CALIFORNIA FUTURE HEALTH WORKFORCE COMMISSION

MEETING THE DEMAND FOR HEALTH

TOP PRIORITIES, CHALLENGES, AND PROPOSED ACTIONS FOR THE PRIVATE SECTOR TO SUPPORT THE WORKFORCE CALIFORNIA NEEDS

KEY INFORMANT INTERVIEWS WITH CALIFORNIA PRIVATE SECTOR HEALTH CARE LEADERS

Since the release of the California Future Health Workforce Commission's final report in February 2019, the Newsom Administration and state legislators have taken a range of decisive actions to advance key Commission recommendations for addressing the state's looming health workforce shortage. While important steps have been taken to date, the urgent case for action outlined in the report is a reminder that shared ownership requires equal leadership by the private sector.

Key informant interviews were conducted with selected health system and heath plan leaders between November 2019 and January 2020 to identify specific actions that can be taken by the private sector consistent with the recommendations outlined in the ***Meeting the Demand for Health*** report. (For a list of those interviewed, see page 8.)

In the short time since the completion of the key informant interviews, the world was upended by the COVID-19 pandemic, which confronted the health sector and the larger society with unprecedented challenges. In the U.S., the profound inequities exposed by the patterns of viral infection and mortality have been further illuminated by police violence in Minneapolis, Wisconsin, and elsewhere, which has spurred a belated national dialogue about confronting discrimination and structural racism in their many forms and impacts.

These world-changing events created an imperative to re-engage the health care leaders to learn what has changed and what has become even more urgent.

Follow-up key informant interviews were conducted between late April and June of this year. There were four areas of inquiry in the two sets of interviews:

1. **TOP PRIORITIES** for building the workforce of the future.
2. **SIGNIFICANT CHALLENGES** in providing clinical care and meeting the social needs of patients, as well as addressing the social determinants of health in communities.
3. **LEADERSHIP ROLES AND ACTIONS UNDERWAY** among private sector health employers in the coming year to build the health workforce of the future.
4. **PROPOSED ACTIONS** by the public sector, philanthropy, and across sectors to stimulate, scale, and sustain efforts to build the health workforce of the future.

Findings from the interviews can be found on the following pages, highlighting priorities, challenges, and proposed actions — both before COVID-19 and in the midst of the pandemic. Further work is needed to align the priorities and actions proposed by these leaders with complementary actions in the policy arena.

The devastating economic impacts of COVID-19 at all levels of society and the moral imperatives exposed by the pandemic have further heightened the need to strengthen California's health workforce.

1. TOP PRIORITIES FOR WORKFORCE INVESTMENTS AND ADDRESSING INEQUITIES IN THE HEALTH CARE SYSTEM AND ITS WORKFORCE PIPELINE

NEW SKILLS FOR PROVIDERS AND LEADERS

Build provider emotional intelligence, critical thinking/curiosity, soft skills, agility, resilience, empathy, learning to live with ambiguity, strategic thinking, and change leadership.

Educate clinician leaders in business and leadership proficiency and knowledge of community health.

REMOVE BARRIERS TO OPTIMAL DEPLOYMENT OF EXPERTISE

Allow workers to work at the top of their licenses by removing barriers preventing optimal deployment of their expertise.

Address geographic maldistribution in primary care, behavioral health, and other key specialties.

INVEST IN HEALTH CAREER PATHWAYS

Increase workforce diversity, instilling the idea in the minds of young Californians that futures in the health sector are appealing regardless of background, socioeconomic status, race/ethnicity, and gender.

Partner with schools and companies to develop pipelines for jobs and remove barriers to continuing education.

WORK ACROSS SECTORS

Shift to a value-based payment environment to better manage geographic populations through increased focus on community well-being.

Promote genuine collaboration across sectors, promoting senior leader skill sets and fiscal leadership needed to improve outcomes and secure revenue from multiple sources in the private, public, and philanthropic sectors.

Empower and invest resources in people with lived experience to better meet patient complex needs and reflect California's population.

EXPAND INVESTMENT IN VIRTUAL CARE AND TRAINING

Accelerate the health professions educational process by virtualizing the first two years of higher education to reduce costs and increase access.

COVID-19 RELATED PRIORITIES UPDATE

In general, leaders indicated that experience during the pandemic suggests that priorities are in the right place, but the profound inequities exposed by events increase the imperative for definitive action.

INVEST IN PUBLIC HEALTH INFRASTRUCTURE

Significantly increase public health infrastructure investments, making government public health a more prestigious place to work that attracts and keeps the best and brightest.

CONTINUE TO EXPAND VIRTUAL CARE & WORK

Embrace telehealth expansion, which has major implications for health providers, such as nearly zero no-shows and a significant increase in access to behavioral health. In terms of care delivery, investments in technology are a priority, particularly for physician practices. In terms of analytic infrastructure, there is a need to increase numbers of data scientists and virtual care capacity to co-manage care, build working relationships, and process design to reduce wait times.

Adapt to major increase in telecommuting, which has resulted in limited drops in productivity and saved hours a day in commuting, for many representing a significant increase in quality of life.

REMOVE SILOS THAT LIMIT ACCESS TO PROGRAMS AND SERVICES

Promote an integrated approach to health improvement and care, including physical, social, and behavioral health services — de-siloing enrollment and the provision of a full spectrum of services and supports.

2. SIGNIFICANT CHALLENGES IN PROVIDING CLINICAL CARE, MEETING THE SOCIAL NEEDS OF PATIENTS, AND ADDRESSING SOCIAL DETERMINANTS OF HEALTH

WORKFORCE SHORTAGES

Acute shortages exist across a range of key specialties, including nurses, lab techs, pharmacists, medical social workers, case managers, home health workers, peer providers and other behavioral health specialists, dental assistants, primary care, psychiatry, and pediatrics.

Difficulty with recruitment and retention, paired with competition among larger providers (particularly in rural areas), is limiting efforts to meet critical needs.

MINDSET REQUIRED TO ACHIEVE OUTCOMES AT SCALE

Providers continue to limit their focus to care management for defined patient populations, despite growing evidence that community and policy level interventions are also needed to produce sustainable outcomes at scale.

COMPLEXITY OF GROWING FOCUS ON PREVENTION

Delays in access to care are exacerbating challenges at the interface between the social determinants of health in the community and adverse childhood experiences in the home, the product of which contributes to youth violence, bullying, and depression.

Lack of livable wages are forcing many adults to work multiple jobs, with associated toxic stress producing myriad negative impacts.

Absence of sufficient gap analysis and service redesign for people who are currently or at-risk of homelessness is hampering the private sector's ability to strengthen screening, better target services, and strengthen relationships with the broader health sector and related sectors (e.g., community development, business, education).

Lack of clarity about the role of government public health is raising questions about the public-private interface and how to connect and evolve roles without destabilizing existing community assets.

COVID-19 RELATED CHALLENGES UPDATE

NEAR TERM STATE BUDGET CHALLENGES

COVID-19's impact on the State budget threatens essential investments in the workforce.

Stubborn disconnects remain in the policy dialogue and reimbursement structure between reducing health care costs and investing in the social determinants of health.

IMMEDIATE WORKFORCE ISSUES IN FIELD

Pressure is building to reduce non-clinical workforce at a time when non-clinical services are more important than ever — with hospital community benefit dollars increasingly being redirected from strategic initiatives to fill shortfalls in education and immediate needs (e.g., food, shelter).

Financial strain on hospitals is growing, challenging health leaders to minimize layoffs and furloughs and provide a safe work environment — at the same time they must increase competition for supplies while facing cratering revenues.

Closure of smaller primary care practices is reducing access in rural areas, in particular.

EVOLVING "NEW NORMAL" IN WORKSPACE

Virtual workers are struggling with 'always on' dynamics amidst a significant shift to virtual, at-home workspaces, creating a need for new boundaries for employees. While some employers see virtual engagement as permanent, others are exploring ways to create safety that enables return to shared workspaces.

2. SIGNIFICANT CHALLENGES

DATA ANALYTICS SHORTCOMINGS

Significant shortages of IT specialists are causing providers to overbid for positions, driving up costs.

Burdensome nature of existing health information systems/ exchanges, with many of these systems using different electronic health record systems, is complicating projections of the impact of digital technology. Betters estimates of the workforce are needed. Challenges include risks of algorithm-driven biases.

HIGHER EDUCATION INFLEXIBILITY

Lack of flexibility and responsiveness by public sector higher education to the changing needs of employers continue to cause bottlenecks — especially at the regional level. Much of education is still oriented to fee-for-service care and inadequately focused on prevention. The state should test assumptions about the quality of training: Are the same hours necessary? Are we meeting expectations, or is there a more efficient way to produce high quality professionals?

BEHAVIORAL HEALTH STIGMA, INSUFFICIENT WAGES

Stigma around behavioral health complicates treatment — and limits resources available to meet the need. With the field often considered a "second-class" service, wages are insufficient for recruiting and retaining high-quality professionals.

COVID-19 RELATED CHALLENGES UPDATE

PUBLIC HEALTH CRISIS

Lack of consistency in local public health agencies in terms of capacity, expertise, and approach is complicating the health system's response to COVID-19. Public health education should be less siloed, more focused on practice in complex environments, but the field is wrestling with decades of disinvestment.

Public health agencies are tied to audit role, rather than forward thinking to improve health in community, requiring a retooling on focus and funding.

TELEHEALTH LIMITATIONS

Remote delivery remains difficult for some critical health care modalities, including behavioral health and children's health.

Lack of access to broadband technology limits access to effective telemedicine for patients and some providers.

LACK OF COMMUNITY-BASED PREVENTION

Continuing shortages of prevention-oriented mental health interventions remain at the community level (e.g., parenting education on adverse childhood experiences, increased access to early childhood education and childcare).

Reluctance to provide services in patient homes is a missed opportunity to leverage the unique skills of community health workers and *promotores* in relationship, trust, and personal engagement.

3. LEADERSHIP ROLES & ACTION UNDERWAY

BY PRIVATE SECTOR HEALTH EMPLOYERS IN THE COMING YEAR COMMITTED TO THE FUTURE WORKFORCE

ADVENTIST HEALTH launched a campaign to invest $1 billion to address the social determinants of health over the next 10 years; half through internal funds and half through fundraising.

BLUE SHIELD OF CALIFORNIA made a $20 million contribution to Governor Newsom's California Access to Housing and Services Fund to support affordable housing, rent subsidies, and supportive services. They also launched the Blue Shield of California BlueSky Initiative in 2019 to provide mental health services and training in high schools. Recently, Blue Shield also launched Health Reimagined, a comprehensive strategy to provide data and technology to providers and patients.

CEDARS-SINAI HEALTH SYSTEMS made a $1.2 million contribution to support the development of a new medical degree program at Charles Drew University.

COTTAGE HEALTH supports a Health Career Academy at San Marcos High School in Santa Barbara, partnered with Cal State Channel Islands to add a local BSN program and pay for a majority of program costs, launched an NP-led virtual care platform and NP-led urgent care centers in the region. Cottage is also adding a pediatric residency program and employs social workers and community health nurses in its Center for Population Health.

DIGNITY HEALTH partners with SEIU-UHW and is investing $10 million over four years to focus on hard-to-hire jobs, and recently completed a pilot apprenticeship program for Medical Coders with the aim to launch more strategic apprenticeship programs statewide.

INLAND EMPIRE HEALTH PLAN established a $34 million Network Expansion Fund to address physician shortages and works with local medical school deans to create selection criteria that are specific to students in the region.

KAISER PERMANENTE established a medical school and has partnered with SEIU-UHW to invest $130 million to launch Futuro Health to train 10,000 allied health workers by 2024. Separately, Kaiser has also committed $63 million to support the training of contact tracing teams embedded in local public health departments.

L.A. CARE HEALTH PLAN has a five-year commitment for $155 million in grants to safety net clinics or practices that hire PCPs and Psychiatrists, medical school debt relief up to $180,000 if MDs agree to practice for three years, an L.A. Care Scholar program that has to date awarded 24 full four year medical school scholarships (92% are Black, Asian or Latinx), and training of In Home Support Service (IHSS) workers (2,800 trained to date). In addition, in conjunction with **LOMA LINDA UNIVERSITY HEALTH,** L.A. Care offers Community-Based Care Management Entities (CB-CMEs) and CHWs in multidisciplinary care teams to participate in trainings with LA Care covering training costs.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA has a Provider Recruitment Plan that has provided over $8 million to date to recruit physicians in its primarily rural 14-county region.

4. PROPOSED ACTIONS

BY THE PUBLIC SECTOR, PHILANTHROPY, AND ACROSS SECTORS TO STIMULATE, SCALE, AND SUSTAIN CALIFORNIA'S HEALTH WORKFORCE

PUBLIC SECTOR

Support pilot programs that increase the capacity to train more people (e.g., online, strategic engagement of practitioners) and reduce regulatory barriers to implementation.

Provide targeted funding tied to outcomes to support more flexibility with the California State University and California Community College systems — and encourage collaboration to develop a workforce that can meet employer/patient needs.

Accelerate movement towards risk-based reimbursement to stimulate collaboration and investment in prevention. Ensure funding mechanisms support engagement of community health workers, peer health workers, and home care workers, and give attention to workforce shortages and their impacts upon higher wages.

Take regulatory action to support top of license practice and pilot alternative care delivery models.

Increase engagement and coordination across state agencies and departments that deal in one way or another with health workforce development.

Move toward regionalization of public health and social services by transitioning beyond traditional service jurisdictions (e.g., counties), particularly for rural areas.

PHILANTHROPY

Establish funding pools for targeted initiatives available to health care employers who raise matching funds and collaborate across competitive lines at the regional level. To be effective, this support should be selective and more focused, providing scaled funding at fewer sites to produce measurable outcomes that will provide the basis for public policy development.

COVID-19 RELATED UPDATE - PROPOSED ACTIONS

PUBLIC SECTOR

Promote effective Covid-19 testing by eliminating license requirements around test ordering and supporting development of consortia, supply chains, and stockpiles of PPE (with periodic renewal). COVID-19 has driven home the critical need for a statewide health information exchange (HIE) that provides all patients full access to their medical records and allow them to make them available to all providers and hospitals.

Adopt alternative payment models for Medi-Cal, which are even more urgent now, with elements that support actions in lieu of prescribed services and provide reimbursement for non-traditional workers. Establish "county pilots" that support integration across categories of services.

Retain reimbursement rates for telehealth.

Align and regionalize public health functions across county lines, in cooperation with philanthropy, while increasing funding and establishing clear standards.

Expand investment in social workers, who have the skill set to deal effectively and humanely with issues such as substance abuse and homelessness — and can be more successful in this role than law enforcement.

4. PROPOSED ACTIONS

CROSS-SECTOR COLLABORATION OPPORTUNITIES

REGIONAL COLLABORATION

Significant expansion of regional collaboration is still needed to promote workforce development, which has been discussed frequently but still lacks a definitive strategy. Measuring return-on-investment doesn't have to be strictly financial, if organizations can make the case that there is value added in reforming the workforce development system at a regional scale.

Collaboration and co-investment can be accelerated in recuperative care and affordable housing, which has emerged as a top priority as hospitals and health plans respond to SB 1152 (2018) requirements for hospital policies and protocols to ensure proper care, shelter, and support services for patients identified as homeless

Streamlined referrals to community services should also be expanded, something health plans have the data to move forward on, potentially informing efforts to redesign service and educational career tracks.

CO-FINANCING EDUCATION AND TRAINING

Co-financing of education and training between the public sector and business community should be expanded to ensure business leaders are knowledgeable about what services are included in benefit packages (e.g., behavioral health) — and to ensure employees get proper and timely support. While building critical thinking and emotional intelligence skills, attention must be increased to ensure that licensure requirements match the evolution in training. This will require bringing tech leaders to the table to redesign education to reduce costs, accelerate the process, and ensure that the workforce matches emerging needs.

COVID-19 RELATED UPDATE - PROPOSED ACTIONS

PHILANTHROPY

Increase funding to train home care workers and community health workers, from philanthropy **and** the State, to support health providers who serve as an interface between the safety net and communities.

Bring together networks of health, education, and industry to design comprehensive strategies for service integration and health professions training — allowing philanthropy and the state to address under-investment in higher education in the broader health professions.

CROSS-SECTOR COLLABORATION

Health plans and hospitals should serve as designated agents for food and housing insecurity – and need to integrate services synergistically. For example, Kaiser Permanente partners with Meals on Wheels to extend reach, increase awareness of CalFRESH nutrition benefits, which are currently underutilized, and also with Best Buy to provide technology and set up in patients' homes.

Behavioral health providers and social workers should be embedded with law enforcement on appropriate calls – with an emphasis on de-escalation and care rather than incarceration.

Investments in data interoperability across competitive lines and sectors must be accelerated as part of service integration.

APPENDIX - INTERVIEWEES

NAME	TITLE	ORGANIZATION
Scott Reiner	CEO	Adventist Health
Delvecchio Finley, MPP	CEO	Alameda Health System
Russell C. Petrella, PhD	President and CEO	Beacon Health Options
Briana Duffy	EVP and West Market President *(COVID-19 follow-up)*	
Paul Markovich	President and CEO	Blue Shield of California
Don Campbell	VP, Corporate Communications *(COVID-19 follow-up)*	
Thomas M. Priselac	President and CEO	Cedars-Sinai Health System
Ron Werft	President and CEO	Cottage Health
Jarrod B. McNaughton, MBA, FACHE	CEO	Inland Empire Health Plan
Janet Nix, EdD	Chief Organizational Development Officer	
Patrick Courneya, MD	Former Executive Vice President and Chief Medical Officer	Kaiser Foundation Health Plan, Inc. and Hospitals
Janet Liang	Executive Vice President, Group President and Chief Operating Officer, Care Delivery *(COVID-19 follow-up)*	
John Baacks	CEO	L.A. Care Health Plan
Liz Gibboney	CEO	Partnership HealthPlan of California

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