs at community colleges statewide, serving as many as 340 students who took non-introductory courses in the Occupational Therapy Technology program code (TOP 1218).

OTA students are:

- **Successful** – 92% of students successfully complete their OTA classes.
- **Committed** – 64% of students successfully complete more than 15 units annually.
- **Majority female** – 81% of students identified as female; 17% as male (remaining masked).
- **Proven** – about one-third of students previously earned a community college award and 35% of students have already completed a Bachelor's degree.
- **Largely White or Hispanic** – 32% of students identified as White; followed by 29% students who identify as Hispanic, 13% as Asian, 9% Filipino, and 6% Black.

OTA students become:

- ✓ **Graduates** – in 2018-19, 77 students completed Associate degrees in Occupational Therapy Technology.
- ✓ **Licensed occupational therapy assistants** – in 2016-17, 88% of former students reported they had obtained third-party credentials.
- ✓ **Employed in field of study** – a majority (92%) of former OTA students surveyed reported being employed in their field of study.
- ✓ **More financially secure** – OTA students recorded a median change in earnings of 31% within one year (when compared to wages earned prior to course taking); the median annual earnings one year later total $35,230. Older data show progression to earnings of about $54,000 within three years after exit.

Clinical Placements

During the 2019-20 program year, three OTA programs reported 52 clinical placements at 31 sites across the state. Programs reported that students proficient in Spanish, Chinese, Tagalog and at least one other non-English language were introduced into clinical sites.

The table below lists each clinical site alphabetically, their license number or EIN (as available), the total number of OTA clinical placements for the 19-20 program year, and non-English languages reported (as available).

Provider/Site	License # or EIN	# of Students at Site*	Languages Reported