First Commission Meeting!

SEPTEMBER 28, 2017
Commission Charge (by December 2018)

• Develop a strategic plan for building the future CA health workforce (2030).
  o Promote practical short, medium, and long term solutions for the State, education and employers to address current and future workforce gaps.
  o Agree on a cooperative strategy that promotes shared ownership and priorities and that makes optimal use of diverse stakeholder resources.

• Seek commitments for effective plan implementation.

• Build on, align with, and leverage relevant public and private efforts for greater collective innovation, efficiency, and impact.

• Act as a private commission with state government participation.

• Educate and engage key public and private stakeholders to support success.
Meeting Objectives - First Step Together

1. Shared understanding of our vision, process and success
2. Relationship and trust building
3. Level set and discuss:
   ◦ key demographic, health and economic trends and drivers
   ◦ relevant health workforce data, projections and gaps
   ◦ emerging educational pipeline challenges and opportunities
4. Engage in envisioning our future health system & workforce implications
5. Decide on priority content and foundational areas of focus
6. Share our aspirations, expertise and innovations
7. Strengthen our commitment and approach to our collective charge
How We Engage Together: Key Meeting Agreements

• Be present and stay engaged
• Make it both real and a possibility zone
• Step up/step back
• Respect for differences, openness to other views
• Understand this is an evolving creative process:
  o Candor, disagreement and discomfort are part of the creativity process
  o Seek bold, breakthrough solutions
  o We are doing something that hasn’t been done before
  o Allow for mistakes
  o Go slow to go fast
• Keep our shared end goal in mind:
  o Communicate the interests of your constituents but represent the collective good
  o Focus on what is best for our patients, communities and students
Introductions
(90 seconds each)

• Name
• Organization
• Title
• How you are involved with health workforce or education
• One word that comes to mind about the commission
How Will We Work Together to Accomplish our Charge?

PRINCIPLES, PROCESS, PRODUCTS, SUCCESS

JEFF OXENDINE AND KEVIN BARNETT
Guiding Principles

Forward-looking
- Workforce needs between (now until 2030).
- Practical, rooted in the most likely scenarios given what is known today.
- Flexible and iterative, course corrections will be made

Economic benefits of a robust health workforce

Educational enablers for the future workforce
- Students at public and private institutions
- K-12, community college and four-year students, health professions school students
Guiding Principles

Aligned and harmonized with education sector plans.

Health workforce including health care and population health in public, nonprofit, and private sectors.

Equity as an overarching goal to address the needs of the underserved and seek to eliminate disparities.

Greater educational, employment, and economic opportunity for Californians to become the next generation of diverse health leaders and professionals who positively impact the health of their communities.
Process Design Objectives

Current gap and future workforce needs-oriented
Out-of-the-box thinking, going beyond traditional approaches, silos
Problem and evidenced-based
Actionable collective solutions with new ways of working together
Proven frameworks provide focus and structure
Leverage and align with other efforts:
 ◦ Inform and accelerate process with previous recommendations
 ◦ Align process with current efforts led by others
Plan and process align with guiding principles
Commission and key stakeholder buy-in and support
Completed by 12/18
Process Design Objectives: Balancing

Transparency

Safe space for
◦ Candid discussions
◦ Radical, bold proposals
◦ Tradeoffs and commitments

Broad stakeholder engagement
◦ Community and patient voice
◦ Effective solutions
◦ Build support

Efficiency
◦ Time and resource constraints
Pre Commission Work

Key informant interviews regarding plan value, outcomes and success

Lessons learned from initiatives in CA and other states

Inventory and data base of health pathway programs
Key Success Factors
(From Key Informants)

Clear objectives, end product & definition of success
Inclusive but efficient process
Practical solutions to priority problems, early wins
Results and outcomes focused process
Strong educational campaign in parallel with content
Build on previous recommendations and good data
Top leaders develop collaborative solutions and commit resources and support

“Cant do it all”
Key Success Factors
(From Key Informants)

Align state-level solutions with regional strategies
Build on existing initiatives & innovations
Engage associations, unions, agencies, consumers
Focus on what is good for patients & population
Invest sufficient resources in plan development & implementation
Seed money for implementation
Others lead in their expertise areas
What is Our Definition of Success (Process/Systems Change Outcomes)

Agreement on common, multi-year agenda
Alignment and coordination among:
  ◦ education, workforce and regional initiatives
Focused on priority problems and needs, ROI
Shared success metrics and tracking
Stakeholder engagement and investment
Greater policymaker awareness and interest
Infrastructure for execution and data
Plan for reporting, accountability, adjustment
<table>
<thead>
<tr>
<th>Potential Statewide Plan Outcomes (Types of Recommendations)</th>
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<tbody>
<tr>
<td>Priority workforce needs</td>
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<tr>
<td>Training requirements</td>
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<tr>
<td>Policy and regulatory</td>
</tr>
<tr>
<td>Scope change</td>
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<tr>
<td>Program scaling &amp; sustainability</td>
</tr>
<tr>
<td>Education capacity and investments</td>
</tr>
<tr>
<td>Pilot projects</td>
</tr>
<tr>
<td>In-kind contributions</td>
</tr>
<tr>
<td>Allocation of current or new public and private funding</td>
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<tr>
<td>Changes in other statewide plans</td>
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<tr>
<td>Support for and investment in regional workforce and pathways</td>
</tr>
<tr>
<td>Infrastructure</td>
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<tr>
<td>Data requirements and sharing</td>
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</tbody>
</table>
# Plan Format

<table>
<thead>
<tr>
<th>Components</th>
<th>Time Horizon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision and Mission</td>
<td>Near (1-3 years)</td>
</tr>
<tr>
<td>Goals</td>
<td>Medium (3-5 years)</td>
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<tr>
<td>Strategies</td>
<td>Long Term (5 plus years)</td>
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<tr>
<td>Objectives and Metrics</td>
<td></td>
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<tr>
<td>Action Plans</td>
<td>Prioritized and Sequenced</td>
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<tr>
<td>Resources</td>
<td></td>
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<tr>
<td>Responsible entities</td>
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Managing Complex Change

1. Vision → Skills → Incentives → Resources → Action Plan → Change
2. Skills → Incentives → Resources → Action Plan → Confusion
3. Vision → Incentives → Resources → Action Plan → Anxiety
5. Vision → Skills → Incentives → Action Plan → Frustration
6. Vision → Skills → Incentives → Resources → False Starts
Future health workforce - the right people in the right places - with the competencies and capabilities to promote and deliver health in all communities.

OUTCOMES
IMPROVED ECONOMIC OPPORTUNITY
REDUCED HEALTH DISPARITIES
BETTER HEALTH
BETTER CARE
LOWER COSTS

QUALITY EDUCATION, CAPACITY, AND TRAINING ALIGNED WITH NEEDS
DIVERSITY
race/ethnicity, gender, sexual orientation, socioeconomic status

EQUITY
geographic distribution, access to opportunity - education, living wage

TECHNOLOGY
leveraging technology to accelerate transformation across settings

FOUNDERATIONAL ELEMENTS
Primary Care & Prevention, Behavioral Health, Aging

Focus Areas

SHARED OWNERSHIP
of the problem and solution among key stakeholders, and working together differently to achieve results.
<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>YEARS 1-3</th>
<th>YEARS 3-5</th>
<th>YEARS 5-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply &amp; Capacity</td>
<td>Sufficient workforce capacity within 3 focus areas in targeted regions and settings</td>
<td>Increased # of certified Peer Support Specialists in public mental health settings, reimbursement for their services</td>
<td></td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>Capacity, skills, training, production align with priority employer needs and are accessible, affordable and equitable for population</td>
<td>Content and experiences to prepare students to effectively address social determinants integrated in clinical training curriculum</td>
<td>Additional residency training slots in primary care and mental health with rotations in community settings in underserved regions</td>
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<tr>
<td>Diversity &amp; Equity</td>
<td>Geographic and setting distribution and racial/ethnic representation of workforce reflects population and promotes inclusion, equity, excellence</td>
<td></td>
<td>X increase in number of Latino and African American male medical and dental students in CA schools</td>
</tr>
<tr>
<td>Economy &amp; Economic Opportunity</td>
<td>Utilize workforce cost effectively for Triple Aim, fuel economy and increase job, internship and economic opportunity</td>
<td>Large scale funding to increase in paid internships for pre-health K-12, college and post bac students in priority professions. 60% get jobs, 80% go on to health training programs.</td>
<td>X residents get training and jobs in growing technology and data roles.</td>
</tr>
<tr>
<td>Health</td>
<td>Targeted access, quality, cost, and outcomes within 3 focus areas. Disparities reduced in key metrics</td>
<td>Improved primary care &amp; preventive service access for Medi-Cal patients yielding x percent reduction in acuity and preventable utilization</td>
<td>X percent reduction in diabetes incidence among defined Medi-Cal populations.</td>
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<tr>
<td>Accountability &amp; Monitoring</td>
<td>Sufficient resources and institutional commitment secured for infrastructure and priority recommendation implementation</td>
<td></td>
<td>Increased CHW use, roles &amp; integration leads to reduced asthma complications and cost</td>
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Process for monitoring, reporting and accountability implemented. Adjustments made as needs and priorities shift.
Evita Limon Rocha

Pipeline Program Product
MD and MPH
UC Irvine Psychiatry Resident, Peds focused
Policy Advocate
Plans to return to serve in Inland Empire
How Will We Get There?
6 quarterly meetings

Up to 8 mtgs (4 in-person, 4 web)

2-3 meetings

2 (No. & So. Cal) CHPC/CHWA meetings to provide targeted regional input
Standardized input from trade associations/advocacy groups, education or employer systems
Foundation direction, guidelines and input
Online and in-person events for regional, community and other stakeholder input
Our Process & Products

1) Consensus on future scenarios of health delivery & population health in CA
2) Prioritize 3 major health challenges areas within future models
3) Agree on the workforce and education implications of future models and solutions to address priority health challenges
4) Understand current workforce & education realities, innovations and recommendations
5) Select priority workforce challenges to be addressed by Commission
6) Future models, roles, needs and paths and associated barriers and solutions (for each workforce challenge)
7) Short, medium and long term recommendations and action plans to meet targeted, measurable outcomes and ROI
8) Final 12 year road map with priorities, sequencing & timeline
9) Stakeholder roles and resource commitments
10) Plan for implementation, adjustment, accountability & sustainability
Coordinated Health Workforce Pathway

Target Groups:
- Incumbent Workers
- High School and Community College Students
- Career Changers
- Displaced Workers
- Undergraduates
- Immigrant Health Professionals
- Graduate Public Health Students
- Medical Students and Residents
- Veterans

K-12 Education

Career Awareness
Assessment
Academic Preparation & Entry Support
Financial & Logistic Feasibility
Health Professions Training Program Access
Training Program Retention
Internships
Financing & Support Systems
Hiring & Orientation
Retention & Advancement

Pre-Training
Health Professions Education
Workforce

Cultural Sensitivity and Responsiveness

Coordination and Support Infrastructure

Quality, Diverse Health Workforce

Jeff Oxendine©
MFT Workforce Pathway

Target Groups:
- Un-licensed mental health professionals
- Community college students
- Career Changers
- Displaced Workers
- Undergraduates
- Immigrant Health Professionals
- Consumers and family members
- Educators (pre-school – 12)
- Veterans

Pre-Training
- Career Awareness
- Assessment
- Academic Preparation & Entry Support
- Financial & Logistic Feasibility

Health Professions Education
- Health Professions Training Program Access
- Training Program Retention
- Internships
- Financing & Support Systems
- Hiring & Orientation

Workforce
- Internships
- Financing & Support Systems
- Hiring & Orientation
- Retention & Advancement

Cultural Sensitivity and Responsiveness
- Cultural Sensitivity and Responsiveness

Restrictions on billing Medicare for services and in HQHCs
- Bias against hiring MFTs in some community organizations

Limited information about the range of work settings and activities
- Lack of basic education skills for some groups
- Cost and geographic availability of education and training
- Academic and social challenges of persons with lived experiences entering the field
- Lack of MFTs prepared to work in integrated healthcare settings

Adapted from the coordinated health career pathway developed by Jeff Oxendine.
Decision-making Process

Public Input

Staff summary

Commissioners, TAC Members, Experts

Subcommittee 1

Subcommittee 2

Subcommittee 3

ROLE: Advise on recommendations

ROLE: Develop & refine recommendations

Technical Advisory Committee

Subcommittee & staff refines

Commission

ROLE: DECISION-MAKING

Public Input
## Commission Subcommittees

**PARTICIPANTS**

<table>
<thead>
<tr>
<th>Commissioners</th>
<th>TAC Members</th>
<th>Experts</th>
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**ROLE AND COMMITMENT**

- **Develop solutions in Priority Areas of Focus**
- **Meet 2 times between Nov and Feb**
- **Additional meeting or communication or meetings refine recommendations**
- **Co-Chairs**
- **Volunteer to Veronica by 10/7**
Opportunities for Stakeholder Input

- Subcommittee participation
- Participate in public portion of Commission/TAC meetings
- Staff to attend events & meetings
- Submit comments via website & online surveys
- Send reports & research to staff
- Present to subcommittees
- Meet with staff
- Participate in public portion of Commission/TAC meetings

Master Plan
Challenges to Work Through Together

- Financial
- Political
- Institutional
- Competitive dynamics
- Size, complexity and diversity
- Competing priorities
- Alignment
Align with and Leverage other Initiatives (examples)

Strong Workforce Initiative
CA Primary Care Association- Primary Care
Leading the Way Coalition- Behavioral Health
Health Impact- Nursing
OSHPD
Health Lab Workforce Initiative
California Workforce Pathways Advisory
Building Healthy Communities
“It always seems impossible until it is done”
CFHWC
Technical Advisory Committee

ROLE IN PROCESS, PRE-MEETING SURVEY FINDINGS, AND POST-MEETING ONE TAKE AWAYS

CALIFORNIA FUTURE HEALTH WORKFORCE COMMISSION
TAC Charge

Purpose:
Share in-depth knowledge and expertise on health workforce issues to inform the dialogue and decision-making of the commission.

Function:
Advisory to the core management team and the Commission.
Roles

**Provide early input** on the process, products and priorities

**Facilitate** effective stakeholder communication, input and support

**Inform** the commission and each other about promising innovations and initiatives

**Assist** in the proactive identification of potential problems and assist in the development of creative solutions

**Align and leverage** stakeholder workforce efforts

**Work together** to promote and advance agreed upon collective solutions
Q1: What are the top 3 current HW challenges that CA needs to address?

1. Shortage of health care providers and health professionals
2. Educational capacity; training and opportunities to increase workforce diversity
3. Geographic distribution and supply in rural and underserved areas

Other:
- Reducing costs – health care, education, housing
Q2: What are the top 3 future HW challenges that CA needs to address through 2030?

1. Increasing education and training capacity
2. Cost of education
3. Demand for health care providers, especially for growing elderly population

Other:
- Preparing workforce for delivery system, technology advances, new models/non-traditional roles, addressing social determinants of health
Q3: What are the 3 most important future HW challenges in CA the Commission and/or other organizations should address?

1. Strengthening health care workforce
   - Primary care - GME funding, scope of practice, team-based care, care integration, shifting to community health focus/approach
   - Training mental health and behavioral health providers
   - Retiring workforce and caring for aging population

2. Education capacity, training, career development/advancement opportunities

3. Increasing workforce diversity pipeline
Q3
Q4: What are the 5 most significant trends you see impacting health and health care in CA over the next 10 years?

1. Shift toward value-based care and payment, pressure on costs and outcomes
2. Focus on addressing social determinants of health, care coordination and integration
3. Aging population - retiring workforce and caring for the elderly
4. Primary care and behavioral health integration
5. Technology innovations and impact on care delivery
Meeting #1 Takeaways

- Strong interest in getting to core assumptions about the future and their implications.
- Need for visual(s) to sort through different domains, foundational principles, and to inform priority setting.
- Question among some whether diversity (and perhaps equity) are priorities to pursue separately, or whether are core issues to address within each of the three priority areas of focus.
- Ensure input from diverse stakeholders, beyond medical model.
- Legacy standards (e.g., accreditation, certification) are substantial obstacles to meaningful (and timely) change.
Session Objectives

To level set knowledge
To stimulate discussion
To be provocative and encourage innovative, outside the box thinking with regard to future possibilities
To ground the effort in evidence and past experience with pace of change

Ultimately, to bring us toward agreement on assumptions about the future of health in California and the implications for the health workforce
Presentation Overview

California’s population and population health

California’s evolving models of health care:
◦ Shared Principles of Primary Care - Patient-Centered Medical Homes;
◦ Accountable Care Organizations;
◦ Accountable Communities for Health

Potentially disruptive innovations
Looking toward the future

Timeframe: tomorrow through 2030

It is easier to agree on the direction of change than the pace of change

“The future is unknowable”
Welcome to California

ENTERING PACIFIC TIME
Influences on Population Health are Interdependent

Population growth

Increasing diversity of population

Aging population

Chronic illness

Social ills
Costs of Care: High and Increasing

Access to Care: Progress Made, More to be Done

California uninsured rate dropped from 17.2% in 2013 to 7.4% in 2016 (decreasing faster than U.S.)

Roughly 2.9 Million Californians still have no health insurance

Medi-Cal covers 1 in 3 Californians

Over 5 million California adults suffer from mental illness – and only about a third received mental health service in the past year.

Quality

Overall, system continues to underperform

Small improvements in some areas over past 10 years

Inequities persist
Shared Principles of Primary Care

Person and Family Centered
Continuous
Comprehensive and Equitable
Team Based and Collaborative
Coordinated and Integrated
Accessible
High-Value

Sources: Shared Principles of Primary Care, Fall 2017
Payment Reforms: From Volume to Value

Two payment models will dominate:

- **Episode based payments**
  - Single target budget for entire bundle of services needed during an episode of care
  - E.g.g. joint replacement, chemotherapy, pregnancy

- **Population based payments**
  - Risk-adjusted target budget to care for a defined population over a specified period, generally a year.
  - If spending falls below the “benchmark”, providers share in the savings
Aging in Place

Sources: Beck, L. and Johnson, H., 2015, Planning for California’s Growing Senior Population, Public Policy Institute of California; ACS; Decennial Census.
Disruption Ahead
Potentially Disruptive Innovations

Wearable monitors
Virtual Medicine/Telehealth
Precision Medicine
Machine Learning
Artificial Intelligence
Robots
Genomics
Pattern recognition software
Robotic surgeries
3D printing
Stem cell-based therapies
# Future Health System: California

<table>
<thead>
<tr>
<th>Patient-Centered Medical Homes</th>
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<td>Accountable Care Organizations</td>
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<td>Accountable Communities for Health</td>
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- Patient-Centered
- Coordinated and Integrated
- Accountable
- Population Health Focused
- Prevention Focused
- Social Determinants of Health
- Interdisciplinary Perspective
- Value Based
- Technology Enabled
Chronic Care Model
Let’s Get Healthy California Task Force Framework

The Triple Aim:
Better Health • Better Care • Lower Costs

Health Across the Lifespan
Living Well: Preventing and Managing Chronic Disease
Healthy Beginnings: Laying the Foundation for a Healthy Life
End of Life: Maintaining Dignity and Independence

Pathways to Health

Redesigning the Health System: Efficient, Safe, and Patient-Centered Care
Creating Healthy Communities: Enabling Healthy Living
Lowering Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes

Health Equity: Eliminating Disparities
3.0 Transformation Framework

Health Delivery System Transformation Critical Path

Acute Care System 1.0
- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

Coordinated Seamless Healthcare System 2.0
- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0
- Healthy population centered
- Population health focused strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

Halfon N. et al, Health Affairs November 2014
Redefining Population Health in the Era of Health Care Transformation

California Future Health Workforce Commission
Thursday, September 28, 2017

Kevin Barnett, DrPH, MCP
Senior Investigator
Public Health Institute
Overview

The Imperative for Health Care Transformation

Social Determinants of Health

Engagement, Leverage and Alignment Across Sectors

The Community Development Opportunity

Implications for Health Workforce
Imperative for Health Care Transformation

Expanded coverage and shift in financial incentives
Providers/payers increasingly at financial risk for poor health driven by SDH
Increasing transparency re: quality, community benefit
Emerging societal imperative to address fundamental inequities
Align health and community development sectors
Better align and optimally leverage EXISTING resources
Local infrastructure to manage, evaluate, and sustain comprehensive strategies
Health Care Transformation Continuum
Evolution of payment models and analytic capacity

Hospital as “Total Health” Anchor Institution
With shared ownership for the health of the community

Global Payment
- Shared Risk
- Shared Savings
- Bundled Payments

PCMH
Pay for Performance

PCCM
ID and Analyze Geographic Concentrations Of Inequities

ID and Analyze Factors Influencing Panel
ID and Analyze Common Diagnoses

Episodic Patient Care
ID and Analyze

Hospital as Acute Care “Body Shop”

Fee for Service
Readmission Penalty

Align Resources With Diverse Stakeholders

Improve Health of Community

Evolution of payment models and analytic capacity

- Hospital as “Total Health” Anchor Institution
- With shared ownership for the health of the community
Tools for Increased Transparency and Equity
Public access GIS analytics ([www.chna.org](http://www.chna.org)) support ID of relative alignment between hospital defined communities (for community benefit purposes) and census tracts (in tan color) where poverty and health disparities are concentrated. Black outline shows a hospital defined area that avoids low income census tracts.

From Insularity to Engagement
Patterns of community engagement in community health assessments and beyond

CHNA

Priority Setting

Implementation Strategy
Community Engagement - Lessons from History
Importance of moving beyond tokenism to meaningful engagement for optimal mobilization of community assets

In 2014, the Hospital of the University of Pennsylvania provided $7.1 million worth of charity care equal to only .32 percent of its $2.2 billion in net patient revenue, while it had about $150 million in profits.

Meanwhile, Temple provided $29.2 million worth of charity care, equal to 3.42 percent of its $856 million in net patient revenue, while losing about $5 million on operations that year. The revenue made it the eighth largest hospital by revenue.

HUP had much more bad debt — $29.3 million or 1.31 percent — compared to Temple’s $1.8 million or .22 percent in bad debt.
Center to Advance Community Health and Equity
National center supported by RWJF to strengthen alignment of hospitals, health and community development sector stakeholders to address SDH

CACHE uses tools and technical assistance to build shared ownership for health through collaborative problem solving, focusing where health inequities are concentrated. Forms of TA and support include:

- 990H analysis and interpretation
- GIS analysis of social determinants of health and related data.
- Analysis of hospital utilization data.
- Assessment of alignment opportunities across sectors.
- Community development capacity assessment and alignment with population health strategies.
Re-Defining Population Health

Importance of moving beyond the medical model and patient panel management to a place-based approach to improving health.

Medical Model Population Health

Assess patient health status

Ensure timely access to clinical services and medications

Clinical case management through team-based care

Patient education

Use EMR to ID and group risk populations, monitor service utilization and patient outcomes

Lament persistent patient noncompliance

Place-Based Population Health

Assess patient health status, *social and environmental risk factors*

Ensure access to clinical services & link to *social support systems*

Case management through clinical and *community-based teams*

Community-based education, *problem solving, and advocacy*

Use *EHR* and *GIS* to identify geo conc. of *health disparities, target interventions*, & monitor population health outcomes

Leverage HC resources through *strategic engagement* of diverse stakeholders
IHI 100 Million Healthier Lives Initiative
Portfolios of population health reflecting movement from person centered, to targeted populations, to broader community problem solving

- Portfolio 1: Population management: (mental and/or physical health)
  - Proactively optimizing mental and/or physical health

- Portfolio 2: Population management: (social and/or spiritual wellbeing)
  - Addressing social or spiritual drivers of wellbeing

- Portfolio 3: Community health and wellbeing
  - Active partners to improve the health and wellbeing of subpopulations of the community

- Portfolio 4: Communities of solution
  - Stewards of community wellbeing in partnership with people with lived experience

Portfolios 1-4 reflect movement from person centered, to targeted populations, to broader community problem solving.
Coming to Terms with Health Inequities
Meaningful partnerships are needed to address these drivers of poor health, all of which are outside of clinical service delivery.

• Unhealthy housing
• Exposure to array of environmental hazards
• Limited access to healthy food & basic services
• Unsafe neighborhoods
• Lack of public space, sites for exercise
• Limited public transportation options
• Inflexible and/or poor working conditions
• Impact of chronic stress
Redlining Health inequities are a product of many decades of discriminatory practices, starting with federal policies and associated business decisions that have devastated the potential for accumulation of capital by people of color.
Problem Analysis

Addressing the high costs of chronic illnesses requires a thoughtful approach to causes and associated impacts.

Root Causes
- Epigenetic triggers
- Toxic stress/helplessness
- Unsafe Neighborhoods
- Poverty
- Food Insecurity
- Limited healthy food access
- Food mktg influence
- Limited access to preventive services
- Limited transport options

NT Causes
- Limited physical activity

NT Impacts
- Diabetes
- Bullying, isolation in school
- Low self esteem

LT Impacts
- Increased societal HC costs
- Reduced career options
- Reduced productivity
- Poverty/dependency
- High morbidity
- High service utilization
- Poor medical mgmt
Potential Partners – Roles

Strategic alignment of resources (and shared ownership) involves alignment that makes optimal use of complementary skills.

- **Public health agencies**: Assessment, community outreach, evaluation, policy development
- **Social service agencies**: Service coordination/integration, enhancement, leveraging
- **Service-based CBOs**: Community engagement, mobilization, facilitation, policy advocacy
- **Community Action As**: Core operating infrastructure development, sustainability
- **Faith Community Advocacy CBOs**: Alignment with planning priorities, secure political support
- **United Way Local Philanthropy**: Core operating infrastructure development, sustainability
- **City agencies Associations**: Core operating infrastructure development, sustainability
Community Health Assessments  We’re assessing our communities to death! More effort is needed to strategically target and allocate resources after assessments.

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<thead>
<tr>
<th>Opportunities for Alignment</th>
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<tbody>
<tr>
<td><strong>Issue-Specific Assessments</strong> (Health Impact Assessment)</td>
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<tr>
<td>When available, HIAs provide an additional layer of information, most often relating to broader environmental impacts, in the design of strategies to improve health.</td>
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Health System Leaders in SDH Investments
A growing number are directing portions of investment portfolios to stimulate investments in areas such as affordable housing, healthy food financing, etc.

Dignity Health
- Engaged in targeted investments since 1980s with portfolio over $100M in loans

Trinity Health
- $70M in targeted investments
- Transforming Communities Initiative

Bon Secours
- $70 million in targeted investments in Baltimore, Richmond, VA, etc.

Cincinnati Children’s Hospital
- $10M in community benefit agreement to support development in Avondale

ProMedica
- Comprehensive revitalization in Toledo, OH; convener of national Root Cause Coalition

United Healthcare
- $350M in LIHTC investments, focused on 6M Medicaid members
Providence Health to redevelop hospital campus into 'health village' (Washington Business Journal, 8-16-17)
Example of recent decision by one of our largest health systems for a facility in DC

Ascension, the St. Louis-based system that owns the hospital, is looking to create a "health village" on the site of the 408-bed hospital. CEO Darcy Burthay said Providence wants to provide services that can impact the overall health of the community outside of "traditional health care." That means affordable housing, retail, education and other social services could all be part of the new plan to replace the traditional hospital building.
Focus on Diabetes and its Antecedents
Sample profile of key stakeholders and potential areas of focus

Community

Public Sector
Public Health
Parks and Recreation
Community Development

Care Management
Health Education
Policy Development
Community Mobilization

Backbone Entity

Shared Metrics
↓ Diabetes PQI
↑ Food Access
↑ + Options in schools
↑ Awareness/knowledge
↑ Physical activity

TOD/Walkability
Affordable HSG with support services
Grocery/corner store development
Child care/development
Façade Renovation

CBOs/Coalitions
After school programs
Neighborhood Walking
Local Philanthropy
## Alignment for Excellence Framework from national initiative for strategies of internal alignment and metrics for investment in SDH

<table>
<thead>
<tr>
<th>Internal Integration</th>
<th>Internal/External Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integrate data systems, finance, community benefit and clinical care management</strong></td>
<td><strong>Build Ethic of Shared Ownership for Health</strong></td>
</tr>
<tr>
<td>Establish <strong>protocols for data sharing</strong> and alignment of strategies among clinical and population/community health leadership and staff</td>
<td><strong>Co-invest</strong> with other providers and payers in the establishment and funding of a shared infrastructure to support the alignment of services to address the social determinants of health.</td>
</tr>
<tr>
<td>Develop and implement strategies that employ care redesign, <strong>predictive analytics</strong>, and <strong>geocoding</strong> to focus strategies <strong>where health inequities are concentrated</strong></td>
<td>Engage the community development sector in strategies to <strong>align health improvement interventions with real estate investments</strong> (e.g., grocery stores, housing, childcare centers, FQHCs), including allocation of a portion of provider and payer investment portfolios.</td>
</tr>
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<td>Integrate data on the <strong>social determinants of health</strong> into electronic health records and establish <strong>protocols for enhancement of care coordination</strong> strategies.</td>
<td>Strategically allocate resources/expertise to <strong>mobilize the assets of diverse community stakeholders</strong>, with focus in geo areas with concentrated health inequities.</td>
</tr>
</tbody>
</table>

### Short Term
- Evidence-based comprehensive CHI strategies in place
- Framework for regional risk stratification across providers and payers, alignment of service delivery and infrastructure investments, and pooling of stakeholder resources

### Long Term
- Reduction in PQIs, acuity for defined panels, and readmissions
- Cost savings in value-based reimbursement reallocated to address the SDH
- Aggregate improvement in health status, social conditions, and economic vitality in neighborhoods where health inequities were previously concentrated
- Focus of resources in neighborhoods where health inequities are concentrated
Top 10 Readiness Factors
Lessons learned from national initiative focusing on strategies to align hospital population health strategies and community development investments

1. Resident and CBO engagement with cohesion in spirit and priorities.
2. Local philanthropy and anchor institutions fund infrastructure.
3. Comprehensive approach to health / CD alignment that includes allocation of returns for communities.
4. Provider/payer commitment to pursue risk-based contracts.
5. Partner commitment to data/information sharing.
6. Focus on a health problem with SDH across the time/ROI continuum.
7. Evidence-based intervention (with wrap around services, activities, policies, etc. to build comprehensive framework) at the core.
8. Engaged local government agencies (e.g., PH, SS, P&R, CED)
9. Engaged local elected officials, including city/county reps and mayor.
10. Links to regional planning strategy and priorities, including transportation.
Implications for Workforce

Accelerated hiring of leaders and staff with expertise in
- Public health and social services
- GIS analysis, technology applications, data sharing
- City and regional planning
- Community development finance/investment
- Policy analysis and advocacy

Increased expectation of senior leader engagement in civic affairs
(e.g., UW boards, food policy councils, chambers of commerce, etc.)

Scaling of team-based care, engagement of community health workers, promotores

Expanding contracting with CBOs/agencies across sectors
Discussion of Future Scenarios
Scenario Planning

KEY DRIVERS

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SCENARIO 1: Optimistic Conditions

SCENARIO 2: Pessimistic Conditions

SCENARIO 3: Improved Conditions in Some Drivers

FUTURE HEALTH & HEALTH CARE SYSTEM

WORKFORCE IMPLICATIONS
How We Will Use Scenarios

Stimulate discussion and future thinking
◦ Inevitable, uncertain, scenarios
◦ Not choosing the most likely scenario

Make decisions about key drivers, assumptions and workforce implications
◦ Which we want to proactively address

Decide how can we best plan prepare the future workforce
Types of Scenarios

Health landscape and systems (today)
Population
Health status and challenges
Education: production, quality, attainment, cost, pipeline, equity (Coffman presentation)
Workforce supply and competition (health and overall)
Economic
Community
<table>
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<td>Roles and responsibilities</td>
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<td>Competencies</td>
</tr>
<tr>
<td>Settings</td>
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<tr>
<td>Relationships within and across organizations</td>
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<tr>
<td>Adaptability and Flexibility</td>
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Implications for Workforce (examples)

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Scaling of team-based care, engagement of community health workers, promotores

Expanding contracting with CBOs/agencies across sectors
Next Steps

• Initial discussion today
• Feedback from your organizations and stakeholders
• TAC Feedback
• Additional expert perspectives
• In-depth discussion and decisions on Nov 8
### Scenario Planning

#### Key Drivers

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#### Scenario 1: Optimistic Conditions

- **Future Health & Health Care System**
- **Workforce Implications**

#### Scenario 2: Pessimistic Conditions

- **Future Health & Health Care System**
- **Workforce Implications**

#### Scenario 3: Improved Conditions in Some Drivers

- **Future Health & Health Care System**
- **Workforce Implications**
Scenario Planning Discussion Questions

• Which of these scenarios and drivers are you and your organization using to plan for the future health system? What are your assumptions about the pace and magnitude of progress?

• Which do you think are most relevant for the Commission to consider in planning for the future workforce?
Educating California’s Health Workforce

Janet Coffman, PhD, MA, MPP
HEALTHFORCE CENTER
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Introduction

- Findings presented in the slide deck for the pre-meeting packet suggest:
  - Potential shortages of primary care clinicians and some types of behavioral health professions because supply is not keeping pace with demand
  - Maldistribution of the workforce in many occupations across and within regions
  - Lack of racial/ethnic diversity in professions that required a bachelor’s or graduate degree
Introduction

• These findings
  • Underscore the limitations of available data on the workforce in most health occupations
  • Raise questions about the adequacy of the pipeline of trainees in health occupations
Objectives

• To summarize data about the pipeline of trainees in health occupations in California
  • Supply
  • Distribution
  • Demographic characteristics

• To identify challenges and opportunities in health workforce education
Supply of Trainees
First-Year Primary Care Residency Positions by Specialty, California, 2017

Graduates of NP and PA Training Programs, 2015

Physician Assistants: 355
Nurse Practitioners: 866

Sources: Blash et al. California Board of Registered Nursing 2015-2016 Annual School Report; Physician Assistant Education Association Program Surveys 2015, private tabulation;
Graduates of Behavioral Health Training Programs, 2015

- Psychiatrist: 148
- Psychiatric Nurse Practitioner: 56
- Clinical/Counseling Psych - Doctorate: 1,029
- Clinical/Counseling Psych - Master's: 4,629
- Social Work - Master's: 1,937
- Psychiatric Technician: 659
- Substance Abuse Counseling: 1,671

Source: National Resident Matching Program, California Board of Registered Nursing, Integrated Postsecondary Education Data System.
Geographic Distribution
Geographic Distribution of Primary Care Residency Programs in California, 2017
Geographic Distribution of Behavioral Health Training Programs in California, 2016
Racial/Ethnic Diversity
Graduates of MD, DO, PA, NP, and RN Training Programs by Race/Ethnicity, California, 2015

Sources: Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Integrated Post-secondary Education Data System, American Association of Colleges of Nursing, California Board of Registered Nursing.
Graduates of Behavioral Health Education Programs by Race/Ethnicity, California, 2015

- Doctorate - Psychology: 6% African-American, 11% Latino
- Master's - Psychology: 9% African-American, 20% Latino
- Master's - Social Work: 9% African-American, 39% Latino
- Psychiatric Technician: 14% African-American, 37% Latino
- Substance Abuse Counselor: 22% African-American, 28% Latino
- California Population: 6% African-American, 38% Latino

Source: Integrated Post-secondary Education Data System
Conclusion

• Number of graduates of primary care and psychiatry residency programs unlikely to be adequate to meet future demand

• Limited availability of training in many professions in the Far North, Central Coast, San Joaquin Valley, eastern Inland Empire

• African-Americans and Latinos are underrepresented among physician, PA, NP, RN trainees & Latinos are underrepresented among psychology/counselling trainees
Challenges and Opportunities in Health Workforce Education
General Challenges and Opportunities

- Cost
  - Institution level
  - Student level

- Requirements for
  - Accreditation
  - Certification
  - Licensure

- Employer demand
Funding Challenges and Opportunities

- General funding for higher education
  - State support for public colleges and universities and financial aid
  - Federal resources

- Targeted funding for health professions education
  - Medicare graduate medical education funding
  - Federal and state grants for health professions education
  - Scholarships and loans for health professions students
Discussion Questions

• Have we correctly identified the major challenges and opportunities facing health professions education?

• How are these challenges and opportunities likely to change in the future?

• What impact are these challenges and opportunities having on our ability to produce California’s future workforce needs?
Commissioner Initiative Discussion Qs

• What initiatives are you/your organization involved with that are relevant to the Commission’s charge and areas of focus? How can you best contribute?

• What issues are critical for the Commission to follow in order to ensure a successful process & outcome?

• What advice & considerations can you share for how to work collaboratively & build momentum?