New Commissioner

Barbara Ferrer, PhD, MPH, MEd
Director, Los Angeles County Department of Public Health
California Future Health Workforce Commission: Foundation Funders

blue of california foundation

California Health Care Foundation

The California Endowment

The California Wellness Foundation

Gordon and Betty Moore Foundation
Meeting Objectives - Step 4 Together

1. Updates on:
   - overall Commission process;
   - progress to date;
   - next steps toward master plan development and key stakeholder support.

2. Note pending legislation relevant to health workforce.

3. Share preliminary results of the California Higher Education Health Professions Steering Committee’s Inventory of Health Related Programs.
Meeting Objectives (con’t)

4. Discuss cross-cutting and infrastructure themes for Commission for direction and discussion.

5. Discuss subcommittee progress on envisioning the future workforce and strategy development:
   ◦ Present results of future envisioning process, including “North Star” statements.
   ◦ Present overview of latest draft of strategies informed by future envisioning process.
   ◦ Secure targeted input from Commissioners for a subset of promising strategies.
   ◦ Outline next steps for further development of strategies and stakeholder engagement process.
Update on Commission Process and Progress
Commission Charge
(by December 2018)

• Develop a strategic plan for building the future health workforce
  o Include practical short, medium, and long term solutions to address current and future workforce gaps.
  o Agree on a cooperative strategy that makes optimal use of resources.
• Secure commitments for effective plan implementation.
• Build on, align with, and leverage relevant public and private efforts.
• Function as a private commission with state government participation.
• Engage key public and private stakeholders to support success.
Commission Framework: Focus Areas & Foundational Elements

**Focus Areas**
- Primary Care & Prevention
- Behavioral Health
- Healthy Aging & Care for Older Adults

**Foundational Elements**
- Diversity: race/ethnicity, gender, sexual orientation, socioeconomic status
- Equity: ensuring opportunity (e.g., education, living wage), geographic distribution, racial equity
- Technology: leveraging technology to accelerate transformation across settings

**QUALITY EDUCATION, CAPACITY, AND TRAINING ALIGNED WITH NEEDS**

**OUTCOMES**
- Improved Economic Opportunity
- Health Equity
- Better Health & Safety
- Better Care
- Lower Costs
- Healthy Workforce

**Future health workforce - the right people in the right places with the right competencies and capabilities**
- working effectively to promote and deliver health in all communities
Key Assumptions

FUTURE HEALTH SYSTEM: YEAR 2030

POPULATION DEMOGRAPHICS

PAYMENT LEVELS

HEALTH COVERAGE

PAYMENT METHOD & INCENTIVES

TEAM-BASED MODEL

FEDERAL POLICY & BUDGET

FOCUS ON SOCIAL DETERMINANTS OF HEALTH

IMMIGRATION POLICY

TECHNOLOGY INTEGRATION

MASS INCARCERATION

CULTURE, PRACTICE & SYSTEMS CHANGE WITHIN HEALTH & EDUCATIONAL INSTITUTIONS SUPPORT ADOPTION OF ASSUMED TRANSFORMATION
Commission Guiding Principles

Forward-looking
- Workforce needs between now and 2030.
- Practical and rooted in likely scenarios given what is known today.
- Flexible and iterative so that course corrections can be anticipated.

Economic benefits of a robust health workforce for the state.

Educational enablers for the health workforce of the future.
- Including students at public and private institutions, K-12, community college and four-year students, health professions school students (medicine, social work, psychology, MFT, LPCC, substance abuse counseling, public health, pharmacy, nursing).
Commission Guiding Principles

Aligned and harmonized with education sector plans.

Health workforce focused including *health care* and *population health* in public, nonprofit, & 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.
Progress toward our Collective Charge: Process

✓ Launched Commission and 4 meetings
✓ Selected 3 Priority Areas
✓ Agreement on Future State Assumptions
✓ Developed Blue Sky Vision
✓ Agreement on future care & prevention models
✓ Advanced 3 Sub-committees, Higher Ed Steering
✓ Engaged TAC and secured valuable guidance
✓ Extensive key stakeholder engagement
✓ Ongoing funder support and engagement
Progress toward Collective Charge: Products

✓ Identified, analysis of strategies for known workforce problems.
✓ Future envisioning and North Star in each area with corresponding workforce implications
✓ Initial technology analysis
✓ Additional future strategies identified
✓ Summary analysis of selected strategies
✓ Proposed “End Product”
✓ Convergence on Cross-Cutting themes
✓ Identified promising initial cross-cutting strategies
✓ Draft Higher Education Inventory
Today’s work

▪ Refinement and direction on selected strategies
▪ Begin discussion of strategy alignment toward future state
▪ Actions to be taken and Next Steps
Major Remaining Process Components

Define End Product/Process
- Format, depth, outcomes
- Goals/metrics.
- Process steps

Stakeholder Engagement
- Broad stakeholder input.
- Affected stakeholder engagement
- Build stakeholder support and secure initial commitments.
- Actions of Key Stakeholders

Strategy Refinement
- Current state, future state, gaps
- Further refinement of strategies
- Assess strategy cost, feasibility, impact.
- Agreement on criteria and prioritization method

Finalize Plan and Support
- Sources of funds & sustainability.
- Select priorities and sequencing
- Communication plan
5 STAGES OF THE CREATIVE PROCESS

STAGE 1: POSSIBILITY
STAGE 2: DOUBT
STAGE 3: AGONY
STAGE 4: EPIPHANY
STAGE 5: FINESSSE

HAPPINESS
TIME
@SALLYHOGSHEAD
Areas to Strengthen Progress

➢ Clarity and agreement on end product & process
➢ Timely scheduling and communications
➢ Optimize Commissioner, Co-Chair, TAC, sub committee roles, time and contributions
➢ Strengthen role, task, outcome clarification
➢ Political and financial feasibility and support
➢ Increase tech and private sector engagement
➢ Additional solutions to advance equity & diversity
Proposed End Product - Master Plan

A. North Star

B. Overarching Goal/ Future State
   1. Area of Focus
   2. Goals
   3. Strategies
   4. Measurable Objective(s) (near, mid, long term)
      i. Key Actions (Sequential, within time frames)
## Build Gov’t Public Health Capacity

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>End State Goals (2030)</th>
<th>Strategies (how to achieve the goals)</th>
<th>Key Action Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2030, meet the demand for govt. public health workers in key areas such as administrative leadership, epidemiology, program evaluation, &amp; laboratory science.</td>
<td>By 2030, integrate key roles and functions of govt. PH with health care stakeholders.</td>
<td>A. Build public knowledge of opportunities for government PH positions at the local and state level, revise undergrad &amp; graduate curricula to build knowledge, interest, &amp; streamline application and advancement.</td>
<td>1. Conduct inventory of PH workforce to establish a baseline for current career paths; expertise, skills (incl. health equity, SDH), &amp; functions, regional &amp; pop focus, and demographics (e.g., age, race, etc.).</td>
</tr>
<tr>
<td></td>
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<td>B. Develop state pipeline with pathways to build early interest (K-12) for spectrum of government public health positions.</td>
<td>2. Document &amp; publish applicants, enrolled, and graduation rates for all CA accredited and non-accredited SPHs and programs.</td>
</tr>
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<td></td>
<td></td>
<td>C. Strengthen focus on pop health/social epidemiology in undergraduate and graduate public health programs.</td>
<td>3. Establish expectations for PH professionals, assess curricula that meet expectations, &amp; publish..</td>
</tr>
<tr>
<td></td>
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<td>D. Build knowledge, standards, &amp; expectations of HC leaders to develop &amp; implement comprehensive strategies (local procurement, hiring, carbon footprint reduction, co-investing in health career pathways at the regional level, investing in healthy environments, policy advocacy) that optimally leverage their capabilities to improve health and well being in communities.</td>
<td>4. ID steps, timing, &amp; implement curricula improvements. Accelerate Cal HR civil service review process..</td>
</tr>
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<td></td>
<td></td>
<td>E. Build the social epidemiological capacity of local PH agencies to partner with HC providers and payers in the design, implementation, and evaluation of comprehensive CHI strategies.</td>
<td>5. Conduct statewide GIS-based analysis of preventable utilization to inform regional partnership development.</td>
</tr>
<tr>
<td>Increase the supply, diversity, and distribution of qualified govt. public health workers to meet target demand by strengthening attractiveness, recruitment, training, and roles in improving health and well-being.</td>
<td></td>
<td></td>
<td>6. Convene local/regional meetings of health and related sectors to ID and develop comprehensive strategies to leverage the expertise, resources, and influence.</td>
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<td>7. Fund and support the development of “Academic Health Departments”, partnerships between SPHs and PH departments, to strengthen links and infrastructure &amp; enhance PH education, research, teaching and service.</td>
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<td></td>
<td>8. ID public sector funds with required match of local contributions to engage social epidemiologists through LPHAs that align and focus comprehensive strategies where health inequities are concentrated.</td>
</tr>
</tbody>
</table>
## Community Health Workers

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>End State 2030 Goal(s)</th>
<th>Strategies (how to achieve the goals)</th>
<th>Key Action Steps (specific process steps – sequential)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase the supply, diversity, and distribution of qualified community health workers to meet target demand by increasing attractiveness, establishing common standards for expanded engagement, and fully integrating into clinical care and CHI strategies.</strong></td>
<td>By 2030, there will be systematic, coordinated engagement of CHWs and Promotors by providers, payers, and other stakeholders as fundamental bridges between clinical service delivery and broader strategies to improve health and well-being in communities.</td>
<td><strong>A.</strong> Standardize and implement certification of an expanded model of CHW engagement that optimizes their contributions to improve quality of care, address the social determinants of health, and serve as advocates for people and their communities. <strong>B.</strong> Establish protocols, practices, and reimbursement structures that preserve “agency” of CHWs as representatives of the interests of communities and intermediaries with health care delivery system.</td>
<td>1. Secure agreement on scope of practice that clarifies CHW roles and relationships with licensed and non-health professionals in team-based care and population health improvement. 2. Standardize and strengthen training for consistency, quality, and effective CHW integration into diverse settings. 3. Establish formal State recognition of CHW standards &amp; infrastructure to support scaling. 4. Establish financing mechanisms to support engagement across settings while preserving roles in community health improvement. 5. Strengthen employer capacity to integrate CHWs into efforts to improve community health. 6. Build capacity across community and care delivery settings to monitor and share data.</td>
</tr>
</tbody>
</table>
Strategy Portfolio Framework

1. Increase the supply, diversity and distribution of qualified workers to meet target demand

2. Align education and training program content and modalities with changing roles to prepare workers with the competencies to secure and succeed in emerging roles

3. Strengthen the capacity, effectiveness and retention of the current workforce through changes in the roles, functions and configuration of workers and teams

4. Accelerate innovations in technology, process, payment and collaboration to cost effectively achieve access, outcome and equity goals
Application of the Strategy Framework

Ensure pursuit of strategies beyond producing more of the current categories of workers

Develop portfolio of strategies needed to build future workforce capacity and meet emerging health needs

Promote emphasis on leveraging teams, technology, transformation AND health promotion and delivery at most appropriate, impactful and cost effective levels.

Optimize roles of workers, consumers, families, community and other key stakeholders

Align education and training with needs and skills
Cross-Cutting and Infrastructure Strategies
Converging on Common Themes

- Promote team based health promotion and care
- Strengthen integration and whole person care
- Increased and optimize use of well trained “unlicensed” health workers for appropriate roles. Standardize roles, training, certification. Increase financial incentives
- Advance & scale worker practice at top of scope
- Expand practice authority with established standards
- Integrate Social Determinants into training
- Accelerate and support practice transformation
- Address provider renewal and burnout
Converging Technology Themes

- All health workers trained in data, relevant IT
- Expanded use of data analytics
- Leverage Tele-health, increased viability
- Emphasis and resources for transformation
- Adoption impact on productivity, jobs
- Facilitates new and changing roles
- Greater patient engagement and self care
- Advance population health improvement
Common Themes to Strengthen Diversity and Equity

➢ Expand K-16 exposure, support, pathways
➢ Scale and sustain proven pathway programs
➢ Increase opportunities and support for URM and people from underserved CA communities
➢ Financial incentives and reduced costs
➢ Investment in regional pathway programs
➢ Local hiring
➢ Career ladders for incumbent and lower skilled
➢ Pathways for people with barriers
Common Elephants in the Room

- MediCal Reimbursement
- Value-based payment
- Scope of Practice
- Living wage
- Equity
- Diversity
- Impact of technology?
- Where will the money come from?
Subcommittee Strategy Development
Subcommittee Strategies

• Subcommittee Co-Chair Reports and Discussion

  1. Behavioral Health
  2. Healthy Aging & Care for Older Adults
  3. Primary Care & Prevention

• Work through the 6 core questions
• Feedback on 3-4 strategies
Discussion Questions

1) Beyond what has been described in the analysis, in what ways will this strategy contribute to building the future workforce we need?

2) What additional elements are needed that will contribute to the successful design and implementation of this strategy (i.e., what is missing)?

3) What are key obstacles and/or competing issues that need to be addressed in order to successfully design and implement this strategy?

4) What entities might support or oppose this strategy, and why? Which key stakeholders should be engaged further and what is the best approach?

5) What other actions might be needed before undertaking this strategy?

6) What actions can your institution take that would help contribute to the successful design and implementation of this strategy?
Behavioral Health Subcommittee Strategy Development Progress Report and Discussion
Behavioral Health Burning Platform

- Severe shortage and maldistribution of behavioral health providers
- Shortages are adversely impacting access, quality and costs for providers & payers, particularly for safety net & in underserved communities
- People in underserved rural & urban communities have long waiting times and distances to care
- 45% of psychiatrists & 37% of psychologists are over 60 years of age
- Lack of racial/ethnic diversity in BH professions that require a graduate degree
- A large majority of adults with mental health need receive inadequate care or do not receive treatment
- Stigma around BH limits care seeking & interest in BH careers
2030 Behavioral Health North Star

By 2030, California’s supply of public and private behavioral health providers, at all levels of service provision and leadership in the workforce, will:

• Reflect the diversity of the communities they serve;

• Have the roles, tools, education and competencies to provide accessible, recovery-oriented, affordable high-quality services at the right time and in the right places, at the right level; and

• Have the working relationships with key stakeholders across sectors to effectively engage in prevention, early identification and intervention, promote self-care, and improve health equity and well-being in all communities.
Behavioral Health Strategies

✓ Integrated Care – Primary Care & Behavioral Health
✓ Allow Same-Day Reimbursement for Primary Care & Behavioral Health Visits/Alternative Payment
✓ Sustainable Financial Strategies for Workforce Development (Residencies, Internships, Stipends and Loan Forgiveness)
✓ Grant full practice authority to Nurse Practitioners, including Psychiatric MH Nurse Practitioners
✓ Create Statewide Certification for Peer Support Specialists
  • Substance Abuse Counselor Workforce Development
  • Certified Psychiatric Rehabilitation Practitioners (CPRP)
Behavioral Health Subcommittee Envisioning

- BH professionals & unlicensed staff
- Health Information Technology (HIT)

- BH and PC professionals & unlicensed staff
- HIT for monitoring, assessing outcomes, self-management
- Community-based settings, schools

- Peers, promotoras, clergy, schools

- Wellness activities, health information & assessment technology for self-care

Adapted from: World Health Organization. (2009). Improving health systems and services for mental health
Coordinated Behavioral Health Workforce Pathway

Target Groups:
- Incumbent Workers
- Middle School, High School and Community College Students
- Retired Workers
- 4-year College/University students
- People with Lived Experience/Family members
- Graduate BH Students, Medical Students and Residents
- Veterans
- Reentry Population

Pre-Training
- Health Professions Education
- Career Awareness
- Assessment
- Academic Preparation & Entry Support
- Financial & Logistic Feasibility
- Training Program Access
- Training Program Retention
- Clinical Placements & Residencies
- Financing & Support Systems
- Hiring & Orientation
- Retention & Advancement

Cultural Sensitivity and Responsiveness

Coordination and Support Infrastructure

Near-term impact (1-3 yrs)
- Increase awareness of behavioral health careers among K-Post bac students
- Reduce stigma in BH Careers

Mid-term impact (4-7 yrs)
- Increase BH residencies, internships & stipends in underserved communities
- Increase clinical placements for BH students in underserved communities

Long-term impact (8-12 yrs)
- Increase BH residencies, internships & stipends in underserved communities
- Increase clinical placements for BH students in underserved communities
- Address provider renewal, retention, health & burnout issues
- Increase loan repayment programs & financial incentives for practice in underserved communities
- Allow for same-day billing for PC & BH visits/alternative payment pilots

Quality, Diverse Health Workforce

Jeff Oxendine©
Behavioral Health Strategy Alignment

Increased Integration of Primary Care and Behavioral Health Care
Increase early identification and intervention for BH conditions

Sustainable Financing for Workforce Development
Sustainable strategies to address shortages, incentivize diverse workforce and address maldistribution

Same Day Billing/Alternative Payment
Allow same day billing for primary care and behavioral health care visits

Substance Abuse Counselors:
Establish state level certification/workforce development strategies

Peer Specialists:
Create statewide standards for staff with lived experience and relevant reimbursement standards

Certified Psychiatric Rehabilitation Practitioners:
Recognize unlicensed workforce & create reimbursement standards

Nurse Practitioners:
Standardize practice authority of Psychiatric MH NPs to increase prescribers and access to care

Overall Increase in Access to Care

Improved Quality of Patient-Centered Care

Strengthened capacity, effectiveness and retention of current workforce

Reduced stigma in the workforce

Reduced inequities and increased diversity in workforce

Focus on prevention and integration of care

Reduced inequities and increased diversity in workforce

Strengthened capacity, effectiveness and retention of current workforce

Reduced inequities and increased diversity in workforce
North Star / Mission Statement

• Define and operationalize the “ideal vision” for the roles of multiple people across the care continuum and the community, providing appropriately timed, culturally inclusive care for older adults, starting in the home

• Generate strategies to support person-centered, team-based and technology-enabled care in partnership with key stakeholders

• Strategies to include optimizing roles, recruitment into the field, training and preparation, and improving working conditions and incentives, all designed with older adults at the center
“Burning Platform”

Aging Population

By 2030:
Senior population age 65+ will double to 9 million
Youngest baby boomers will hit retirement age 75+ will be fastest growing age group beginning 2020

Source of Care

CA senior population age 65-75 facing difficulties with self-care will be living at home and double by 2030 to ~1 million
Limited self-care population age 65-75 in nursing homes by 2030 100,000

Workforce

200,000 additional homecare workers needed in CA by 2024
33% annual turnover of IHSS workers in CA

33% of CA counties have highest concentration of residents age 65+ living below FPL

Projected increase of age 65+ population with Alzheimer's, from 630,000 in 2017 to 840,000 in 2025

Future Health Workforce Commission

Sources of Funding for Nursing Home Residents

- Medicare 15%
- Medicaid 65%
- Private Insurance 2%
- Self-pay 9%
- All other 6%
- Managed Care 7%

$97K annual cost of nursing homes

$57K annual cost (average) of homecare*

*cost varies based on number of hours needed
Who constitutes the team for the Aging population?
Virtually ALL Health Care Workers + Community

- Virtually ALL Health Care Workers + Community
- Nurses (multiple)
- Physicians NP, PA, Geriatrics
- Direct Care Workers (multiple)
- Mental Health Providers (multiple)
- Direct Care Workers (multiple)
- Dieticians
- OT
- CM
- Pharmacists
- Social Workers
- And others! Health Coach, Navigator, CHW, MA, EMT, Oral Health, Paramedic, Dementia Care Specialist, Allied Workers
- Hospice Palliative Care reflect multiple roles: MD, RN, LVN, SW, HHA, Spiritual Counselor, Family Caregiver

Older Adults
Age in Place Home

Healthy Aging
1-2 chronic conditions (92% report having 1 cc*), min to no functional limitations

Moderate to High Complexity
2+ chronic conditions (70% report having 2+ cc*), 2+ ADLs/IADLs

*Hung et al. 2011

And others!
Health Coach, Navigator, CHW, MA, EMT, Oral Health, Paramedic, Dementia Care Specialist, Allied Workers

Hospice Palliative Care reflect multiple roles: MD, RN, LVN, SW, HHA, Spiritual Counselor, Family Caregiver
Technology Integration Drives Value

“Work” and “Jobs” change dramatically

VALUE

ADOPTION OF TECHNOLOGY OVER TIME

OUTCOMES

PROCESS

STRUCTURE

Real-time data sharing and interoperability, better decision making

Better communication and coordination with patient/family

Better self-management to optimally and proactively manage health and well-being

Significant leaps in communication over distance across care continuum

AI Tools – Learning Health System

Cross-Cutting

Access
Quality
Experience
Cost

SDOH Technology  High Touch, High Tech
Platform  Home Care

Healthify honor

CA FUTURE HEALTH WORKFORCE COMMISSION
Considerations – Structure & Process

• Wide stakeholder engagement and alignment for system transformation

• Sound ethical standards that respect and honor the preferences and values of those who we serve

• Optimal regulatory framework (regulation & standards)

• Education system reform (K-12+) to keep pace with tech advancements through agile learning and produce graduates with critical thinking, problem solving and end-to-end process skills
Workforce Implications – Disruptive Technology

Adoption / Change Management

• Dynamic: evolving information, protocols, best practices
• Learning curve can be steep, stakes are high
• Much more software and hardware to know and use
• Provider time already at a premium
• Massive amounts of data to make sense of
• Typically less receptive

Outcomes

• Increased knowledge, availability of information and data
• Improved communication
• Enhanced decision-making support, clinical and social care
• More personalized care
• Broader access and reach
• Greater engagement and compliance
• Efficiencies, scale, operational improvements

Source: https://www.slideshare.net/cornerstoneondemand/disruptive-technology-in-healthcare-implications-for-the-workforce-hr-professionals (adapted)
Discussion

Your reaction and thoughts to how technology will dramatically change “work” and “jobs”?
Strategies for Discussion

Universal Home Care Worker

• Meet the demand for 200,000 new home care workers by 2030 and provide meaningful work, improved employment, enhanced quality of life and health profession opportunities

Overlooked Workers

• View the aging population as a viable and vibrant resource, not as a burden to society, to provide care for older adults. Develop a value proposition and attract workers from other industries whose positions have been phased out and older adults seeking post-retirement careers

Team-based Care

• To contribute to achieving the Quadruple Aim by enabling new models of evidence-based technology enabled and team-based care through an integrated and skilled workforce across the continuum
# Current State: Direct Care Workforce Tasks

<table>
<thead>
<tr>
<th></th>
<th>Family Member</th>
<th>Home Care Worker</th>
<th>IHSS Worker</th>
<th>Home Health Aide</th>
<th>CNA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care</strong></td>
<td>5/5</td>
<td>3/5</td>
<td>5/5</td>
<td>4.5/5</td>
<td>5/5</td>
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<tr>
<td><strong>Support Living</strong></td>
<td>1/1</td>
<td>P</td>
<td>P</td>
<td>P</td>
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</tr>
<tr>
<td><strong>Medical &amp; Nursing</strong></td>
<td>14/15</td>
<td>2/15</td>
<td>14/15</td>
<td>4/15</td>
<td>6/15</td>
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<tr>
<td><strong>Monitoring</strong></td>
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<td>1/2</td>
<td>2/2</td>
<td>1/2</td>
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<td><strong>Evaluation &amp; Docu.</strong></td>
<td>2/8</td>
<td>1/8</td>
<td>1/8</td>
<td>1/8</td>
<td>1/8</td>
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<tr>
<td><strong>Care Coord &amp; Coaching</strong></td>
<td>4/5</td>
<td>3/5</td>
<td>3/5</td>
<td>2/5</td>
<td>2/5</td>
</tr>
</tbody>
</table>

- □ = full responsibility
- ○ = partial responsibility
- ◁ = limited to no responsibility

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**Slide 10**

California Future Health Workforce Commission
## Current State Example

### Direct Care Worker: In Scope or Not?

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>HOME CARE WORKER (employed by home care agency)</th>
<th>HOME CARE WORKER (independent &amp; consumer directed)</th>
<th>IHSS WORKER (consumer directed)</th>
<th>HOME HEALTH AIDE (employed by home health agency)</th>
<th>CNA (employed by home health agency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

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Slide 11
Strategy 1: Universal Home Care Worker

**Outcome**
Meet the demand of 200,000 new home care workers by 2030

- Establish and gain widespread adoption of new universal home care worker role with entry and advancement levels to meet demand and improve employment, quality of life and health profession opportunities
- In partnership with key stakeholders, establish clear and meaningful standards for training and certification
- Pilot nurse delegation to provide oversight and training
- Curriculum development and blended learning solutions through Community Colleges and other training sources
- Convene conversations with target payers, regulators, state certifying bodies, foundations, educational institutions, consumer advocacy groups to obtain broad stakeholder engagement and alignment
Discussion

Your reaction and thoughts to the Universal Health Care Worker strategy?
Strategy 2: Target Overlooked Workers

Outcome

View the aging population as a viable and vibrant resource, not as a burden to society, to provide care for older adults. Develop a value proposition and attract workers from other industries whose positions have been phased out and older adults seeking post-retirement careers.

- Expand untapped workforce by creating new, meaningful and flexible job opportunities for previously overlooked workers to care for older adults.
Discussion

Your reaction and thoughts to the Overlooked Worker strategy?
Strategy 3: Team-based Care

**Outcome**
To contribute to achieving the Quadruple Aim by enabling new models of evidence-based, technology-enabled and team-based care through an integrated and skilled workforce across the continuum

- Establish and implement clearly defined interdisciplinary team-based roles with appropriate knowledge and/or credentials to enable high quality, technology enabled, person-centered and cost-effective care to meet demand in all communities
- Promote interdisciplinary team-based education across the continuum with inter-professional faculty, and teaching as a valued role for all health workers with recognition and pay/bonus for excellence in teaching
- **Full Practice Authority:** all members of the health care team practice to the full extent of their education and preparation
Discussion

Your reaction and thoughts to the Team-based strategy?
# Crosswalk of Strategies and CA LTSS Scorecard

<table>
<thead>
<tr>
<th>Aging Subcommittee Strategies</th>
<th>CA LTSS Scorecard</th>
</tr>
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<tbody>
<tr>
<td><strong>Universal Home Care Worker</strong></td>
<td><strong>Support for Family Caregivers</strong></td>
</tr>
<tr>
<td></td>
<td>● Nurse Delegation (CA rank 45)</td>
</tr>
<tr>
<td></td>
<td><strong>Effective Transitions of Care</strong></td>
</tr>
<tr>
<td></td>
<td>● % of nursing home residents with low care needs (CA rank 20)</td>
</tr>
<tr>
<td><strong>Overlooked Workers</strong></td>
<td><strong>Indirect connection</strong></td>
</tr>
<tr>
<td><strong>Team-based Care Enabling New Models of Care</strong></td>
<td><strong>Support for Family Caregivers</strong></td>
</tr>
<tr>
<td></td>
<td>● Person-centered care (CA rank 14)</td>
</tr>
<tr>
<td></td>
<td>● Nurse Delegation / NP scope of practice (CA rank 45)</td>
</tr>
<tr>
<td></td>
<td><strong>Effective Transitions of Care</strong></td>
</tr>
<tr>
<td></td>
<td>● % of nursing home residents with low care needs (CA rank 20)</td>
</tr>
</tbody>
</table>
Achieving Success…

we expect the following outcomes

• Older adults aging in place with dignity and respect enabled through an engaged community and a fully integrated person-centered and technology-enabled team (medical + social + behavioral) to deliver appropriated timed, evidence-based best practices, and culturally-inclusive care

• Optimal regulatory framework

• All members of the care team practice to the full extent of their education and preparation and are compensated accordingly through value-based reimbursement

• Workforce mirrors diversity of the population; under-represented workers choose health care professions with educational opportunities, rotations, mentorship and expanded pathways
Discussion Questions

1) When thinking about some of the driving forces, such as technology and consumerism, coupled with the political landscape, what is the Commission’s appetite for transformative change over the next 12 years?

2) Beyond what has been described in the analysis, in what ways will this strategy contribute to building the future workforce we need?

3) What additional elements are needed that will contribute to the successful design and implementation of these strategies (i.e., what is missing)?

4) What are key obstacles and/or competing issues that need to be addressed in order to successfully design and implement this strategy?

5) What entities might support or oppose this strategy, and why? Which key stakeholders should be engaged further and what is the best approach?

6) What other actions might be needed before undertaking this strategy?

7) What actions can your institution take that would help contribute to the successful design and implementation of this strategy?
Coordinated Home Care Workforce Pathway

Target Groups:
- Incumbent Workers
- Middle School, High School & Community College Students
- 4-year College/University students
- Pre-health Undergraduates
- Family members
- Graduate Students, Medical Students & Residents
- Retired Workers
- Older Adults
- Veterans
- Reentry Population

- Increase awareness & promote the benefits of careers in caring for older adults among K-16 & other target groups.
- Establish standard roles, training & certification for home care workers.
- Establish and expand home-related roles that can be provided by retired adults & older workers
- Institute new IHSS role with standard-hire training, certification & requirements

- Expand & standardize training options leveraging technology and community-based providers.
- Increase on-the-job training & apprenticeship opportunities.
- Develop options for increased pay of direct care workers & improved working conditions.
- Expand training options with community colleges & other training sources.
- Establish clear & meaningful standards & certification for training of home care workers.
- Establish a common set of competencies.

Pre-Training | Health Professions Education | Workforce

Coordination and Support Infrastructure

200,000 direct home care workers reflecting the community, in the right places
PICKING UP THE PACE OF CHANGE
A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers

CA LTSS Scorecard

AARP PUBLIC POLICY INSTITUTE

longtermsscorecard.org

The Commonwealth Fund

THE SCAN FOUNDATION

AARP Foundation
### Affordability & Access – CA Rank Overall 19

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017 Rate</th>
<th>Rank</th>
<th>Top State Rate</th>
<th>All States Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADRC (Aging &amp; Disability Resource Center) / No Wrong Door Functions</td>
<td>0%</td>
<td>50</td>
<td>92%</td>
<td>60%</td>
</tr>
<tr>
<td>(composite indicator)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Support for Family Caregivers – CA Rank Overall 8

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017 Rate</th>
<th>Rank</th>
<th>Top State Rate</th>
<th>All States Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person and family-centered care (composite indicator)</td>
<td>3.00</td>
<td>14</td>
<td>4.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Nurse delegation and NP scope of practice (composite indicator)</td>
<td>0.50</td>
<td>45</td>
<td>5.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>
## Effective Transitions of Care – CA Rank Overall 22

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017 Rate</th>
<th>Rank</th>
<th>Top State Rate</th>
<th>All States Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of nursing home residents with low care needs</td>
<td>10.7%</td>
<td>20</td>
<td>4.1%</td>
<td>11.2%</td>
</tr>
<tr>
<td>% of home health patients with hospital admission</td>
<td>23.4%</td>
<td>17</td>
<td>18.3%</td>
<td>24.4%</td>
</tr>
<tr>
<td>% of long-stay nursing home residents hospitalized in a 6-month period</td>
<td>18.5%</td>
<td>35</td>
<td>5.0%</td>
<td>15.7%</td>
</tr>
<tr>
<td>% of nursing home residents with 1+ potentially burdensome transitions at end of life</td>
<td>27.0%</td>
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<td>23.8%</td>
</tr>
<tr>
<td>% of new nursing home stays lasting 100 days or more</td>
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<td>25</td>
<td>8.9%</td>
<td>18.3%</td>
</tr>
</tbody>
</table>
# AARP CA LTSS Scorecard

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline Year</th>
<th>Baseline Rate</th>
<th>Current Year</th>
<th>Current Rate</th>
<th>All States Median</th>
<th>Best Rate</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long-Term Services and Supports Scorecard Overall Ranking</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Affordability and Access</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median annual nursing home private pay cost as a percentage of median household income age 65+</td>
<td>2012-13</td>
<td>243%</td>
<td>2015-16</td>
<td>249%</td>
<td>233%</td>
<td>164%</td>
<td>9</td>
</tr>
<tr>
<td>Median annual home care private pay cost as a percentage of median household income age 65+</td>
<td>2012-13</td>
<td>82%</td>
<td>2015-16</td>
<td>77%</td>
<td>81%</td>
<td>48%</td>
<td>19</td>
</tr>
<tr>
<td>Private long-term care insurance policies in effect per 1,000 people age 40+</td>
<td>2012</td>
<td>49</td>
<td>2015</td>
<td>46</td>
<td>48</td>
<td>164%</td>
<td>27</td>
</tr>
<tr>
<td>Percent of adults age 21+ with ADL disabilities at or below 250% of poverty receiving Medicaid</td>
<td>2011-12</td>
<td>62.8%</td>
<td>2014-15</td>
<td>66.8%</td>
<td>53.4%</td>
<td>78.1%</td>
<td>6</td>
</tr>
<tr>
<td>Medicaid LTSS beneficiaries per 100 people with ADL disabilities</td>
<td>2019</td>
<td>80</td>
<td>2012</td>
<td>76</td>
<td>54</td>
<td>111%</td>
<td>5</td>
</tr>
<tr>
<td>ADRC/No Wrong Door Functions (composite indicator, scale 0-100%)</td>
<td>*</td>
<td>*</td>
<td>2016</td>
<td>0%</td>
<td>60%</td>
<td>92%</td>
<td>50</td>
</tr>
<tr>
<td><strong>Choice of Setting and Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities</td>
<td>2011</td>
<td>56.1%</td>
<td>2014</td>
<td>58.4%</td>
<td>33.1%</td>
<td>68.5%</td>
<td>6</td>
</tr>
<tr>
<td>Percent of new Medicaid aged/disabled LTSS users first receiving services in the community</td>
<td>2009</td>
<td>67.8%</td>
<td>2012</td>
<td>74.6%</td>
<td>55.4%</td>
<td>83.6%</td>
<td>6</td>
</tr>
<tr>
<td>Number of people participant-directing services per 1,000 people with disabilities</td>
<td>*</td>
<td>*</td>
<td>2016</td>
<td>131.9</td>
<td>9.6</td>
<td>131.9</td>
<td>1</td>
</tr>
<tr>
<td>Home health and personal care aids per 100 adults age 18+ with ADL disabilities</td>
<td>2010-12</td>
<td>27</td>
<td>2013-15</td>
<td>28</td>
<td>19</td>
<td>41%</td>
<td>8</td>
</tr>
<tr>
<td>Assisted living and residential care units per 1,000 population age 75+</td>
<td>2010</td>
<td>72</td>
<td>2014</td>
<td>59</td>
<td>52</td>
<td>121%</td>
<td>15</td>
</tr>
<tr>
<td>Subsidized housing opportunities (place-based and vouchers) as a percentage of all housing units</td>
<td>2011</td>
<td>5.4%</td>
<td>2015</td>
<td>5.8%</td>
<td>5.8%</td>
<td>17.7%</td>
<td>24</td>
</tr>
<tr>
<td><strong>Quality of Life &amp; Quality of Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Rate of employment for adults with ADL disabilities ages 18-64 relative to rate of employment for adults without ADL disabilities ages 18-64</td>
<td>2011-12</td>
<td>22.8%</td>
<td>2014-15</td>
<td>20.9%</td>
<td>21.9%</td>
<td>43.3%</td>
<td>35</td>
</tr>
<tr>
<td>Percent of high-risk nursing home residents with pressure sores</td>
<td>2013</td>
<td>6.4%</td>
<td>2015-16</td>
<td>5.8%</td>
<td>5.5%</td>
<td>3.4%</td>
<td>31</td>
</tr>
<tr>
<td>Percent of long-stay nursing home residents who are receiving an antipsychotic medication</td>
<td>2013</td>
<td>17.4%</td>
<td>2015</td>
<td>13.2%</td>
<td>16.8%</td>
<td>8.0%</td>
<td>5</td>
</tr>
<tr>
<td><strong>Support for Family Caregivers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Supporting working caregivers (composite indicator, scale 0-9.0)</td>
<td>2012-13</td>
<td>4.05</td>
<td>2014-16</td>
<td>4.75</td>
<td>1.00</td>
<td>6.50%</td>
<td>3</td>
</tr>
<tr>
<td>Person- and Family-Centered Care (composite indicator, scale 0-5.5)</td>
<td>2012-13</td>
<td>2.00</td>
<td>2016</td>
<td>3.00</td>
<td>2.41</td>
<td>4.30%</td>
<td>14</td>
</tr>
<tr>
<td>Nurse Delegation and Nurse Practitioner Scope of Practice (composite indicator, scale 0-5.0)</td>
<td>2013</td>
<td>0.50</td>
<td>2016</td>
<td>0.50</td>
<td>4.00</td>
<td>5.00%</td>
<td>45</td>
</tr>
<tr>
<td>Transportation Policies (composite indicator, scale 0-5.0)</td>
<td>2019-12</td>
<td>2.50</td>
<td>2012-16</td>
<td>2.50</td>
<td>1.00</td>
<td>4.00%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Effective Transitions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life</td>
<td>2011</td>
<td>29.5%</td>
<td>2013</td>
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<td>2012</td>
<td>18.3%</td>
<td>18.3%</td>
<td>8.9%</td>
<td>25</td>
</tr>
<tr>
<td>Percent of people with 90+ day nursing home stays successfully transitioning back to the community</td>
<td>2009</td>
<td>10.7%</td>
<td>2012</td>
<td>10.5%</td>
<td>7.4%</td>
<td>14.8%</td>
<td>6</td>
</tr>
</tbody>
</table>
What is the impact of improvement from AARP?

If California improved to the average of the top 5 states in each domain....

• **$573,100,000** more would go to HCBS instead of nursing homes

• **176,180** more people would receive Medicaid LTSS (combination of eligible beneficiaries not enrolled and those enrolled who shift from SNF to community/home)

• **48,584** more home health and personal care aides in the community
Washington Spotlight

- No Wrong Door (top rank)
- 64.9% of Medicaid/state-funded LTSS goes to HCBS (rank=2)
- 53.4% of people with disabilities have consumer-directed care (rank=3)
- 103 assisted living/res care units per 1000 pop 75+ (rank=3)

- Nurse delegation & NP scope of practice (top rank)
- Robust home care aide training and certification
- Transportation policies (rank=3)
- Low rates of hospital admissions from home health & nursing homes (ranks 5 & 7)
California Spotlight
Does home care aide training matter?

CMS Innovation Award: California Long-Term Care Education Center
- Contra Costa, LA Care, Health Net, Care 1st, Molina, Inland Empire Health Plan

Trained IHSS workers to:
- Integrate into the larger health care team through improved communications with primary care team
- Identify emergent conditions
- Manage chronic conditions

<table>
<thead>
<tr>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduced hospitalizations, ED visits, and costs associated(^1)</td>
</tr>
<tr>
<td>• Decrease of 44 ED visits/1,000, $1,522 cost savings per beneficiary in year two</td>
</tr>
<tr>
<td>• Workers reported high satisfaction with training, learned caregiving skills, increased knowledge base, more prepared and confident to perform job</td>
</tr>
<tr>
<td>• Care recipients and informal caregivers reported better quality of care provided by direct workers post-training</td>
</tr>
</tbody>
</table>

\(^1\) small number of participants; results are suggestive, not definitive
Define and operationalize the “ideal vision” for the roles of multiple people across the care continuum and the community, providing appropriately timed, culturally inclusive care for older adults, starting in the home. Generate strategies to support person-centered, team-based and technology-enabled care in partnership with key stakeholders. Strategies to include optimizing roles, recruitment into the field, training and preparation, and improving working conditions and incentives, all designed with older adults at the center.
Primary Care & Prevention Subcommittee
Primary Care and Prevention
Burning Platform

Substantial **limits to primary care access**, particularly among MediCal and in urban inner city and rural areas.

**Excess health care expenditures for treatment of preventable conditions** due to a lack of access.

**Inadequate reimbursement** for primary care services, particularly for MediCal populations.

**Growing burdens and burnout among PCPs**, particularly in underserved areas where they are most needed.

**Lack of investment in primary prevention** areas such as social infrastructure (e.g., affordable housing, healthy food, public schools) contribute to higher incidence and acuity in key disease categories (e.g., diabetes, CV disease, asthma), particularly among low income populations and racial and ethnic minorities.

Profound **income inequity and lack of a living wage** contributes to toxic stress and negative health behaviors.
2030 Primary Care and Prevention North Star

By 2030, California’s primary care and prevention workforce will have the competencies, agency and diversity as well as the cross-sector partnerships and institutional support to:

1. Improve health, equity and well-being in all communities,

2. Close health gaps within and across populations, and

3. Provide accessible, affordable, high quality whole person services at the right time, right level, and in the right places.
## Primary Care and Prevention Strategy Alignment

<table>
<thead>
<tr>
<th>Social Epi/PH Capacity</th>
<th>CHW Scaling</th>
<th>Primary Care Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital CB resources with State match</td>
<td>Common standards for expanded engagement</td>
<td>Common standards for primary care resource allocations</td>
</tr>
</tbody>
</table>

- **Focus resources where health inequities concentrated**
- **From small scale programs to comprehensive CHI strategies**
- **Increase engagement and investment in community-based prevention**
- **Increase primary care access in low-income communities**
- **Increase alignment with FQHCs (and leverage their expertise)**
- **Reinforce imperative for data interoperability**
- **Align with value-based reimbursement**

### Outcomes
- **Reduced acuity and incidence of chronic diseases**
- **Reduced inequities in health and well-being**
- **Reduced preventable ED and Inpatient utilization**
Coordinated Primary Care Workforce Pathway

**Target Groups:**
- Incumbent Workers
- High School and Community College Students
- Career Changers
- Undergraduates
- Immigrant Health Professionals
- Medical Students and Residents
- Veterans
- People with Lived Experience and Family Members


Increase awareness of primary care careers among K-Post bac students

Increase # of post-bac slots for people from UR communities

Increase financial incentives for PC & PH training for people from underserved communities

• Sustain & increase enrollment in PRIME programs
• Sustain & grow UCR medical school
• Establish branch campuses of current medical schools

• Increase PC residencies in underserved communities
• Increase clinical placements for CA students in underserved communities

Address provider renewal, health & burnout issues

**Coordination and Support Infrastructure**

Cultural Sensitivity and Responsiveness

**Target supply, diversity and distribution**

Near-term impact (1-3 yrs)

Mid-term impact (4-7 yrs)

Long-term impact (8-12 yrs)
Established Strategies: determine priority, sequencing and funding

- Increase Post-Bac program slots
- Sustain and expand PRIME; primary care focus
- Explore Branch campuses of current med schools
- Grow C.R. Drew Medical School and residencies
- Sustain and expand UCR Medical School
- Sustain current state funding for residencies
Strategies for Commission Direction Today

➢ Increase primary care residencies; particularly in outpatient settings and underserved communities
  ➢ Increased, sustainable CA funding (public and private)
  ➢ Advocacy to increase Federal allocation to CA

➢ Primary care spend

➢ Community Health Worker scaling

➢ Funding for social epidemiologists

➢ MediCal reimbursement increase