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Jennifer Kent, Director
California Department of Health Care Services
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VIA EMAIL: jennifer.kent@dhcs.ca.gov

RE: Comments on Workforce Concepts within the 1115 Waiver Renewal

Dear Ms. Kent,

On behalf of our 700,000 workers in California, including hospital, clinic and 280,000 represented In-Home Supportive Services workers, I write to offer input and recommendations related to workforce elements under consideration in the California Department of Health Care Services' 1115 Waiver Renewal. In this next waiver, rather than build a bridge, we are building toward California's 2020 Vision - to realize the delivery system and payment transformations called for under the Affordable Care Act, which will ultimately require significant investments and changes in our health care workforce.

California's Waiver Context

California is one of four majority person of color states in the nation, and even still, people of color are overrepresented within our Medi-Cal program, making up between 75-80% of beneficiaries. The overall diversity of the program is why, from our perspective, disparities and equity matter as an overarching waiver priority. Achieving health equity will not be captured by Triple Aims. Language and culture – broadly defined to include affinity groups such as disability, or formerly incarcerated or homeless, in addition to race and ethnicity – should be factored into the vision for what we want our delivery system to look like in 2020, and how we define patients' access and quality of care.

Improving the diversity and cultural competency of our workforce is therefore a key element to achieving Triple Aims, getting the most efficiency from our waiver-funded programs, and ensuring equity, care integration, and access.

Workforce Workgroup

SEIU commends the state for its vision in developing a workforce component and related workforce workgroup as part of the 1115 Waiver Stakeholder process. To our knowledge, this is the first time California has taken this topic on so directly as part of an 1115 Waiver deliberations and stakeholder processes. While several important topics surfaced during these discussions, we would like to offer additional comments on those elements most in need of waiver investment.

First, we would like to encourage the direction brought forth at the February 11th DHCS Stakeholder Advisory Committee (SAC) meeting to use Waiver investments as a way to expand access for the Medi-Cal population, improve the quality of care, the cultural and linguistic competency of care, and to leverage the non-physician workforce to drive value. We believe these are the right set of goals for the workforce component and they reflect the input from SEIU and other stakeholders in our process.

Non-licensed Frontline Workers

We are extremely supportive of investment in workforce training for non-licensed frontline workers, both new and incumbent, as part of a broader care team. Non-licensed frontline workers, such as community health workers, health coaches, patient navigators, and others, create a role for authentic representatives of the target Medi-Cal patient communities to be integrated into care teams and health systems in ways that have proven to add value to the delivery model. They can improve cultural alignment between the medical teams and the patient population, teach patients how to navigate the health system, and play an important role in preventative healthcare services. There are numerous successful examples that have been demonstrated in a range of care settings such as: high-risk pregnancies, behavioral health, palliative care and chronic disease management, among others. The key is to create a career pathway for persons with lived experience and cultural alignment to be able to play an appropriate role, without the requirement that they have a license. Other states waivers have taken on significant investments in developing these new roles as part of their delivery system transformations, including notable examples in Oregon¹ and New York². The benefits are numerous:

- Value – Non-licensed frontline workers have been shown to improve care, avoiding unnecessary utilization and thereby reducing the cost of care. For, example, a recent study of community health workers (CHWs) shows that for every dollar spent managing children with asthma the return was \$4³. In a study of the Denver Community Voices program, CHW's improved care while reducing unnecessary utilization resulting in a reduction of monthly uncompensated costs by \$14,244 producing an ROI of 2.28:1 and a savings of \$95,941 annually⁴.
- Access – Non-licensed frontline workers increase the care team's efficiency by taking on important non-clinical tasks such as patient education and activation, care navigation, and health promotion. When done right, the care team should be able to increase its panel size while also ensuring the care matches the patient's needs. Non-licensed frontline workers can engage the patient and connect to the care team to ensure the care plan is culturally and linguistically appropriate, and therefore more effective and efficient.
- Quality - Patients with a culturally and linguistically appropriate team-based care model report better satisfaction with their care.

¹ Oregon Waiver created a goal of training 300 community health workers: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>

² New York State Medicaid Redesign Team Waiver Amendment:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

³ <http://www.iom.edu/~media/Files/Perspectives-Files/2015/CommunityHealthWorkers.pdf?la=en>

⁴ Whitley, E, (2006) Measuring Return on Investment of Outreach by Community Health Workers. *Journal of Health Care for the Poor and Underserved*, February 2006, Vol 17 pp. 6-15

We have concerns, however, with the state's proposal to have the health plans administer the training funds for this workforce. While there are some examples of Local Initiatives who do innovative work in the area of training and deploying health navigators, coaches, or promotoras, we want to ensure the workforce training takes into account the sustainability of this model, which means taking into consideration where the worker will be situated beyond the life of the waiver. In addition, health plans are already trying to absorb and master many new and important changes – from new benefits, to new populations and new functions – all at once. We question whether this new set of responsibilities is the right fit for them in an already challenging time of growth and worry that workforce training and development will be lost among their other important, competing plan priorities. Plans should be involved, as key stakeholders, but the investments need to happen at the provider-level.

It is the providers, in fact, who will need to adopt this care model as part of the larger delivery system reform efforts envisioned in this waiver. Our vision is to make a significant investment in training non-licensed frontline workers to work alongside doctors, nurses, clinical case managers, and social workers as peers and members of the care team. The provider care teams are the ones who will need to establish ongoing relationships to integrate the non-licensed front-line worker into their teams, and ultimately their delivery system transformations. Between the state, plans, and providers, it is the providers who are closest to the patients and the unique communities they come from. Long-term, the qualities we need in non-licensed frontline workers will be realized by hiring from the communities being served. We urge the state to reconsider this approach and to instead link the training of non-licensed frontline workers to Whole Person Care, Plan/Provider incentives, DSRIP 2.0, and Safety Net Financing waiver initiatives. Wherever the waiver seeks to improve care coordination, incent team-based care, and non-traditional care models, or improve cultural and linguistic competency, the waiver should allocate additional state dollars so that risk-bearing provider organizations can make the necessary workforce and training investments that will be needed.

Also at the recent DHCS SAC, the state rightfully noted the importance of ensuring that the state puts forward a model of transformation that is sustainable beyond the 5-year waiver proposal. In keeping with that important goal, SEIU supports the recommendations brought forward as part of the Waiver Plan/Provider Incentive Stakeholder Workgroup to alter Medi-Cal financing so that care coordination activities, especially those provided by non-licensed frontline workers, can be built into the Medi-Cal managed care rates and accounted for as non-administrative costs beyond the life of the waiver. Medi-Cal payments need to acknowledge the value of these services and the disincentives that currently exist for this transformation to really take hold long-term.

Finally, the training outlined in the waiver should be provided by entities with experience in workforce training and education. SEIU's experience is that these sorts of endeavors are difficult. Along with the state's considerable investment in workforce training, we would encourage the state to focus its investments with those institutions and organizations with a proven track-record of success working with the targeted populations. In addition, the model of unit-based teams with joint labor management participation has proven successful at sustaining transformation that continues and is course-corrected after the consultants and demonstrations have wrapped up.

Advanced IHSS Worker Training

SEIU California also supports the proposal submitted by the California Long-Term Care Education Center (CLTCEC) for a voluntary pilot program to invest in training in-home supportive services (IHSS) workers in Coordinated Care Initiative (CCI) counties. This model is built on the foundation of the IHSS social model, upholding the waiver's overarching principle of patient-centeredness. In this regard, participation by

consumers should be voluntary. The goal of the pilot should be to test ways to integrate the IHSS worker into the consumer's care team, with his or her consent, and to train IHSS workers to be better prepared to care for consumers by supplementing the training provided by the consumer themselves. SEIU supports providing this training through a variety of training entities with experience in training IHSS workers, and fidelity to CLTCEC's tested training curriculum. This is an evolution of the IHSS worker's traditional role. Early work by CLTCEC in this area show promise that engaging the IHSS worker with additional training targeted at consumers with numerous hospital visits and high avoidable costs can help to improve the consumer's health while bringing down the cost of care.

Cross-Training and Use of Multi-disciplinary Teams

We were also very pleased to see the state's goal to invest in cross-training and use of multidisciplinary teams to achieve the waiver's care integration goals. This piece will be needed to supplement training for new and emerging roles (like those of the community health worker or health navigator) to ensure incumbent workers as well as nurses and physicians understand the concepts of patient-centered care coordination, new roles and responsibilities, and enhanced functions.

Financial Incentives for Provider Participation and Medical Residency Slots

SEIU also supports the comments of the SEIU Committee of Interns and Residents (CIR) related to physician recruitment and retention strategies. Specifically, the CIR suggested that California expand on our existing physician loan reimbursement efforts by targeting additional investments in increasing the diversity and cultural competency of our physician supply in California. We would urge California to think through how to target investments to increase physician participation in Medi-Cal, as suggested by CIR, rather than just add funding or volume to existing programs or concepts.

California kicked off an ambitious vision for making sure that our state is the healthiest in the nation by 2020 through the Secretary's Let's Get Healthy, California Task Force. Among the Task Force Final Report recommendations were components of system redesign needed to ensure that vision, including culturally and linguistically appropriate, coordinated patient care. SEIU is excited to see these ideas carried over into the 1115 Waiver process and reflected so well within the workforce proposals and we look forward to continuing to weigh in as the waiver development unfolds. Please do not hesitate to reach me directly with any questions on our comments at: mcabrera@seiucal.org or (916) 752-5976.

Sincerely,



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Director of Research

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