California Future Health Workforce Commission
Fourth Meeting

April 26, 2018
10:45 am – 4:00 pm
The California Endowment's Center for Healthy Communities
2000 Franklin Street, Laurel Room
Oakland, CA 94612

Meeting Notes

Participants

Commissioners
Janet Napolitano, Lloyd Dean, Anne Bakar, America Bracho, David Carlisle, Patrick Courneya, Barbara Ferrer, Hector Flores, Jane Garcia, Liz Gibboney, Alma Hernandez, Rishi Manchanda, Arnie Milstein, and Heather Young.

Management Team/Foundation Staff
Kevin Barnett, Jeff Oxendine, Cathryn Nation, Wade Rose, Roza Do, Janet Coffman, Katherine Flores, Lisa Folberg, Kim Mayer, Rona Sherriff, Joanna Spetz, Abigail Stavros, Lisa Tadlock, Lisa Williams, George Flores, Kathryn Phillips, and Sandra Shewry

Welcome & Introductions

Introduction of new Commission member Barbara Ferrer by Janet Napolitano
Meeting objectives

- Secure input for refinement and direction on selected strategies
- Align strategies toward future end state
- Identification of actions to be taken and next steps

Commission Process Update

Kevin B and Jeff O provided an overview of the process to date. Comments from Commissioners:

- There is still time to add additional public health input.
- Need concrete examples to illuminate what we're talking about, e.g. reimbursement, roles, etc.
- As the health system moves toward a rapid learning system, one of the criticisms of workforce development strategies is that they tend to have a value lag. Need to articulate a deliberate process to better and more rapidly translate the impact of efforts.
- Want to be sure we address all 4 quadrants of strategies.

Cross-cutting and Infrastructure Strategies Update

Overview provided by Jeff O. and Kevin B. Commissioner comments included:

Medi-Cal reimbursement - Major interest is driving workforce policy to improve health of population of CA. Healthcare "deserts" across CA; greatest opportunity to get providers (not just PCPs) into these under-resourced areas. Medi-Cal reimbursement rates are 49th in the country. As a result, providers don't work in these communities. This is a fundamental challenge. Can we use Medi-Cal reimbursement policy to improve health in CA by empowering providers to work in under-resourced areas in CA?

Important for Commission to weigh in on this issue. From prevention and primary care perspective, need to both increase and align reimbursement with value-based care and team-based approach to address physical and social needs.

Need for realignment of Medi-Cal reimbursement. Not just what's covered, but who's covered and how they're covered. The reimbursement is driving the system of care. If there are more prevention-oriented activities in the future, then we will need a different workforce.

- Looking at series of studies from CHCF (2013) re: Medi-Cal access, private practice physicians are suffering the most in terms of Medi-Cal reimbursement. Prop 56 showed improved access to care (although was not long enough to evaluate). Need to make a high priority - perhaps resourcing with existing dollars and stimulate some creative thinking on how those dollars should be spent. We should spend time studying how Prop 56 money was spent and the outcomes.
- We are hopeful that the Commission will approach problem in a different way that gets us beyond "urging" the State legislature and executive branch. Need to step back and look at how to present the problem and build an evidentiary case.
- We need to be creative about identifying the resources to finance an increase, and factor in the role of technology and expansion in teams help to reduce costs.
- It will be important to talk about Medi-Cal reimbursement and value-based reimbursement together, with a focus on redistribution of resources toward primary care and prevention. It is also important to look at whole picture on public and private side re: reimbursement, and look at potential realignment of Medi-Cal – some elements in the state system act as disincentives to moving to value-based reimbursement.
  We need specific examples that help drive and accelerate the change process.
  We need to address trade-off between a desire to place professionals in newly created jobs providing remote services from anywhere in the world and the issue of affordability.
- We need to make the argument for transparency and attention to core problems before going to a set of solutions.
- Some would make the case that there is enough money in the system. What we think is available in the system, others don't see as part of the system; currently defined as segregated system. Need to define the parameters of the system.

California Public Higher Education Health Professions Steering Committee Update

Overview provided by Cathryn Nation. See preliminary report in meeting packet (pg. 23-53).

The report highlights powerful resource the three education segments are for preparing the future workforce. Priority areas of concern:

- Need for more stable State funding.
- Nursing production – not preparing enough BSN level nursing in public sector. Need more clinical placements and faculty to sustain programs. Expansion in for-profit schools is contributing to escalation of costs and purchasing of clinical placements at the expense of state schools.
- Limit accreditation/credential creep – increases education costs and contributes to higher costs for consumers.
- Increase intersegmental partnerships - seeing specific partnerships to build curriculum that is co-owned by partners. There is a need in community and not enough availability of program space; not competing for clinical spots. More coordination between CC, CSU, and UCs to ensure more seamless articulation process.

There is a need to keep this Steering Committee going and crosswalk with recommendations that comes out of Commission and subcommittees. Alignment between workforce identification needs and needs and capacity with higher education. Commissioner comments included:

- Seems like a lot of the solutions require additional dollars. What would we do to solve the problem if we didn't have additional dollars? Are there levels not on the list that we can add to portfolio of skill sets to address this. How can you use the three systems to address the capacity in a non-traditional way? Any opportunity there? Examples or models, other states that have taken any leaps that we haven't?
- The disinvestment in health professions during the Great Recession has had a staggering impact.
- Need to stay grounded in reality as we get creative.
- Data on enrollment vs. degrees awarded? How does this break down by degrees being offered and students in the program? The committee used enrollment numbers as a proxy for some HPEIs -- for UC medical schools, graduate 99% of students enrolled.
- Is there existing money from other sources and perhaps wasted in other areas? e.g., STEM. We should look at what the end-users are saying about the workforce they're getting

Behavioral Health Subcommittee Strategy Development Progress Report and Discussion

Presented by BH Co-Chair Liz Gibbony and Subcommittee consultant Kimberly Mayer. Commissioner comments include:

- In LA we don't an integrated behavioral health system. We need to expand an integrated care model to include primary care, mental health, and substance use. Also need to integrate virtual care. There is still discussion around what integration means clinically, financially, and administratively. We need to look at each of these areas in terms of best practices.

- There is a key issue of early identification and early detection and getting them into the system. Our approach could be viewed as incomplete if we don't talk about identification and early detection. The subcommittee did discuss this issue and the need for earlier ID in non-traditional settings, e.g. schools. Increase the flexibility of peer supports and offer training for teachers.
- Treatment modalities and methodologies - did the subcommittee discuss inappropriate use of pharmaceutical agents?
- What is the link between treatment, early detection and what is the workforce necessary?
- We have siloed funding in the public system, and we are beginning to outline ways to think about integrated care, including education and incentives and create structures to support that.
- If we're looking at goal of prevention and protective factors, it takes us into issues of equity.
- What people with lived-experience bring to the system is not a "lay" experience; physicians are not the only experts. How do we position the different sectors so we're on a level playing field?
- We need to be able to partner and move the needle on collective work. Inclusion of partners in designing and informing this; not just providing services.
- Pharmaceuticals are overused because they're promoted heavily. Educating professionals of the availability and fitting into care plan and those with prescribing authority on limited benefits.
- One of the types of interactions needed is with those who are developing technology solutions. Technology will affect how much the workforce will need. Certain things will be solved technologically. How do we set up the workforce to adapt to those changes?
- One model that is helpful to replicate is CPIC (Community Partners in Care) model. It addresses how to change norms and destigmatize issue. Strategy to increase capacity to recognize community expertise. Can we scale collaborative care model?
- Technology is interwoven across all areas. In the safety net, patients will not have access unless providers have access. We need to address both in person and virtual care as we approach the issue of integration.
- For the safety net, access to technology is an issue. We have to address this head on…
- In addition to clinical, financial, and administrative integration, I would add political integration. Need to think about integration in ways that are operational, not just policy and clinical.
- One of the most important issues in integration as it relates to equity is in the realm of scope of practice. Many of those with the expertise to identify issues (e.g., CHWs/ Promotors) aren't in a potion to act on their knowledge.
- The continuum spans from primary prevention to recovery. Figuring out the workforce in community setting is important. We broaden future workforce to understand that other sectors are also the health workforce, e.g. teachers, police, faith leaders, etc. in ways that affirm health or negate health. Responsibility of this group to create that frame around issues of equity and trauma and training opportunities.
- We need to be more explicit in pyramid re: base of primary care providers are equipped to detect behavioral health issues.
- Who would oppose the strategies focusing on integration? Those who have a different paradigm and not willing to share resources and funding...
- There are a number of categories of trainees in the Public Higher Education Steering Committee report who are not physicians or nurses that can be assets in addressing BH issues.


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Healthy Aging & Care for Older Adults Subcommittee Strategy Development Progress Report and Discussion

Presented by Subcommittee Chair Heather Young and consultant Lisa Williams. Commissioner comments included:

- What's the equity dimension to the proposed solutions (those who are dual-eligible) re: access? Dual-eligibles actually have more in-home supports.
- CMS announced non-clinical supplemental benefits have been added to Medicare Advantage plans (effective 2019). Chronic Care Act (effective 2020) was also passed and enables those benefits to be permanent.
- There is a challenging reality for aging people in communities of color. How do we move the needle so we are not providing solutions to have more workers doing the same and it's not sustainable? One of things that needs to clear in our paradigm - need to have conversation about how older populations have been displaced.
- How will the universal home worker connect to entire community, not just as a care provider?
- The committee looked into dimensions that impact costs - social isolation, functional decline, and misaligned care.
- The health care system is an evolving beast, and imagine a form of health care system in CA that's like a weather system - what are the biggest unmet opportunities to modify our workforce to make it a model of great care at the lowest cost in a wealthy country? How can we imagine a health worker that is trained in a rapidly evolving, learning system?
- Care for aging populations presents the greatest opportunity for scope and regulatory review.
- NP crosses all areas (PC&P, BH, and Aging). Within nurse delegation, there are models in other states that have expanded services at a higher level. In states where nurses have independent authority, they have a tendency to subspecialize so there could be an unintended consequence. The training of NP has to increase including residency programs...
- What are the competencies you anticipate the universal home care worker having? What kind of training would you recommend? See slide 11 (Current State: Direct Care Workforce Tasks). In Washington, 60-hr course at basic level; next level will be additional XX hours. The CNA curriculum exists in CA is a certificate but not a requirement. Social support, SDOH is another set of cross-cutting skills.
- What is the relationship between universal home care workers and transition moments in medical care? How does this role/person get acknowledged as a team member in an institutionalized care system? It is important to recognize that the team will not be the same team over time; person-centered; some continuous members (e.g., family).
- Re: addressing social isolation - is there a way to see these universal home care workers performing duties in more social settings? Use a group visit model and use the same trained worker in multiple settings. Could we think of a curriculum and training opportunity for not just home-based care, but also group-based and community-based settings? In Alameda County, we are building capacity in community with health navigators in churches.
- How have you considered how these workers might view expansion in scope? What is the strategy for bringing them on board with that? Least trained members will get blamed when things don't go well. How do you establish approach to establish reassurance and credibility with family members?

- We need to have this ladder start with where we are now and offer opportunities for advancement. Also, about consumer direction and navigating that balance with getting enhanced supports when needed. We could extend the CCI pilot and do more testing to see overall impact. Workers that went through this had much more confidence.
- One path to the universal home care model idea is to call out education and family capacity building as a discreet activity and competency - How do we build family capacity rather than supplant it? We need to bridge this to the CHW strategy for PC&P subcommittee - similar conversation may make sense for CHW to talk about competencies to lay the groundwork for certification.
- Collaborative care model for behavioral health can be template for how to integrate home care worker into the care team.
- In fhe PC&P subcommittee, we discussed having a universal pre-health professions major.

Primary Care & Prevention Subcommittee Strategy Development Progress Report and Discussion

Overview presented by PC and P Subcommittee Co-Chairs Hector Flores and Rishi Manchanda. Commissioner comments included:

- CHW scaling - How do we optimize ways in which care teams address SDOH with CHW's as a key team member?
- If we establish certification standards, we have to be cautious about the degree to which CHWs represent communities at the same time they work for the health care system. There are models (e.g., Pathways Hub Model) that preserve the independence of CHWs in separate 501c3s.
- What roles will CHWs have in the development and approval of competencies? What role will they play in educating other health care providers? (current model in SoCal KP where CHWs serve as preceptors for MD residents for rotations.
- Funding for social epidemiologists – important to build capacity of public health department to lead community regional health improvement campaigns
- Need to give further visibility to public health and primary prevention in communities. Real effort is around policy, systems, and practice change that keep people healthy. Our workforce needs to be more interdisciplinary - need planners, community organizers, and people with communication skills.
- Fully integrated is also public health and health care - leadership training and thinking what would that alignment really look like and what does that workforce need.
- Can we work with CCs to get approval for credit for courses to gain their competencies as CHW.
- Important to think about who supervises a CHW.
- What does it look like to create a continuum of support to help the field grow?
- We are faced with two opportunities in the field - 1) to substantially boost productivity of primary care physicians via team-based care and technology, or 2) lose providers to concierge care and in turn deplete available primary care workforce for those who are non-affluent.
- We need to have family and community as a frame of reference for CHWs. Primary care providers are not trained to think of building community capacity to address hypertension. This shift in frame will have implications for productivity, value, and panel size.

- Certify competencies, not community workers… then go to addressing regulatory framework. 5 things CHWs do:
    - Improve community and family engagement through relationships
    - Bring attention to known issues affecting health (SDOH)
    - Keep voices of patients and communities in the center
    - Assist communities in addressing SDOH
    - Support health promotion, disease prevention, disease management
- There is a way of recruiting and training CHWs that honor their wisdom
- We need to be asking what are the strategies that we can incorporate that can address market failures.
- Important to expand who is eligible for those programs; others are also part of health professional world and contributing to good health and should enjoy the same benefits. Another suggestion is to create a trust fund for prevention that does support public health and prevention initiatives.
- How do we boost the productivity of PCPs? Can we increase panels (not if we move to concierge care)? Could have loan repayment benefits for those who make a commitment to practice in underserved areas. What about loan repayment for public health professionals?
- We need to link social epidemiology to action vs. having public health depts. being "repositories of data". An important component is to help convene other sectors. Move from problem ID to problem solving.
  A bill passed out of appropriations to give tax credits to MDs who practice in underserved areas.
- It will be important for the three subcommittees to share thinking and notes, and identify early wins that can will help inform the next Commission meeting. Common themes from today include the observation that all subcommittees can benefit from a competency-based approach

Public Comment

- Victor Rubin & Erika Rincon with PolicyLink
    - In about 2 weeks, releasing report re: building an inclusive workforce in California (sponsored by CA Wellness Foundation). Will focus on policies to increase positive outcomes of health career pathways.
    - Appreciate comments made earlier around working across broad-based coalition of partners
- Dansel Tung with Greenlining Institute
    - Appreciate consideration and review of letter. We want to help support and ensure Commission's recommendations get implemented. Happy to partner to support that - e.g., development of regional work groups in geographically isolated areas. What are some ways CA can work to address concern that might out of the purview of the state to address federal barriers?
- Jessica Rother with National Alzheimer's Association
    - Love proposal for cross-disciplinary teams. Urge that Alzheimer's detection and management be a competency for those who care for the aging population.