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
Welcome Senator Richard Pan

Dr. Richard Pan was elected to the State Senate in 2014 and represents Sacramento, West Sacramento and Elk Grove. Dr. Pan is a pediatrician and continues to practice medicine at an Oak Park Community Clinic even while in the legislature because he is passionate about building healthier and safer communities. In the legislature, he chairs of the Senate Budget Subcommittee on Health and Human Services, the Senate Committee on Public Employment and Retirement and the Senate Select Committee on Children with Special Needs. He now chairs the Senate Committee on Health. He is leading the way on health care reform to provide all people with access to quality health care.
Objectives for our work together today

1. Review and provide direction on priority cross-cutting and focus area critical path strategies and key issues

2. Discuss the importance of health workforce to major purchasers of health and understand their priorities

3. Agreement regarding actions commissioners will take to further refine and advance strategies

4. Assistance with process for stakeholder engagement and building momentum
Commission Process Update
Commission Charge
(by December 2018)

- Develop a strategic plan for building the **future health workforce**
  - Include *practical short, medium, and long term solutions* to address current and future workforce gaps.
  - 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.
# Master Plan Target Audiences

<table>
<thead>
<tr>
<th>New Administration</th>
<th>Health Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislature</td>
<td>Associations</td>
</tr>
<tr>
<td>State Agencies</td>
<td>Health Plans</td>
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<tr>
<td>Higher Education</td>
<td>Private Industry</td>
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<tr>
<td>Health Professions</td>
<td>Business</td>
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<tr>
<td>Education</td>
<td>Regional Partnerships and Pathways</td>
</tr>
</tbody>
</table>
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.
Commission Status and Next Steps

- Agreement on end product and success
- Subcommittee and cross-cutting strategy. Critical path development
- Co-Chair collaboration
- Stakeholder engagement
- Stakeholder survey - 7/20
- From strategies to proposals, plan, priorities
  - refinement/feasibility
- Priorities for 10/2
Critical Path Strategies

A combination of sequenced aligned strategies and actions that will lead to achievement of the North Star and specific goals and indicators by 2030

- Includes a portfolio of strategies from 4 quadrants
- Needs to address the current-future state gap & barriers
- Includes building blocks/dependencies for other strategies and to reach ultimate goal
- Creates conditions and systems for further change
- Other priority strategies can also be pursued
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
Feasibility and Impact Assessment

Action Steps/Sequence
Experience to date
Areas of Need
Resource needs
Source of funds
Impact on workforce

Political considerations
Stakeholders who may oppose and support
Path forward
Levers to drive change
Proposed End Product - Master Plan

North Star

Overarching Goal/ Future State

Indicators

Areas of Focus

Goals

Strategies

Objective (s)

Actions

▪ Near (1-3 years)
▪ Mid (4-7 years)
▪ Long Term (8- 12 years)
Our Process

- Initial problem identification
- Future Envisioning
- Strategy Generation
- Critical Path
- Strategy Refinement, Feasibility and Impact
- Proposal & Plan Develop.
- Prioritization
- Plan approval
- Resources and Commitments

- Open
- Narrow
- Close
How Many Recommendations are we Aiming for?

<table>
<thead>
<tr>
<th>Master Plan Components*</th>
<th>Range of Priority Recommendations**</th>
</tr>
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<tbody>
<tr>
<td>Cross Cutting</td>
<td>7-10</td>
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<tr>
<td>Infrastructure</td>
<td>5-7</td>
</tr>
<tr>
<td>Focus Area Critical Path</td>
<td>5-7 in each</td>
</tr>
</tbody>
</table>

*Detailed critical path plan with action steps.  
** priorities for immediate action/investment.
Definitions of Success and Products

Outcomes:
Near Term:
- Plan completion
- Commissioner & stakeholder support
- Increased awareness and urgency
- Priorities and Road Map
- Uptake on priorities
- Action & resource commitments
- Alignment & Leverage

Products:
- Press Release
- Compelling Messaging
- Briefs for stakeholder
- Detailed 12 year master plan
- Actions for partners
- Implementation plan
Mid and Longer Term Success Indicators (TBD)

1. **Health Impact**: Access, cost, prevention, equity
2. **Workforce/employer Impact**: supply, Diversity, MSA, Cost, turnover, retention, Jobs, wellness
3. **Educational Impact**: capacity v. demand, investment, cost, competencies, practice in CA
4. **Equity and Diversity Impact**: opportunity, education outcomes, jobs, institutional change, composition, inclusion, excellence
5. **Successful Master Plan Implementation**: completion, adoption, implementation, impact, funding, adjustment
Draft Commission North Star (2030)

BY 2030, California’s health workforce will have the capacity, competencies, agency and diversity as well as effectively leverage technology, cross-sector partnerships and institutional support to:

Provide accessible, affordable, high quality whole person services at the right time, right level, and in the right places.

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

Close health gaps within and across populations.
Common Elephants in the Room

- MediCal Reimbursement
- Value-based payment
- Scope of Practice
- Certification of CHW’s?
- Living wage
- Equity and Diversity
- Investment and focus on Behavioral Health, Public Health, Prevention
- Impact of technology?
- Where will the money come from?
Essential Conditions for Change

Adequate Medi-Cal reimbursement
Move to value-based payment
Increased investment in
  ◦ Primary care (with focus non-claims-based capacity building)
  ◦ Primary prevention (e.g., early childhood education, affordable housing, K-12)
  ◦ Behavioral Health
  ◦ Technology for low income residents and providers in rural and inner city communities
  ◦ Rural and inner-city care providers between clinical care and community/cultural centered improvement in health and well-being.
K-16 education and health pathways
Health professions education and training
Our Incredible Subcommittees, Co-Chairs and Lead Consultants!

7 Meetings!
Leadership
Vision
Expertise and Connections
Ownership and Consensus
Continued Engagement
Ambassadors/Champion

THANK YOU!
Technical Advisory Committee and Partners

Problem Identification
Vision refinement
Strategy generation
Critical Path
Candid feedback
Communication
Stakeholder engagement & survey
Ambassadors/Champion
Critical Path Discussions Today

1. Strategy and action step refinement
2. Energy and enthusiasm to move forward
3. Concerns, suggestions, alternatives
4. Your commitments to assist
How can you assist?

<table>
<thead>
<tr>
<th>Roles:</th>
<th>Strategy to proposal:</th>
</tr>
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<tbody>
<tr>
<td>Lead</td>
<td>Consult</td>
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<tr>
<td>Partner</td>
<td>Convene</td>
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<tr>
<td>Support</td>
<td>Connect</td>
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<td></td>
<td>Commit</td>
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<td></td>
<td>Champion</td>
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Shared Ownership
Survey and Stakeholder Engagement Update
Broad Stakeholder Survey

CA Future Health Workforce Commission

https://www.surveymonkey.com/r/TQMJSSPP

855 responses!

Extended to July 20
Survey Objectives

The survey was shared with key stakeholders throughout the state to meet the following objectives:

• Increase awareness of and interest in the commission and the nature of the work

• Secure input regarding priority workforce challenges, future workforce opportunities and potential strategies.

• Gather feedback on current draft strategies including: language refinement, importance and potential impact; key considerations and suggestions; missing strategies.

• Identify promising practices that are related to the strategies being analyzed or that could be considered.

• Promote transparency by providing the opportunity for input into the strategy development process in advance of commission decisions.
Survey Dissemination

The survey distributed through the following channels starting on June 8, 2018 closing on June 20, 2018 for Commission Reporting (Survey deadline was extended to June 29, 2018 for additional feedback opportunities):

- Emailed to 1511 subscribers of the CFHWC newsletter and partner shared lists
- Shared with the five foundation funders to post on their websites and share with their partners.
- Shared by those who received the initial survey with their partners
- Surveys were distributed and promoted by Technical Advisory Committee members to their organizations and networks and also by subcommittee members.

N=855 Total received
Key Takeaways

Responses to the survey largely validate the work that has been done by the subcommittees

• Many respondents praised the proposed strategies as thorough, comprehensive, and well thought out.

• Some also shared concerns about implementation and evaluation of so many strategies at once.

• Subcommittee leaders reviewed the feedback specific to their areas of and confirmed that the feedback aligned with priorities set by each subcommittee.
Increasing Equity

To equitably improve health outcomes, respondents called out the need for more – in every way:

• More diversity, including greater and more varied cultural and linguistic competence
• More workers, at every level in the system, from home health care workers and primary care physicians, to educators and mental health providers
• More support in regions of need, particularly sparsely populated rural areas and chronically underserved urban areas
• More wages for workers in critical, but underpaid, fields, especially those with high emotional labor that can lead to burn out
• More attention to wellness, population health, and the social determinants of health to move beyond a focus on managing chronic illness.
• More collaboration and teamwork within and across disciplines and organizations.
Increasing Equity

To get to *more*, respondents made many suggestions that align with the proposed strategies, such as:

- Launching promotional campaigns to raise awareness of health careers, particularly in under-represented populations
- Building health career education into grades K-16
- Improving financial support for students in health professions programs
- Incentivizing work in underserved areas and with underserved populations
Cross-Cutting

Among the promising practices and additional strategies identified for cross-cutting strategies, were:

• Replicating successful high school career pathway programs for health professions
• Learning from integration of service pilots being implemented in several California counties
• Better leveraging technology and AI such as for telehealth services, virtual education, and electronic health records handling
Primary Care and Prevention

Among the promising practices and additional strategies identified for primary care and prevention were:

• Providing primary care in community-based settings that serve as centers of health and wellness
• Emphasizing team-based work and learning, starting in school
• Support programs that address the social determinants of health
• Expanding scope of practice for roles such as NPs, PAs, and Clinical Pharmacists to better meet needs for primary care
Behavioral Health

Among the promising practices and additional strategies identified for behavioral health were:

• Using mobile applications and other technology to reach underserved communities and populations

• Promoting integrated care models

• Adopting certifications for varying levels of substance abuse and mental health support services
Healthy Aging and Care for Older Adults

Among the promising practices and additional strategies identified for healthy aging and the care for older adults were:

- Supporting aging in place and socialization for seniors
- Implementing stronger systems to coordinate care among teams and with family members
- Pairing seniors with young people (children or college students) in mutually beneficial programs
Letters Received

California Primary Care Association
CSU Chairs and Faculty in Health Sciences and Public Health
Cross-Cutting Strategies
## Cross-Cutting: Priority Strategies Overview

<table>
<thead>
<tr>
<th>Strategy</th>
<th>State Policy/Regulatory Changes</th>
<th>Existing Funding</th>
<th>New Funding</th>
<th>Institutional Policy Changes</th>
<th>Stakeholders Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy</td>
<td>Regulation</td>
<td>Public</td>
<td>Private</td>
<td></td>
</tr>
<tr>
<td>Invest in strategies to expose &amp; prepare K-16 &amp; post-bac student for priority health careers &amp; edu program entry</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Higher Ed, K-12, Foundations, Employers, State, Regional players</td>
</tr>
<tr>
<td>Increase investment of health professions in CA to support needs re: diversity, competencies &amp; access</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Higher Ed, K-12, Foundations, Employers, State, Plans</td>
</tr>
<tr>
<td>Create &amp; expand new California Health Corps</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>Higher Ed, K-12, Foundations, Employers, State,</td>
</tr>
<tr>
<td>Develop regional partnerships for co-investment to strengthen training &amp; career advancement</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>State, WIB, Com College, Foundations, Plans</td>
</tr>
<tr>
<td>Provide incentives &amp; support for integration of critical competencies into all health prof. training curriculum</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>Employers, HPEI, Higher Ed, Foundations, Associations</td>
</tr>
<tr>
<td>Enhance/expand capabilities &amp; roles of health workers/teams to optimize capacity &amp; effectiveness</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>Employers, State, Licensing, OSHA, HPEI</td>
</tr>
</tbody>
</table>
**Cross-Cutting: Priority Strategies Overview**

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<tr>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>State, WIB, Employers, Higher Ed, K-12, Foundations, Associations, Statewide organizations</strong></td>
</tr>
<tr>
<td>Develop state level (public &amp; private) infrastructure to assure for effective implementation of master plan</td>
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Note: The table indicates 'X' for 'Yes' and blank for 'No' in the respective columns.
## Cross-Cutting: Select Priority Strategies & Action Steps

<table>
<thead>
<tr>
<th>Practice Authority</th>
<th>CA Health Corps</th>
<th>Health Technology Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associations, UCSF, Leg, Employers, Reg, Foundations</td>
<td>Higher Ed, Pathway Programs, Employers, Leg, Associations, Foundations, Students, K-12, WIB</td>
<td>Tech industry, health employers, foundations, Associations, Higher Ed and HPEI, Center for Connected Health Policy, CITRIS</td>
</tr>
</tbody>
</table>

- UCSF Summary
- Convene Key Stakeholders
- Identify priority problems and outcomes
- Develop path forward
- Propose pilots and other options
- Secure funding and support
- Refine and vet strategy
- Update Inventory of current efforts
- Prioritize initial components and alignment with existing initiatives
- Develop messaging and campaign strategy
- Secure resources
- Refine and vet strategy
- Inventory Efforts
- Identify champions
- Convene key stakeholders
- Define scope and outcomes
- Develop business plan
- Secure resources
Primary Care & Prevention Subcommittee
<table>
<thead>
<tr>
<th>Expand primary care residencies</th>
<th>Primary care / prevention spend targets</th>
<th>Accelerated Primary Care Medical School Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stakeholders:</strong> HPEIs, OSHPD, legislature, philanthropy, teaching hospitals and health centers.</td>
<td><strong>Stakeholders:</strong> Health plans, HC providers, hospitals/HS, LPHAs, SS agencies, CBOs.</td>
<td><strong>Stakeholders:</strong> K-12, Higher education, HPEIs, DOE, CDPH</td>
</tr>
<tr>
<td>• Create a state fund through OSHPD to invest in new teaching health centers in designated medical shortage areas.</td>
<td>Establish or designate state advisory structure with broad representation of stakeholders.</td>
<td>Review experience to date with UCD and programs in other states to assess production levels, student profiles, practice choice, location, and costs.</td>
</tr>
<tr>
<td>• Secure State approval for $33M of previously approved funding for residencies through Song Brown in FY 2018-19 &amp; FY 2019-20; develop strategy to make funding permanent.</td>
<td>Set parameters for what counts and algorithms for calculation of expenditures by health plans.</td>
<td>ID other SOM in CA that may host AMEP and assess marginal costs, ROI, regional contribution, and potential sources of funding.</td>
</tr>
<tr>
<td>• Develop a state funded Medicaid GME program for an additional 100 residents annually leveraging lessons learned from NY, MA and New Mexico.</td>
<td>Pass legislative mandate for reporting in approved format.</td>
<td>Secure funding from a combination of State, private philanthropy, and employers for selected SOM.</td>
</tr>
<tr>
<td>• Monitor Proposition 56: CA Healthcare, Research and Prevention Tobacco Tax Act of 2016 funding for GME growth</td>
<td>Conduct study &amp; publish results</td>
<td>Develop partnerships with residency programs to expand primary care capacity in regions and to streamline matching process.</td>
</tr>
<tr>
<td></td>
<td>Convene state advisory CTE, set targets, incentives and ID TA needs</td>
<td>Develop admissions policies that maximize admission of students with interest in primary care &amp; practicing in underserved area. Ensure are clerkships that prepare for residencies in primary care disciplines</td>
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<td>Publish results and refine.</td>
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### Prevention: Selected Priority Strategies & Action Steps

<table>
<thead>
<tr>
<th>Scale the engagement of CHWs &amp; Promotores</th>
<th>Assess CA PH workforce, build public knowledge of opportunities, and build capacity.</th>
<th>Build the capacity LPHAs to partner with providers &amp; payers in comprehensive CHI strategies.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stakeholders : State, Health plans, HPEIs, Employers, CHWs/Ps</strong></td>
<td><strong>Stakeholders: CDPH, SPHs, LPHAs, HPEIs, Hospitals/HS, CHCs, community advocates.</strong></td>
<td><strong>Stakeholders: PH, Hospitals/HS, cities/counties, philanthropy, State, advocates.</strong></td>
</tr>
<tr>
<td>By 2019, establish a statewide CHW/Ps Advisory Board.</td>
<td>Conduct inventory of Govt PH workforce as baseline of career paths; expertise, skills (incl. health equity, SDH), functions, regional/population focus, &amp; demographics.</td>
<td>Conduct statewide GIS-based analysis (mash up with demographic indices) of preventable ED and inpatient utilization at zip code level to inform local/regional partnership development.</td>
</tr>
<tr>
<td>By 2019, reach consensus on core competencies, strategies, &amp; funding to align programs &amp; ensure access across regions.</td>
<td>Document applicants, enrolled, and graduation rates for all CA accredited and non-accredited SPHs/programs.</td>
<td>Convene H/HS, PH, municipal, philanthropy, &amp; advocacy leaders to develop comprehensive strategies that leverage expertise.</td>
</tr>
<tr>
<td>By 2019, CDHS/CDPH adopt definition for CHWs/Ps for core competencies, &amp; adopt metrics to document contributions, impact &amp; ROI in CHI &amp; care quality.</td>
<td>Establish expectations for public health professionals, assess what elements of current SPH curricula meet those expectations, and publish findings.</td>
<td>ID public sector funds with required match of local contributions to align &amp; focus comprehensive strategies where health inequities are concentrated.</td>
</tr>
<tr>
<td>By 2020, establish sustainable financing mechanisms that expand opportunities across community &amp; clinical settings.</td>
<td>Identify, steps, timing, and implement targeted improvements to SPH curricula.</td>
<td>Establish regional parameters and fund regional partnerships that meet designated criteria.</td>
</tr>
<tr>
<td>By 2020, academic AMCs i CHWs/Ps into residency training models.</td>
<td>Accelerate Cal HR review process for civil service examinations process &amp; timelines.</td>
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<tr>
<td>By 2020, ensure regional training capacity for CHWs/Ps and inter-disciplinary training programs for health care teams.</td>
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Health Purchaser Panel

Dr. Lance Lang

Dr. David Lansky

Jeanne Cain
A Purchaser’s Perspective on The Health Care Workforce

Testimony to California Future Health Workforce Commission

Lance Lang, MD
Chief Medical Officer
June 29, 2018
Configuration of Workforce Matters: Provider Workforce and Quality

General Practitioners Per 10,000 and Quality Rank in 2000

Quality rank

1

26

51

General practitioners per 10,000

SOURCES: Medicare claims data; and Area Resource File, 2003.

NOTES: For quality ranking, smaller values equal higher quality. Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004
Configuration of Workforce Matters: Provider Workforce and Medicare Spending
General Practitioners and Spending Per Beneficiary in 2000

SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

Source: Baicker & Chandra, Health Affairs, April 7, 2004.
MOVING THE NEEDLE ON PRIMARY CARE: COVERED CALIFORNIA’S STRATEGY TO LOWER COSTS AND IMPROVE QUALITY

Four Inter-related Elements

1. Benefit Design
   From the beginning, Covered California has made sure consumers can seek ambulatory care without needing to meet a deductible

2. A Primary Care Physician for Every Enrollee
   Starting in 2017, all Covered California enrollees have a doctor who can serve as their advocate

3. Payment Reform
   Moving away from Fee for Service

4. Patient Centered Medical Home Recognition
   Support PCPs in adopting accessible, team-based, data-driven care

PRIMAR Y C ARE

“If you do not have a foundation of powerful primary care then you can do nothing else.”
Randy McDonald, Sr. VP IBM, 2009

- Healthforce Center at UCSF report on expanding Primary Care Capacity, June 2018, provides a great foundation
- PCP value is in role as first point of contact and advocate > gatekeeper
  - Expand access: virtual, same day, late, weekends
  - Manage deep into episodes
  - Support shared decision-making
  - Select and coordinate with specialists
- Payment must be population-based and redirected to primary care
  - Oregon model requires growing payment to primary care (from 6% to 12% of premium by 2023) to support team-based care
- Physicians alone will not sufficiently meet the workforce need
  - All staff, especially Nurse Practitioners, must expand scope of practice for full extent of training and skills
  - Medical Assistants can expand role to be health coaches & scribes
SPECIALTY CARE

Specialty care needs to evolve

- Less ivory tower and more integration with primary care
- Priorities are behavioral health, most medical specialties, non-operative orthopedics and rehab medicine
- Successful integration leveraging TeleHealth
  - E-Consult
    - Email consultation in advance of or instead of referral
  - Project ECHO
    - PCP education
    - Three way consultation
- Payment must be population-based with joint accountability between primary and specialty care as in ACOs
- Workforce requirements for specialists soon to be impacted by AI
  - Machines will soon read X-rays and retinal scans
TAKing CARE TO THE COMMUNITY

All levels of care are moving to home and workplace
  • Hospitals no longer only site of acute care for medical conditions
  • Outpatient surgery requires follow up & rehab
  • Aging and disabled patients better cared for at home
  • Busy tech-enabled consumers demand new responsiveness

Community care provides opportunity to assess and overcome barriers to care including social determinants

Requirements for the community-based care undefined
  • All levels of expertise and licensure being tested
  • Experiments with Telehealth support team-based care
  • Still working out health data exchange
  • Insurance benefit structures will be stretched
OPTIMIZING CURRENT WORK FORCE

- **Health Care System Today**
  - Fragmented, wasteful
  - Volume rather than quality driven

- **Greatest opportunity is in clinical transformation**
  - Team-based with each provider working at top of training & skills
  - Data-driven
  - Collaborative, integrated and coordinated

- **Barriers**
  - Skills: training emphasizes outdated model of hero medicine
  - Business model: Fee for Service at odds with focus on outcomes, collaboration and shared system accountability

- **California Quality Collaborative at PBGH**
  - Leads clinical transformation programs in partnership with Center for Excellence in Primary Care at UCSF
Information for consumers

CoveredCA.com

Information on exchange-related activities

hbex.CoveredCA.com
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 Subcommittee

- CA BH Planning Council
- CommuniCare
- UC Davis
- Beacon Health Options
- Telecare Corporation
- CBHDA
- Fresno County Mental Health
- Kaiser Permanente/Kaiser Foundation Health Plans
- CA Dept. of Public Health-Office of Health Equity
- Providence St. Joseph Health
- CA Healthcare Foundation
- NAMI California
- CalSWEC
- Xpio Health
- Partnership Health Plan
- CA Hospital Association
- Steinberg Institute
- US Dept. of Veterans Affairs
- UCSF School of Nursing
- Mental Health California
- OSHPD
- Council on Mentally Ill Offenders
- CIBHS – SUDs Consultant
Additional Stakeholder Presentations & Meetings - May & June 2018

- California Association of Social Rehabilitation Agencies (CASRA)
- County Behavioral Health Directors Association of California (CBHDA)
- National Association of Social Workers - California (NASW)
- American Psychiatric Nurses Association
- California Hospital Association
- California Psychological Association
- NAMI California
- California Mental Health Services Authority (CalMHSA)
Behavioral Health Subcommittee Envisioning

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

- 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
### Behavioral Health: Priority Strategies Overview

<table>
<thead>
<tr>
<th>Strategy</th>
<th>State Policy/Regulatory Changes</th>
<th>Existing Funding</th>
<th>New Funding</th>
<th>Institutional Policy Changes</th>
<th>Stakeholders Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sustain/Increase financial incentives for BH, including MHSA WET</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X X</td>
<td>Legislature, OSHPD, Planning Council, Education, Private sector</td>
</tr>
<tr>
<td>2. UC Schools of Nursing Psychiatric MH Nurse Practitioner Expansion</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X X X</td>
<td>UC Schools of Nursing, Funders, Employers</td>
</tr>
<tr>
<td>3. Expand Psychiatric MH Nurse Practitioner Scope/Autonomous Practice</td>
<td>X X</td>
<td>X</td>
<td>X</td>
<td>X X X</td>
<td>Associations, OSHPD, Legislators, Employers</td>
</tr>
<tr>
<td>4. Promote team-based, integrated care</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X X X</td>
<td>Health Professions, DHCS, Health Plans</td>
</tr>
<tr>
<td>5. Establish same-day reimbursement for BH and medical visits</td>
<td>X X</td>
<td>X</td>
<td>X</td>
<td>X X X</td>
<td>DHCS, PCA, Legislators, Health Plans, FQHCs</td>
</tr>
<tr>
<td>6. Increase meaningful BH training in medical, Physician Assistant &amp;</td>
<td></td>
<td></td>
<td>X</td>
<td>X X X</td>
<td>Health Professions Education, Residency progs.</td>
</tr>
<tr>
<td>nursing schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above provides an overview of priority strategies for Behavioral Health, including state policy and regulatory changes, existing and new funding, institutional policy changes, and stakeholders involved for both near-term and mid-term goals.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>State Policy/Regulatory Changes</th>
<th>Existing Funding</th>
<th>New Funding</th>
<th>Institutional Policy Changes</th>
<th>Stakeholders Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Increase access to BH education/training in underserved areas</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>K-16 education, OSHPD, HOSA, Legislature</td>
</tr>
<tr>
<td>8. Establish statewide Peer Specialist Certification</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Legislature, Steinberg Inst., DHCS, OSHPD, MHPs, Education, CBHDA</td>
</tr>
<tr>
<td>9. Standardize training, state-level certification, career pathways for Substance Abuse Counselors</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>CAADPE, DHCS, Education, CBHDA, Legislature</td>
</tr>
<tr>
<td>10. Promote/Create BH Track for Physician Assistants post-licensure/board certification</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>PA Association, Health Plans, MHPs, County MH</td>
</tr>
<tr>
<td>11. Expand paid positions for license-track BH professionals</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>Health Plans, MHPs</td>
</tr>
<tr>
<td>12. Accelerate/invest in BH prevention education, early detection &amp;</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>K-16 education, NIMH, SAMHSA</td>
</tr>
</tbody>
</table>
### Behavioral Health: Priority Strategies Overview (cont.)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>State Policy/Regulatory Changes</th>
<th>Existing Funding</th>
<th>New Funding</th>
<th>Institutional Policy Changes</th>
<th>Stakeholders Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy</td>
<td>Regulation</td>
<td>Public</td>
<td>Private</td>
<td>Public</td>
</tr>
<tr>
<td>12. Increase K-health professions awareness for BH careers</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
# Behavioral Health: Select Priority Strategies & Action Steps

<table>
<thead>
<tr>
<th><strong>#1b Continue/Replace WET Funding</strong></th>
<th><strong>#1.c Promote sufficient allocation of Prop 64 (Marijuana Tax) funds for Substance Abuse Workforce</strong></th>
<th><strong>#5. Establish same-day reimbursement for BH and medical visits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders involved: OSHPD, CA BH Planning Council, Legislature, MHSAAOC Higher Ed, MHPs, Providers, CBOs, UC Psychiatric Residency Programs</td>
<td>Stakeholders involved: DHCS, DOE, CDPH, CAADPE, CBHDA, Providers, Community Colleges</td>
<td>Stakeholders involved: CPCA, Steinberg Institute, FQHCs, Health Plans</td>
</tr>
</tbody>
</table>

- **Establish ongoing MHSA WET funds and replacement dollars, add SA Counselors.**
- **Monitor results of current legislative/budget activity**
- **Determine ultimate and unmet need**
- **Inventory current financial strategies** for efficacy, criteria to meet goals
- **Develop plan to seek additional public and private funding**

- **Support original intent of Prop 64 revenues for SUD workforce.**
- **Engage in process for**
  - DHCS, DOE, DPH formalize stakeholder process, aligned with workforce needs aligned with Commission.
- **Include development of formal SA Counselor Career Pathway/Career Ladder**

- **Monitor current legislative activity**
- **Support integrated primary care/behavioral health treatment strategies**
- **Engage in next steps depending on outcome of legislation.**
## All MHSA WET State Programs 2014-18

<table>
<thead>
<tr>
<th>Item Number</th>
<th>State Administered WET Program</th>
<th>State WET Funding for 4 Year Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stipends</td>
<td>$31,426,699</td>
</tr>
<tr>
<td></td>
<td>Psych Nurse Practitioner</td>
<td>$2,662,772</td>
</tr>
<tr>
<td></td>
<td>Clinical Psychologist</td>
<td>$1,797,734</td>
</tr>
<tr>
<td></td>
<td>Marriage and Family Therapist</td>
<td>$12,866,193</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>$14,100,000</td>
</tr>
<tr>
<td>2</td>
<td>Loan Assumption</td>
<td>$41,500,000</td>
</tr>
<tr>
<td>3</td>
<td>Education Capacity</td>
<td>$16,634,556</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist</td>
<td>$9,500,000</td>
</tr>
<tr>
<td></td>
<td>Psych Nurse Practitioner</td>
<td>$7,134,556</td>
</tr>
<tr>
<td>4</td>
<td>Consumer and Family Member</td>
<td>$12,368,924</td>
</tr>
<tr>
<td>5</td>
<td>Regional Partnership</td>
<td>$9,000,000</td>
</tr>
<tr>
<td>6</td>
<td>Recruitment (Career Awareness) and Retention</td>
<td>$4,344,090</td>
</tr>
<tr>
<td></td>
<td>Mini-Grants</td>
<td>$1,394,662</td>
</tr>
<tr>
<td></td>
<td>CalSEARCH (1)</td>
<td>$500,000</td>
</tr>
<tr>
<td></td>
<td>Retention</td>
<td>$1,449,428</td>
</tr>
<tr>
<td></td>
<td>Pipeline Program (2)</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>7</td>
<td>Evaluation</td>
<td>$900,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$116,174,269</strong></td>
</tr>
</tbody>
</table>
## WET Financial Incentives Funding

### 2017-18 WET Financial Strategies

<table>
<thead>
<tr>
<th>Category</th>
<th>Funding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stipends Psychiatric MHNPs Clinical Psychologists MFTs Social Workers</td>
<td>$8,152,619</td>
<td>328</td>
</tr>
<tr>
<td>Loan Assumption</td>
<td>$10,000,000</td>
<td>142</td>
</tr>
<tr>
<td>Education Capacity</td>
<td>$4,600,000</td>
<td>72</td>
</tr>
<tr>
<td><strong>TOTAL ONE YEAR</strong></td>
<td><strong>$22,752,479</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Proposed 2018-19 General Funds

<table>
<thead>
<tr>
<th>Category</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stipends Psychiatric MHNPs Clinical Psychologists Social Workers</td>
<td>$5,000,000</td>
</tr>
<tr>
<td><strong>TOTAL ONE YEAR</strong> (proposed)</td>
<td><strong>$10,000,000</strong></td>
</tr>
</tbody>
</table>
Behavioral Health: Select Priority Strategies & Action Steps (cont.)

#11e Promote large scale adoption of standard BH and wellness curriculum for K-12 and college campuses

Stakeholders involved:
K-16 education, Health Plans, SAMHSA, NIMH, Unions

- Review current curricula in CA, USA, & internationally
- Develop strategy for how curriculum can impact BH and the workforce
- Determine method for advancing curriculum
- Pilot curriculum/interventions in SB health centers, schools and colleges
- Promote inclusion in educator training and standard K-12 curriculum
- Develop workforce strategies to support implementation
NO HEALTH WITHOUT MENTAL HEALTH
“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

- **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**

**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**

- **100,000** limited self-care population age 65-75 in nursing homes by 2030

**Workforce**

- **200,000** additional home care workers needed in CA by 2024

- **33%** annual turnover of IHSS workers in CA

- **60%** annual turnover of agency-employed home care workers

- **< 5%** of the health professions workforce has expertise in geriatrics

**Sources of Funding for Nursing Home Residents**

- Medicare 15%
- All other 6%
- Self-pay 9%
- Private insurance 2%
- Managed Care 7%
- Modi-Cal 65%
- Other 4%
- African American 2%
- Asian/Pacific Islander 3%
- Latino 7%
- White 10%

**Costs:**

- **$97K** annual cost of nursing homes
- **$57K** annual cost (average) of home care*

*Cost varies based on number of hours needed
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
Healthy Aging & Care for Older Adults Strategies

Universal Home Care Worker

• Meet the demand for **200,000 new home care workers** by 2030 through establishing and securing widespread adoption of a **new Universal Home Care worker / job family** with entry & advancement levels
  • Provide meaningful work and improved employment
  • Enhance quality of life and health profession opportunities
  • Create integration into the medical model

Overlooked Workers

• View the **aging population as a viable and vibrant resource to care for older adults** and **reduce social isolation**. Develop a value proposition and **attract workers from other industries** whose positions have been phased out and **older adults seeking post-retirement careers**
## Current & Future State Level 2 Example

### Universal Home Care Worker: In Scope or Not?

<table>
<thead>
<tr>
<th></th>
<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><strong>CS</strong></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>FS</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Slide 6*
Healthy Aging & Care for Older Adults Strategies

Team-based Care & Competencies

• 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, inclusive of hospice and community-based palliative care. Establish interdisciplinary team-based education with inter-professional faculty.

Full Practice Authority

• Establish full practice authority for Geriatric and Adult Acute Care NPs consistent with education/training to improve primary care access in rural communities and home-based settings, improve preventive care, reduce health disparities and the cost of care (in collaboration with physician partners).

Cross-cutting strategy
### Current State: Direct Care Workforce Tasks*

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>FAMILY MEMBER</th>
<th>HOME CARE WORKER</th>
<th>HOME CARE WORKER</th>
<th>IHSS WORKER</th>
<th>IHSS WORKER</th>
<th>HOME HEALTH AIDE</th>
<th>HOME HEALTH AIDE</th>
<th>CNA</th>
<th>CNA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HOME CARE WORKER employed by home health agency</td>
<td>HOME CARE WORKER independent &amp; consumer directed</td>
<td>IHSS WORKER consumer directed</td>
<td>HOME HEALTH AIDE employed by home health agency</td>
<td>CNA employed by home health agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5/5</td>
<td>3/5</td>
<td>5/5</td>
<td>5/5</td>
<td>5/5</td>
<td>5/5</td>
<td>4.5/5</td>
<td>5/5</td>
<td>5/5</td>
</tr>
<tr>
<td>Personal Care (5 tasks)</td>
<td>Personal Care (5 tasks)</td>
<td>Support Living in Community (1 task)</td>
<td>Medical &amp; Nursing Tasks (15 tasks)</td>
<td>Monitoring (2 tasks)</td>
<td>Evaluation &amp; Docu. (8 tasks)</td>
<td>Care Coord &amp; Coaching (5 tasks)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/5</td>
<td>1/1</td>
<td>14/15</td>
<td>2/2</td>
<td>2/8</td>
<td>4/5</td>
<td></td>
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<td></td>
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<tr>
<td>3/5</td>
<td>P</td>
<td>2/15</td>
<td>1/2</td>
<td>1/8</td>
<td>1.5/5</td>
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<td>5/5</td>
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<td>14/15</td>
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<td>1/8</td>
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<td>14/15</td>
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<td>4.5/5</td>
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<td>4/15</td>
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<td>1/8</td>
<td>2/5</td>
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<tr>
<td>5/5</td>
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<td>6/15</td>
<td>1/2</td>
<td>1/8</td>
<td>2/5</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- ○ = full responsibility
- ◐ = partial responsibility
- ◯ = limited to no responsibility

* For a list of tasks by core area noted above, see Appendix, slide 15
### Conceptual Framework for UHC Job Family

**Level 1**
- Personal care and support living in the community through demonstrating proficiency in performing ADLs and IADLs
  - ADLs: bathing, dressing, toileting, transferring and continence
  - IADLs: finances, transportation, and communications, shopping & meal prep, housecleaning & home maintenance

**Level 2**
- Plus some of the paramedical tasks for individuals with moderate functional limitations and cognitive decline
  - Eye drops, oral meds, special diets, assistive devices, catheter care
  - With remote oversight by a licensed professional (LVN, RN)
  - Required training

**Level 3**
- Plus higher level paramedical tasks for the most complex individuals (e.g., Dementia)
  - Enemas/suppositories, injections, IV fluids, wound care, blood sugar testing, tube feeding, suctioning, oxygen/respiratory care, ventilators, etc.
  - With remote oversight by licensed professional (RN)
  - Required training and certification
Action Steps: Universal Home Care Worker

• Develop a conceptual framework for UHC job family

• Obtain input from stakeholders (private and public payers, regulators, state certifying bodies, professional organizations & associations, educational institutions and advocacy groups), and align on path forward

• Identify and review training requirements and competencies existing in other states (WA, AK, AZ, ID, MN, VA) with uniform requirements for the direct care workforce; learn from WA state’s program and evaluation process, and CALTEC’s pilot training for IHSS workers

• Develop job level specifications, quality standards and training requirements

• Secure sufficient sources of funding from private and public payers (focus on MA Plans – 2019 new Medicare rules for inclusion of supplemental SDOH-like benefits)

• Conduct a health workforce pilot project to test and evaluate expanded scope of practice for the Universal Home Care worker; decide on entity to oversee and manage workforce

• Document process and timeline to introduce nurse delegation legislation, allowing L2 and L3 workers to perform paramedical tasks under licensed supervision
Stakeholders Engaged To Date

- SEIU
- Home Care Agencies
- CMA
- CNA
- Stanford Clinical Excellence Research Center
- CA Long-term Care Education Center (CALTEC)
- Health Plans (MA) – (future)
- DMHC & DHCS (future)
- Technical Advisory Committee
- Stakeholder survey (responders to Aging strategies = 146)
- Interdisciplinary Healthy Aging & Care for Older Adults Subcommittee
- CAHSAH (CA Association for Health Services at Home - underway)
- OSHPD (future)
- Legislature (future)
Strategy 2: Overlooked Worker
(post-retirement and active workers from other service industries)

High-Value Care for Late Life

COMMUNITY
Leverage Aging Community as Companions and Lay Health Workers

CAPABILITY
Optimize Function and Environment

COMMUNICATION
Activate Patients to Define and Share Values and Health Goals

Well-being
Hospital Readmissions at 30, 60, and 90 days

Independence with ADLs
Hospitalization and Institutionalization

Patient Satisfaction
Goal Discordant EOL Care

Reduce Social Isolation

Net Savings $260 PMPM (Range: $98 to $898)
$1.5 Billion Annual Medicare Savings (-$0.6 to $5.3 Billion)

Net Savings $402 PMPM (Range: $71 to $1537)
$6.8 Billion Annual Medicare Savings ($1.2 to $25.9 Billion)

Net Savings $1073 PMPM (Range: $354 to $1397)
$14.3 Billion Annual Medicare Savings ($4.7 to $18.6 Billion)

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Types of Roles to Consider for Overlooked Workers (paid and unpaid)

• Navigators
• Care Coordinators
• Health Coaches
• Universal Home Care Worker
• Companions (friendship, meal prep, transportation, etc.)
Action Steps: Overlooked Worker

Post-Retirement Careers
- Stakeholder engagement:
  - AARP
  - Healthcare employers: recruit, train and build on experience
  - Associations and professional organizations
  - Health Plans (MA)
  - Convene stakeholders hosted by Stanford Clinical Excellence Research Center (CERC)
- Define roles, requirements and training
- Decide on entity to oversee and manage
- Develop value proposition
- Develop plan to seek private and public funding

Active Workforce Displaced from other Service Industries
- All content under post-retirement career with exception of AARP plus the following:
  - Partner with EDD – employer notifications of job eliminations
### Strategy #3
**Team-Based Care & Competencies**

- Stakeholders involved: UC, CSU, Community Colleges, Associations, Boards
- Developed crosswalk of existing competencies across Aging, Primary Care, BH:
  - Interpersonal & Communication Skills
  - Team Care: Collaboration & Teamwork
  - Professionalism & Ethics
  - Care Planning & Coordination
  - Assessment
  - Quality Improvement
  - Cultural humility
  - Population Health/SDOH
  - Self-Development
- Convene multiple stakeholder with UC taking a leadership role

### Strategy #4
**Full Practice Authority**

- Stakeholders involved: CMA, CNA, Other Associations, OSHPD, Legislators, Employers
- Obtain stakeholder feedback – convene multiple groups
- Review literature and summarize legislation, regulation and experience in other states
- Explore potential pilots
Public Comment
Wrap-Up/Next Steps