CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
1115 WAIVER RENEWAL
EXPERT STAKEHOLDER WORKGROUP on WORKFORCE

Thursday, December 11, 2014
10:00am – 3:00pm
Sacramento Convention Center
MEETING SUMMARY

Members present: John Blossom, California Area Health Education Centers; Corinne Eldridge, California Long-Term Care Education Center; Dev Gnanadev, California Medical Association; Sandra Shewry, California HealthCare Foundation; Hafida Habek, California Department of Social Services.

Members on the phone: Michelle Cabrera, SEIU; Kevin Grumbach, UCSF Center for Excellence in Primary Care; Erin Kelly, Children's Specialty Care Coalition; Jim Mangia, St. John's Well Child Center; Leah Newkirk, California Academy of Family Physicians; Gary Passmore, Congress of California Seniors; Patricia Tanquary, Contra Costa Health Plan; Loriann deMartini, California Department of Public Health

Members Not Attending: Bill Barcelona, California Association of Physician Groups; Jennifer Clancy, California Institute for Behavioral Health Solutions; Kathy Flores, University of California, Fresno and California Health Professions Consortium; Thomas Freese, UCLA; Ann Kuhns, California Children's Hospital Association; Anne McLeod, California Hospital Association; Cathryn Nation, University of California Office of the President; Linda Zorn, California Community Colleges.

Others Attending: Anastasia Dodson, DHCS; Wendy Soe, DHCS; Pilar Williams, DHCS; Oksana Giy, DHCS; Sergio Aguilar, OSHPD; Sunita Mutha, UCSF Center for Health Professions; Janet Coffman, UCSF; Bobbie Wunsch, Pacific Health Consulting Group

4 members of the public attended.

Welcome and Purpose of Today's Meeting
Bobbie Wunsch gave an overview of the meeting today, which will include a review of demographic and workforce forecasts, some initial information on program effectiveness and discussion of other state waiver ideas. This meeting will begin to develop initial ideas and recommendations for the waiver.

Demographics and Workforce Forecasts
Janet Coffman, UCSF Center for the Health Professions
Presentation slides available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Janet Coffman presented information on population projections, including racial/ethnic and age projections. It is quite uneven across the state. She also discussed primary care shortages designated for geographic areas or populations. Some areas in the far north do not have significant population growth but do have primary care shortages. She also presented information on health care job growth in California counties.

Member Questions and Comments:
John Blossom, California Area Health Education Centers: On the slide about distribution of population of growth by County by 2030, the frontier counties may decrease, and Fresno will grow by 30% plus. The Inland Empire and Southern California will grow the fastest.
Janet Coffman, UCSF: Yes, that's correct.

John Blossom, California Area Health Education Centers: Is there a more detailed breakdown on Asians? This is a very diverse group.
Janet Coffman, UCSF: We do not have the specific breakdowns but agree that it is a very diverse group.

John Blossom, California Area Health Education Centers: Do you have slides with the population growth in terms of race and ethnicity?
Janet Coffman, UCSF: We will take that back to our team and see what we can do.

Hafida Habek, California Department of Social Services: I just want to echo John's comment because the cultural differences between Asian populations are important to understanding what are the specific cultural competences needed for the workforce.
Janet Coffman, UCSF: We will see what we can do. A lot of the projections are just not made at that level of granularity.

John Blossom, California Area Health Education Centers: The areas that have the fastest growth are also younger – fewer seniors. So what that means is that service demands will not be growing as quickly the elderly?
Janet Coffman, UCSF: I think what it means is that you're going to have relatively fewer seniors in some areas, so your demand will grow overall but not as dramatically among seniors as in areas in which seniors are a larger percentage of the population.

Corinne Eldridge, California Long-Term Care Education Center: Those communities are also growing faster so they'll still have growing needs among seniors.

Patricia Tanquary, Contra Costa Health Plan: Contra Costa County had been told that they had the highest percentage of seniors in the state but that does not appear to be the case in the slides. Can you clarify what the colors signify?
Janet Coffman, UCSF: If you go back to the slide that just has the map of the projections over 65 that should have a key to the percentages that match the color coding on it. Green, for example, is a projection of 20 – 24% growth.

John Blossom, California Area Health Education Centers: When older people retire, they tend to migrate to more rural areas, particularly the gold country. Do we have data about this population's resources in terms of health care coverage? If we're trying to reach the underserved among the elderly, it would be good to have detailed data on that population.
Janet Coffman, UCSF: That's a good question. My guess is that it varies – some may be leaving more affluent areas in search of cheaper housing elsewhere in the state. We can see what we can find on that question.

Erin Kelly, *Children's Specialty Care Coalition:* Is there any information on population growth for kids and adolescents and how that might impact pediatric needs?
Janet Coffman, UCSF: The rates of growth in numbers of children are small relative to the rates of growth of elderly populations.

Corinne Eldridge, California Long-Term Care Education Center: What positions are included in job growth numbers and does that include IHSS and home health care workers?
Janet Coffman, UCSF: This includes any healthcare job growth, including home health to my knowledge.

Corinne Eldridge, California Long-Term Care Education Center: IHSS workers is generally a different category than the home health workers and the numbers seem off given what we know about IHSS worker growth projections. My organization estimates that the number of IHSS workers should be growing by 70%+ over the next several years.
Janet Coffman, UCSF: We will see if we can disaggregate the data more.

Hafida Habek, California Department of Social Services: I agree the data does not correlate with the numbers we have seen in the IHSS population and we are expecting much bigger growth.

Gary Passmore, Congress of Seniors: People generally make logical decisions so why is health care job growth so misaligned with where the populations are growing?
Janet Coffman, UCSF: We will look into that and get back to you.

John Blossom, California Area Health Education Centers: What falls under the category of outpatient centers?
Janet Coffman, UCSF: It would be a mix of things like community health centers, ambulatory care centers, etc. Let me talk with Joanne and get back to you on that.

John Blossom, California Area Health Education Centers: The last question I asked about the definition of those sites – physician offices vs. outpatient care centers – becomes important because it would seem there would be large portions of the population that would be newly insured who may not be able to follow contemporary patterns for care seeking.
Janet Coffman, UCSF: Let me follow up with you on that.

Program Effectiveness and Program Outcomes
Janet Coffman, UCSF Center for the Health Professions and Sergio Aguilar, OSHPD

The presentation can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Janet Coffman presented information on programs and approaches to use health care workforce in new ways, including technology that reduce cost and improve quality.
Sergio Aguilar, OSHPD, presented on OSHPD workforce development programs, including the Health Professions Education Fund loan repayment and scholarship program, the Song-Brown programs and several mental health programs.

Member Questions and Comments:
John Blossom, California Area Health Education Centers: There are a lot of programs that are less effective dollar per dollar but receive a lot more attention. Which of the 3 buckets would the UCLA program to recruit international applicants to residency go?
Janet Coffman, UCSF: I would put that in the education strategies. This is largely focused on physicians because this is where most of the research is.

John Blossom, California Area Health Education Centers: The differential of graduation into primary care of osteopathy programs vs medical schools is not reflected. Osteopathy seems to be doing better in getting their graduates into primary care than medical schools.
Janet Coffman, UCSF: This is correct. About half or more of osteopathy graduates go into primary care. The allopathic medical schools are lower and rates certainly vary by medical school.

John Blossom, California Area Health Education Centers: One of the earlier points was that participants in HCUP program are a pool of minority and culturally diverse physicians who are more likely to practice in underserved areas.

Corinne Eldridge, California Long-Term Care Education Center: The electronic piece (Telehealth, e-referral) is very exciting. The one thing to put on the table is socioeconomic factors for Medi-Cal and Medicare recipients and barriers to entry for these individuals. It's something to keep in mind.
Janet Coffman, UCSF: I think that is certainly true. We should think about not only what people can do for themselves but also what can be provided/offered – what's the infrastructure in rural clinics and elsewhere to do these kinds of Telehealth consults?

John Blossom, California Area Health Education Centers: I think it's important to consider that the SFGH physicians who participated in the SFGH e-referral program were all salaried. This is important given the difference in private settings.

Patricia Tanquary, Contra Costa Health Plan: How many health plans, hospitals and FQHCs are moving toward electronic health records? For example, all of the Contra Costa hospitals and health plans are on EPIC. The CHCs are not on EPIC but are exploring other opportunities for technology linkages and do Telehealth, coordination, etc. This is a model that I would call a hybrid between an urban and suburban model, which I don't think is accounted for in this data.

Gary Passmore, Congress of Seniors: In the most recent Stakeholder Advisory Committee meeting on current bridge to reform waiver the issue of Telehealth came up and was discussed by four health plans. Each of them expressed some caution and the challenges of implementation on the ground. All of them indicated they were struggling to fulfill the full ambition of Telehealth. Also, there are some areas in the state, particularly frontier areas, where the issue of broadband really complicates access to Telehealth.

Bobbie Wunsch, Pacific Health Consulting Group: Can you comment on medical assistants?
Janet Coffman, UCSF: MA training is not as standardized. This is in contrast to some health professions, such as NPs, that have standardized training and requirements that ensure that all NPs are trained to provide the same health care services. There also hasn't been as much research on MAs. Those studies that have been done show that MAs as part of a care team can help patients with some things, like disease management/health coaching.

Gary Passmore, Congress of Seniors: I want to just give a heads up that there is almost nothing except the allocation of water supply that can create a big political fight as fast or as completely as changes of scope of practice laws among the professions. I want us to weigh those political factors when we make decisions. I'm not saying we shouldn't change some things, but it may take a long time.

Leah Newkirk, California Academy of Family Physicians: I would echo that it is a controversial topic. Question, are we able to make changes to state law through the 1115 waiver?
Dodson, DHCS: There could well be state law changes. As Wendy said, there are processes on the federal level to effectuate a waiver. It is a controversial issue at the state level. I think the issue would be if there were significant controversy about something that is part of the overall package at the state level, what is the give and take there to include something like this in the waiver?

Sandra Shewry, California Health Care Foundation: On scope change, California is one of three states that has a program to create a safe harbor for testing scope of practice expansions (health workforce pilot project authority). Then, all changes have to go to the legislature subsequently for approval of permanent changes. Question, is there any literature out there on not changing scope but re-engineering practices for staff to practice at the top of their license?
Janet Coffman, UCSF: There is a report that will be coming out that will address that with NPs. For the other professions, we'd have to take a look. We may need to make a distinction for those positions that have well defined standards (NPs) and those that do not have as defined standards and training requirements (MAs).

Sandra Shewry, California Health Care Foundation: Coming back to a seed I planted in the last meeting, it would be great to try to identify the challenges for health plans to implement Telehealth and for the state to try to create some incentives to move plans and providers into providing these services.

John Blossom, California Area Health Education Centers: Does the loan repayment program require service in an underserved area?
Sergio Aguilar, OSHPD: Yes, they do.

John Blossom, California Area Health Education Centers: So this is a huge return on investment for what you are paying in. Also if we look at the opportunity to increase the number of applicants that are awarded relative to applied for the program we could very quickly have an impact.
Janet Coffman, UCSF: For the most part folks do fulfill their loan repayment obligations. The question is how long do they stay practicing in underserved areas once they have served their required time.
Sergio Aguilar, OSHPD: We've only had two people who didn't stay and complete their obligation over the last four years.

John Blossom, California Area Health Education Centers: I am very impressed with this data too. If you look 3-4 years past the obligation you are seeing about half of those physicians staying in the community. These data are really quite powerful.

Leah Newkirk, California Academy of Family Physicians: What is the service term for the loan repayment program?
Sergio Aguilar, OSHPD: A minimum of two years but they can request annual extensions (up to 6 years).

Gary Passmore, Congress of Seniors: One of my questions is about if the repayment is the same for each year or does it go up every year?
Sergio Aguilar, OSHPD: The first two years are $50K but I think it's $10K per year after that.

Gary Passmore, Congress of Seniors: It would be interesting to look at what the total loan amounts were and what the total costs were. You may want to think about playing with the out-year awards even higher and you might get better retention for more years.

Janet Coffman, UCSF: How much flexibility if any does OSHPD have in doing the things that Gary suggested [for the State Loan Repayment program]?
Sergio Aguilar, OSHPD: There's not too much flexibility. There are some opportunities when you re-apply for the program but it's limited.
Janet Coffman, UCSF: Yes but OSHPD gets money from HRSA and not from CMS and has to follow HRSA's rules regarding program design.

Michele Cabrera, *SEIU*: Do you have any more information on retention rates for rural vs. urban areas?
Sergio Aguilar, OSHPD: Unfortunately we do not have these breakdowns. Many folks do not respond after the obligation is completed.

Gary Passmore, Congress of Seniors: Are we to hold the idea that if people didn't respond they are probably not staying in the high need area?
Sergio Aguilar, OSHPD: I don't think we can make that assumption. People don't respond to surveys for a number of reasons.

Dev Gnanadev, California Medical Association: What I see is that demand is higher than what we are able to offer, and the retention rate is not as high as we want it to be.

Dodson, DHCS: Was that denominator everyone or just a subset of those who responded?
Sergio Aguilar, OSHPD: That was a subset of just the 60 individuals who responded. The survey just assesses if they stayed at the site or if they went to another underserved site, which was still a purpose of the program.

Dev Gnanadev, California Medical Association: Can we get that information?
Sergio Aguilar, OSHPD: Unfortunately we cannot for that survey.

Patricia Tanquary, Contra Costa Health Plan: I want to thank you for this very good information. While it is great that there are both scholarships and awards and that the schools are accepting them, what I don't think we have proof is whether any of the professional schools have increased the total number of candidates that they will accept each year. Do you have information on whether the professional schools have had any increases or not?
Sergio Aguilar, OSHPD: I can look at our clearinghouse. We may have some limited other data. The song-brown funding for the endowment has set aside $4M for the expansion of residency slots. There are some things that we are starting to do but that may not be the case in the program.

Patricia Tanquary, Contra Costa Health Plan: If you look at Berkeley they are taking 30% out of state because of funding shortfalls. If we look at overall workforce, if it's still a zero sum game then there is no add and that makes it more challenging.
Sergio Aguilar, OSHPD: I'll also add that some of the programs may be cutting the slots, so the funding may also help keep the overall

Leah Newkirk, California Academy of Family Physicians: I want to note the strength of the song-brown program in expanding the number of family practice physicians in underserved areas. It has allowed a lot of our family residency programs to expand their numbers. MDs with this funding are serving about 600 patients per year so it is having an immediate impact. There are also 73% of folks staying in underserved areas.

Erin Kelly, Children's Specialty Care Coalition: Our members feel that the loan repayment program is a great retention tool for pediatric sub-specialists to stay in rural areas. Does the state have specific restrictions on which specialties can participate?
Sergio Aguilar, OSHPD: Yes and pediatricians are an included group.

John Blossom, California Area Health Education Centers: Some anecdotal information, what we've seen in Fresno is that it is very common for MDs that start with one Community Health Center (CHC) to move to other CHCs after their loan repayment program. We have this great program but don't have as good a record of tracking that information. It would be really helpful to understanding and making the case for these programs.
Janet Coffman, UCSF: It is true that some Song-Brown programs will cut slots if they don't get the renewed funding. In addition to the teaching health centers, primary care residency programs in California received funding from HRSA to add 60 slots under the ACA. Those slots are expected to go away when the HRSA funding expires, which is problematic.

Dev Gnanadev, California Medical Association: Starting up residency programs is the big issue. Once they are established, CMS can take over the existing and new programs. That's why it is so important. One example, our community hospital never had a residency program. If they start next year they have 5 years to get capped out and CMS will pay until they get capped. If we can assist them to start these programs it will help many hospitals that never had residency programs before.

Other States' Waiver Workforce Ideas
UCSF Center for the Health Professions
The presentation can be found at:
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Janet Coffman, UCSF, was asked to briefly summarize what's happening in other states. Janet focused her description on the Practice Support program in NY. This is a direct provider incentive program so it differs from loan repayment. Bobbie Wunsch added that Inland Empire Health Plan has a similar incentive program.

Member Questions and Comments:
Gary Passmore, Congress of Seniors: Some of the descriptions of what NY State is doing sounded very similar to what the Inland Empire health plan (IEHP) is doing. Sounds like they were making cash grants and other forms of assistance. Is that right?
Bobbie Wunsch, Pacific Health Consulting Group: Yes, that's correct.

Dev Gnanadev, California Medical Association: IEHP is providing $100k per PCP and $150K per specialties. They already approved for us to hire two people (in specialties). I've also asked Brad Gilbert at IEHP to fund the implementation of EPIC with the large medical group/contracted providers. A robust system like EPIC, which is so expensive, is great. These are the innovative ideas that we should be thinking about.

Goals/Criteria for DHCS 1115 Waiver Renewal and Workforce Ideas
Anastasia Dodson, DHCS
The presentation can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Dodson presented the grid of potential workforce development strategies that could be pursued under the waiver.

Bobbie Wunsch, Pacific Health Consulting Group: Could you help the group understand what types of initiatives fit best in a waiver? Should we try to include all the good ideas or narrow down a little bit?

Soe, DHCS: A lot of these strategies really fall in the financial incentive area. And it is important to prioritize. We absolutely want to focus this on viable options.

Dodson, DHCS: We think that these four buckets each have areas with promise and opportunity. Our initial thoughts are to try to get some balance across each of these four areas but we also want to keep in mind evidence we have on outcomes. If we as a group work through and find that there is not enough evidence we do not want to be married to that.

Member Questions and Comments:
John Blossom, California Area Health Education Centers: How much money are we talking about? I could see programs, like loan repayment, that would really benefit from $1 million.
Soe, DHCS: Part of the terms under 1115 is that we would not spend more with the waiver absent of the waiver. We are in the process of calculating that right now. There will be a meeting on January 30 to review some initial calculations.

John Blossom, California Area Health Education Centers: Is there a ballpark figure?
Bobbie Wunsch, Pacific Health Consulting Group: The 1115 waiver brought $10 Billion last time. We don't have exact dollars for this planning project.

Dodson, DHCS: What's most valuable for this group is what is adding the most value. The end dollar amounts we will figure out but the real value is your deep knowledge of these areas, what's working and what could work if it was expanded or initiated.

Patricia Tanquary, Contra Costa Health Plan: I realize we are not going to get into the weeds regarding budget neutrality but it is very important as we think through ideas that people understand the budget neutrality concept. For example, if we are adding PCPs the assumption is that we are reducing ER – those are big assumptions and have been successful in some areas but not in others.

Gary Passmore, Congress of Seniors: The way I approach this task is to try to think of ideas and concepts that will improve the overall care in Medi-Cal without increasing the costs or what the costs would otherwise be in 10 years. Second, I'd like to understand the process. Are we going back to the grid that Anastasia reviewed as the basis for our conversation this afternoon?

Bobbie Wunsch, Pacific Health Consulting Group: Yes, we're going to walk through the grid and get feedback.

Dev Gnanadev, California Medical Association: When I first went through this the dollar signs were going up in my head, but almost all of them are great ideas. First, we need to make sure that especially the training programs get funding separately so they are not thrown in a pot. Just to give an anecdotal example, after the ACA went into effect, most ERs dropped by 20% and all of it was non-ER volume. That is a good thing. We have to take into consideration of what we would be saving in unnecessary ER and inpatient care.

Possible Waiver Renewal Workforce Strategies
UCSF Center for the Health Professions
Conversation Facilitated by Bobbie Wunsch
The presentation can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Bobbie Wunsch led a discussion of the 1115 Waiver Renewal Workforce Strategies and Options document. The group began by discussing Training Incentives.

Member Questions and Comments:
Corinne Eldridge, California Long-Term Care Education Center: It is wonderful to have training and payment incentives. A training program where homecare workers get trained on core competencies really benefits them. If we are able to talk about it as an advanced care aid role it is helpful. Also, wage enhancements that go with that training. Also, a comment on what you've laid out in terms of long-term impact. I'm hopeful that some of the documents we've distributed were reviewed. We have engaged in two pilot projects, with St. John's and CMS. We have been able to show that the role of a trained home health care provider has a positive impact on the health of a recipient. The two big impacts are decreased hospitalizations, ER visits and skilled nursing facility stays and that of course relates to reductions of costs. That gets to the budget neutrality. I am not an expert, but there are ways to think about cost savings from such efforts. The other thing, getting to scale – by June we will have trained 5,200 homecare workers in this advanced aid role. Knowing that we are projecting 700,000 homecare workers in California by 2020, getting programs like this to scale is a big issue.

Habek, CDSS: I'm looking at this as an opportunity as to what can we do to build and improve upon the training that has already been piloted rather than build a new training program.

Michele Cabrera, *SEIU:* We tend to think about the expanded IHSS worker as part of the larger front line worker bucket. It's crucial to us to improve care coordination across the board in populations (overwhelming majority in managed care) but the kind of people that are in managed care are vastly different than those that were in before. Making sure we are providing better coordination happens at the provider level and we can get a lot of ROI out of currently not licensed staff that can work with patients. The problem is finding funding for training and in some cases reimbursing for the actual services. Both related to this and the CHW / front line worker, we need to look at what is happening in managed care and the promises of care coordination – it gets to the access issue by helping people understand where they should seek out care.

Corinne Eldridge, California Long-Term Care Education Center: I want to emphasize the way we see training. We see it as in class, actually a cohort of students led by an instructor, who go through a curriculum and they graduate because they have demonstrated a series of core competencies. The curriculum is written to the adult population. It's important to keep this in mind as we talk about it. Another component is the integration onto the care team, which really makes that fundamental difference, that communication and that role with the PCP.
Hafida Habek, California Department of Social Services: Since we are bound by rules and regulations, it is clear for the purposes of day home supportive services, the consumer has to initiate their home health provider being part of the care team. We have limitations we have to operate within. It's great to have the home health provider as part of the team but there are rules in this entitlement program. But, it's good of the provider to understand the need for these roles/teams should they be invited.

John Blossom, California Area Health Education Centers: Scaling it to the local community, who does the training and where does it take place? Does it go to a community college or a county or what?

Corinne Eldridge, California Long-Term Care Education Center: We currently operate in Contra Costa, LA and San Bernardino Counties. LA is a beast – in a county of that size, we have 46 classes going on in six different languages.

John Blossom, California Area Health Education Centers: Are there other organizations doing this?

Corinne Eldridge, California Long-Term Care Education Center: I don't think to the volume that we are. We have tried to partner with community colleges but they very much focus on continuing education (e.g. working toward an associates) and typically the training for home health care workers isn't included in that area of education.

Patricia Tanquary, Contra Costa Health Plan: Since I am one of these three counties, over the process of the grant we have trained over 200 IHSS workers. We are already starting to see a little benefit of having trained IHSS workers to help at hospital discharge to prevent a SNF admission. I think this is a valuable strategy and I would like to see it included as a strategy in the waiver.

Gary Passmore, Congress of Seniors: I think the notion that the State has of training of IHSS workers as voluntary is ludicrous. If we have people that don't want to have trained caregivers let them opt out of the state program. But to create the idea that we have some people that are caring for some of our frailest members and we spend $8 - 10 billion per year and we have a severely under trained staff is brainless. It is one of the biggest holes under our Medi-CAL program. The idea that we do this now through public authorities is a bogus argument, it's hit or miss. We expect a certified nurse assistant in a nursing home to have 160 hours of training

and we don't require one hour of training for someone who is caring for very similar patients in a home environment.

Gary Passmore, Congress of Seniors: I would add an amendment to the grid. Under the training considerations, it should include that some IHSS recipients may not want to have caregivers with any third party training. We need to deal with that because that is a real world challenge.

Hafida Habek, California Department of Social Services: The mosaic of our population is 70% of our providers are family members. Going back to the challenges, one of the challenges is how can we sell the idea of structured or mandatory training – and that makes it a condition of employment. If you make these two requirements, you may run into the risk that the recipients will say I'm going to have to seek out-of-home care because providers' hours spent at training takes away from their ability to provide in-home support.

Corinne Eldridge, California Long-Term Care Education Center: We have done a lot of focus groups and spoken to home care providers and patients. Consumers that were disabled that previously thought they would be the best trainer for their provider, have seen things differently – some things they can do and others it's best for the trainer to provide. The other thing is that we do see that there are a lot of folks who do want this training. What they learn in these classes are things they thought they already knew. They can learn what it takes years to learn by attending a 63 hour training course.

Bobbie Wunsch, Pacific Health Consulting Group: It sounds like the sense of the group is that this is an opportunity. There are many challenges and issues that will need to be addressed. Moving on to Incentives for Providers to Complete Additional Training in MH and SUD, what are the groups' thoughts?

Dodson, DHCS: This is an important component that should be considered. There are a couple of components to this, including training for PCPs on brief screening processes as well as MH/SUD providers being trained in participating in care coordination teams.

Patricia Tanquary, Contra Costa Health Plan: The concept is good. The requirement to spend 45 hours on training in webinars is unrealistic. There was a compromise that one physician per practice did the training and then did train to trainers. We have found that it is not rocket science. We're building it into the EPIC/EHR system. We need to have realistic and reasonable expectations in place.

Dev Gnanadev, California Medical Association: When it comes to physicians I think if we can provide voluntary resources to be trained that is fine. The entire medical community does not respond to mandated things. It doesn't work.

Gary Passmore, Congress of Seniors: I want us to get at how are we training the health care workforce broadly on identifying the mental health and SUDs issues so they can help make referrals. Each person included in the care team should be equipped to make these referrals.

Bobbie Wunsch, Pacific Health Consulting Group: I think my feedback on this strategy is we probably need to define better who are the providers and the care team.

Dev Gnanadev, California Medical Association: It's the information technology help for the Medi-CAL providers that is more important than just doing Telehealth. The robust IT system will help Medi-CAL providers to better coordinate care.
Bobbie Wunsch, Pacific Health Consulting Group: Are you thinking beyond the ACA's requirements for EHR?
Dev Gnanadev, California Medical Association: It goes beyond that. Unfortunately, everything has a standard but medical information technology does not have a standard. Everything is a proprietary system, which cannot communicate with other systems, so if we can provide them with a robust and comprehensive system so they can manage them just like Kaiser does. That's beyond meaningful use, which is inadequate.

Bobbie Wunsch, Pacific Health Consulting Group: You're talking more about data sharing between entities?
Dev Gnanadev, California Medical Association: Yes, that's correct.

Sandra Shewry, California Health Care Foundation: I want to amend the description of the pilot funding for new/existing Telehealth. I think what we have learned is that training is actually technical assistance. There is a model through the CA Telehealth Network that the waiver could leverage.

Gary Passmore, Congress of Seniors: This generally I think would be good – maybe in the next meeting we could sit down with the plans and think about how to carry this issue further with them. I'm increasingly suspicious that the plans play more of a role than the providers.

Dodson, DHCS: We want your feedback. Our sense from CMS conversations is that it is important to focus on incentive payments instead of infrastructure. We'd like the sense from the group on whether an incentive structure is something to pursue.

Soe, DHCS: it's important to bring us back to the goal to increase access to the beneficiaries.

Hafida Habek, California Department of Social Services: I'm thinking about arming social service workers with laptops. We can input assessment information quickly rather than 3 hours of data entry after the fact. The workload of a social worker in IHSS is really quite scary.

Patricia Tanquary, Contra Costa Health Plan: All of the Medi-CAL managed care CEOs have been notified that the State does intend to move forward regardless of this waiver to have the federal funds matching for health homes. We are eager for this to begin with the counties that are ready. My county would be willing and is already moving toward that. Most of the plans would be interested in expanding dollars with capitation to work with providers to enhance the models in health home pilots.

Dev Gnanadev, California Medical Association: I wouldn't want us to get into a scope battle - that is a battle that nobody wins. I would encourage the group in moving toward a team model. I wouldn't take anything that addressed scope.

Bobbie Wunsch, Pacific Health Consulting Group: Most of the proposals are focused on helping staff practice to the top of their license and taking advantage of existing options under current law, rather than proposing new scope of practice changes.

Dev Gnanadev, California Medical Association: My point still is how can we create teams. This is more important rather than people being solo. If you ask me, even in the physician side, solo and small group is rapidly declining. How can we encourage people to really work in teams?

Michele Cabrera, *SEIU:* I'm troubled by the health workforce education and training grants that we don't need the waiver to do. I agree with Dev on the issue of the idea is not that we train people on cultural appropriateness but that we bring people who are actually from the community into the care team. Our concept is not to replicate what's going on in 2703 but to complement it and add different services that are not provided under the health homes. And that also works well and coordinates with CalSIM efforts. It's important for us to think that expanding PCP access doesn't just happen by putting PCPs on the ground but also by improving the effectiveness of the care teams.

Bobbie Wunsch, Pacific Health Consulting Group: Thank you for the comment. It raised a couple of important points. One, how can the waiver itself accelerate the work in these areas and where do we need the waiver to accelerate? Two, how do we leverage the waiver in coordination with the other efforts underway (CalSIM, 2703)?

Kevin Grumbach, UCSF: I think if the goal is PCMH care that can enhance the capacity of the existing workforce to provide better access and more effective services, what are the key facilitating elements? How much is about training on population health management, how much is regulatory barriers, how much is it payment models under Medi-CAL. If we first agree that this is a workforce objective to move towards a team-based model, then we need to ask what are the key facilitators and obstacles to achieving it.

Leah Newkirk California Academy of Family Physicians: I also support the idea of the medical home model. I'm eyeing the care coordinator idea with PMPM payments. We really like that idea and we have some evidence from a pilot project in Fresno. We've seen a $2 M savings and improvement on every quality metric. That can be a very effective way to increase the efficacy of the team.

Sandra Shewry, California Health Care Foundation: I like team-based care being the unified theme of the workgroup and care coordination has been articulated repeatedly. I don't want to lose the thread of behavioral health expertise, might be peer support specialists, or training for

primary care physicians. If it's team based care and looking at what would make it most effective and not losing the subject line of mental health.

Dev Gnanadev, California Medical Association: One other item is shared savings. We talked about PMPM but we didn't mention shared savings. That's important because then folks are more likely to engage.
Patricia Tanquary, Contra Costa Health Plan: I think we need to be very careful assuming that there will always be savings in a shared savings model. Sometimes providers don't want to take risk and prefer PMPM or FFS. The world is not a nail and we need to not always use a hammer.

Bobbie Wunsch, Pacific Health Consulting Group: Can we get more clarification on certification protocol for MFTs, PAs and other professionals?

DHCS staff will get back to the group.

Patricia Tanquary, Contra Costa Health Plan: All of the managed care plans supported the concept of reimbursing MFTs for behavioral health services. I'm confused about this since we seem to have what we need to engage these providers.

Hafida Habek, California Department of Social Services: The care coordination team. Being able to provide a care coordination team for the high risk and complex patients. In many of our CCI counties, we are not seeing care coordination teams, maybe not the reimbursement now but we need to see it.

Michele Cabrera, *SEIU:* We have to make the promise of care coordination real in underserved communities.

Sandra Shewry, California Health Care Foundation: One of the historical challenges for FQHCs in Telehealth and behavioral health is that you can only have one visit per day and that seems anachronistic to what the state is trying to achieve. I understand that this may be a HRSA issue but this is an issue.
Soe, DHCS: The discussions are underway for the APM and this will be addressed via a state plan amendment but not through the waiver.

Gary Passmore, Congress of Seniors: This document really acts as if there are no health plans. All of the strategies talk about Medi-CAL and the providers. We need to look through this and acknowledge the role of plans. I think we should be thinking about incentives to the health plans. We didn't really hear if the plans have any guidance on how to invest in the plans.

Patricia Tanquary, Contra Costa Health Plan: Every time that the word incentive has been used with the plans it has been a negative incentive. We have to be careful. Sometimes it's easier to do incentives with larger groups.

Dodson, DHCS: We will ask your indulgence that this is just a draft for discussions. We absolutely heard you loud and clear and having the plans excluded does not preclude their involvement. However, we want to keep in coordination with other groups.

Michele Cabrera, SEIU: My question is one I've asked before but it's still an outstanding question. I understand some of our loan programs are federally funded but some are not and come through areas that could be construed as state public dollars. Are there ways to leverage those investments for increased federal dollars? Second, there is a question of geographic distribution. How do we make sure that the physicians that are trained get out to areas with the need? Another element that has gotten less discussion here are strategies to improve cultural competence – not just race and ethnicity but also linguistic. We want to target the funding to address this. We would ask targeting the funding toward provider type and geography.

Dev Gnanadev, California Medical Association: I don't think that generating enough medical students for new residency slots is an issue. 25% of national residency program students are from California.

Janet Coffman, UCSF: A few years ago some of our ~~residencies~~ residency programs were hurting. Is it your perspective that there is enough demand particularly for primary care?

Dev Gnanadev, California Medical Association: The simple answer is yes. The more complicated answer is that you add the number of students graduating from US medical schools and add US residents graduating from foreign medical schools, there are a lot of students. We could double the number of residency slots in CA and still have enough demand.

Kevin Grumbach, UCSF: I generally agree with Dev though I don't think we can fill up twice as many slots. The residencies are generally filling their slots.

John Blossom, California Area Health Education Centers: For the four slots in our unaccredited but certified residency program we had 600 applicants for 4 slots! I think there is a concern that we are not addressing the number of residency programs. If you buy into the model that primary care providers are likely to stay close to where they train, then we should be looking at training sites in those areas where they are needed. OSHPD is doing a pretty good job but what it doesn't do is start new programs. In CA, we've been successful starting programs with the AHEC model. Examples include the Natividad Medical Center. Are you going to give your resources to the major urban areas and hope they will push out to the underserved areas or are you going to give your money to the rural areas and hope they can pull in from the urban areas? I am now much more interested in the capability of a residency program to attract and retain in the communities they serve. It's not just residency positions but new residency sites. I would hope we could find a way in this document to reference the AHEC model and to create new training sites located on the map that Janet showed to us. There are resources there, there are young people that we are not reaching.

Dev Gnanadev, California Medical Association: There are two ways to add new residents in underserved areas: 1) expand existing programs and 2) build a new program. Both are extremely important. Almost all of existing programs are capped out. Where you get more value for your money is in creating new programs because if the community never had a training program and they start a residency next year, they have 5 years to get capped out (2021). What that means is that they are creating continued funding for those programs. Create programs where there is a significant physician shortage and significant shortage of culturally diverse/competent providers.

John Blossom, California Area Health Education Centers: We have 50 residencies in CA and we have only 2 north of the bay area.

Leah Newkirk California Academy of Family Physicians: We would prioritize expanding loan repayment program, song-brown and keeping teaching health centers. One thing that is missing is that in the last waiver the DSRIP program public hospitals were allowed to expand their residencies. We should consider keeping that. I also want to comment on some of the considerations. The idea that some recipients reneged on their obligations, it seems to me that Sergio's presentations strongly suggests otherwise. I also want to echo the sentiment that there are enough folks interested in primary care. We feel confident that we are filling our residencies and that we are actually right now exporting primary care residents to other states. Lastly, in terms of the song-brown programs, there is an important short-term benefit, which is immediate new access for patients.

John Blossom, California Area Health Education Centers: I wanted to raise the issue of the potential role of community health centers in addressing the workforce challenges. It is not part of their responsibility to provide medical education although many of them do. One of the things the waiver could address is that expansion of the role of community health centers as educational resources. That expansion to increase access to care has to be funded. If we keep freeloading training at the CHCs, we are limiting their ability to provide access. We have got to find a way of funding that expansion.

PUBLIC COMMENT

Beth Malinowski, CPCA: I really appreciate the conversation. CHCs value addresses not only how we bring them into the community, but also thinking of it as an investment in teaching health center as an investment in local communities and to really make sure that we are growing our own professionals – RNs, MAs, etc.

Next Meeting: January 7, 2015, Sacramento Convention Center Room 203