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

Thursday, November 20, 2014
10:00am – 3:00pm
Sheraton Grand Hotel, Tofanelli Room, Third Floor, 1230 J Street, Sacramento

Members present:
Bill Barcelona, California Association of Physician Groups; John Blossom, California Area Health Education Centers; Michelle Cabrera, SEIU; Corinne Eldridge, California Long-Term Care Education Center; Richard Figueroa, The California Endowment; Thomas Freese, UCLA; Dev Gnanadev, California Medical Association;; Erin Kelly, Children's Coalition; Ann Kuhns, California Children's Hospital Association; Leah Newkirk, California Academy of Family Physicians; Gary Passmore, Congress of Seniors; Sandra Shewry, California HealthCare Foundation; Patricia Tanquary, Contra Costa Health Plan; Loriann deMartini, CDPH.

Members on the phone:
Kevin Grumbach, UCSF Center for Excellence in Primary Care

Members Not Attending:
Jennifer Clancy, California Institute for Behavioral Health Solutions; Kathy Flores, University of California, Fresno and California Health Professions Consortium; ; Jim Mangia, St. John's Well Child Center; Anne McLeod, California Hospital Association; Cathryn Nation, University of California Office of the President; Linda Zorn, California Community Colleges; Hafida Habek, CDSS

Others Attending: Anastasia Dodson, DHCS; Wendy Soe, DHCS; Sergio Aguilar, OSHPD; Joanne Spetz, UCSF Center for Health Professions; Sunita Mutha, UCSF Center for Health Professions. Barbara Masters, CalSIM on the phone.

Meeting Summary

Welcome and Structure Of Waiver Workgroup Process
Bobbie Wunsch, Pacific Health Consulting Group, oriented the workgroup process and reviewed the other workgroups. All of the materials for the waivers are available at the DHCS 1115 waiver web site.

We have DHCS staff, including Anastasia Dodson and Wendy Soe; Sergio Aguilar from OSHPD and technical consultants, including Dr. Sunitha Mutha, Joanne Spetz and others from UCSF Center for the Health Professions to guide the work. Barbara Masters, representing CalSIM is on the phone to talk about the planned activities of CalSIM in workforce if funded. The waiver will not duplicate their efforts so Barbara will share what they are planning. The work is supported by three foundations, CHCF, TCE and the BSCF.

Overview of 1115 Waivers
Presentation slides available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Anastasia Dodson and Wendy Soe provided an overview of 1115 Medicaid Waivers, including budget neutrality. They reviewed the 2015 1115 Waiver Renewal goals and objectives, timeline and the eight renewal concepts and the purpose of the Work Force Workgroup. The current waiver expires October 2015. The overall goals for this workgroup include:

- increase the number of health workers that care for medically underserved (broadly defined, not just MDs);
- Develop innovative ways to provide whole person care to address physical, mental health and substance use disorder services;
- Create financial and other incentives to encourage greater commitment to serve Medicaid beneficiaries and practice in underserved areas

Criteria for evaluating proposed options to include in the final waiver proposal include:

- Addresses Workforce Goals
- Fits shared CMS 1115 Waiver Renewal Goals
- Feasible
- Measurable

Questions/Comments from Members:

Michelle Cabrera, SEIU: When you refer to medically underserved areas, is this the federal designation or defined more broadly?
Dodson, DHCS: We will talk about that more in Sergio's presentation. We want to make sure we are clear on what we mean by the end of the day.

Patricia Tanquary, Contra Costa Health Plan: Do you include affordable under the "feasible" criteria or should that be added? Most patients will be in managed care and so everything we want to provide has to be affordable under the program. The state and feds will only pay a certain amount to the plans to pay providers. I think we should add affordable under feasible.

Michelle Cabrera, SEIU: When you talk about the bridge to reform, a huge success was transitioning populations into managed care. When I think about workforce, a huge

question is, how do we think about this in the context of the plans and managed care? To the extent we are building off those changes, we might want to think about workforce in the context of these managed care shifts. One of the things we were going to get from the move to managed care is care coordination and much of this happens at the provider level, so how do we make sure we have sustainable systems long term?

Bill Barcelona, California Association of Physician Groups: I agree with Patricia because one of the legs of the Triple Aim is affordability and our program should emulate the Triple Aim.

An*n Kuhns, California Children's Hospital Association:* I want to put a peg in this because I think it is code for a lot of things. When we talk about affordability, the issue is, how do we balance affordability and quality?

Gary Passmore, Congress of Seniors: I want to put my oar in on this issue and I appreciate Patricia for bringing it up. What she is calling affordability is reflected in a number of ways. Yes, cost and quality are sometimes opposing goals. We have affordability challenges because of the rates we pay our providers which means we don't have enough providers, and we have to be concerned about an adequate network. I agree absolutely that it ought to be one of the principle things we consider. We have to have providers that are interested in participating in the Medi-Cal program and if we don't have that because nobody is getting paid then we don't have anything.

Dev Gnanadev, California Medical Association: That is the main issue with Medi-Cal and providers, can the providers afford to care for Medi-Cal patients? We need to look at it both ways, can the plans afford to have a provider network and can providers afford to participate.
Dodson, DHCS: I appreciate that we want to find ways to expand providers and there are many ways to measure access. I hope we can stay focused on the options we have set out with the shared understanding that we do want to find a way to expand the number of providers that can serve this population.

Framework and Ideas for Consideration in 1115 Waiver
Presentation slides available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Sunita Mutha reviewed a series of slides containing data on various provider types, geographic distribution and patients by payer in different regions of California. Three goals were proposed for the workgroup:

1. Increase # in medically underserved areas *or* who serve a high number of Medicaid beneficiaries
    a) Train new health professionals
    b) Increase retention
    c) Explore practice limitations

    d) Work with greater efficiency
2. Develop innovative ways to address whole person care to meet physical and mental health needs
3. Create incentives to encourage greater commitment to serve Medicaid beneficiaries and practice in underserved areas

Questions/Comments from Members:

John Blossom, California Area Health Education Centers: Can you tell us about the boundaries, is Fresno southbound?
Mutha, UCSF: Fresno and Tulare are south valley.
Gary Passmore, Congress of Seniors: With the inland empire, the western side of those counties look very different from the eastern side. I would be very interested to have a more detailed discussion of that specific geographic sub-region.
Dev Gnanadev, California Medical Association: This is one of the reasons we are looking at the residency program in the inland empire.
Spetz, UCSF: There are big differences in several areas, for example, between Bakersfield and its surrounding areas. Fortunately, we have detailed levels of data from OSHPD – this is just a first cut.

John Blossom, California Area Health Education Centers: There are multiple issues that are derivative from this. One is evaluation criteria and how they are designed, because accomplishments in this area can be deceptive.

John Blossom, California Area Health Education Centers: is the map the number of full time Nurse Practitioners?
Spetz, UCSF: I think this is just the number of current certifications. We know from some statewide survey data is that about 50-60% work in primary care, so about 40% in specialty settings. From some work in other states, we know that NPs in rural areas are far more likely to be practicing in primary care and at a higher number of hours. So, probably nearly all NPs in Inyo are in primary care whereas more in SF are in specialty.

John Blossom, California Area Health Education Centers: There are also those that keep their license just in case.
Spetz, UCSF: Yes, we can drill down at the region or state level on that.

Kevin Grumbach, UCSF Center for Excellence in Primary Care: The slide that shows 94%+ of NPs accepting Medi-Cal. This isn't plausible of those that are in private offices. I think this is more about where they are working and not their own participation in Medi-Cal.
Spetz, UCSF: NPs are more likely to work in FQHCs. I will check the details on this.

Dev Gnanadev, California Medical Association: Some data that might help is the number of hours in practice and the percentage of their practice in Medi-Cal. There are 60% of

doctors that accept maybe 1 or 2 Medi-Cal patients. Other than county hospital, nobody in my area wants to accept Medi-Cal. These numbers don't tell us enough.

Gary Passmore, Congress of Seniors: Is it fair to conclude that these numbers would look somewhat different today because of the large increases in Medi-Cal over the last four years and the shift of uninsured into private insurance. People have access to insurance now but whether they are in the same bind as some of these previously uninsured folks we are talking about.
Bobbie Wunsch, PHCG: It also doesn't include all of the MD retirements due to the age.

Patricia Tanquary, Contra Costa Health Plan: If we were to do an overlay of the number of providers in Medi-Cal managed care, there are a higher percentage of providers participating because we have to pay what it takes to establish an adequate Medi-Cal network, which is often higher than Medi-Cal. In Northern California, Kaiser has made the decision that most NPs will move into supporting specialty care, they will not be in primary care.

Ann Kuhns, California Children's Hospital Association: Do we have any way to benchmark this against a normative metric in some other setting?
Mutha, UCSF: Janet is best positioned to answer that question, so let's bookmark it.

Kevin Grumbach, UCSF Center for Excellence in Primary Care: California is below national measures on MD participation in Medicaid, mostly because we are very low on Medicaid reimbursement.
Dodson, DHCS: There are many ways to measure access so I hope we can look at the many good options we have.

Ann Kuhns, California Children's Hospital Association: For NPs and psychologists, there are some weird things going on in Marin County. Is there an anomaly in the data?
Spetz, UCSF: I think some piece of this is the density of training programs in SF area and where people like to live.

Thomas Freese, UCLA: I just want to note that it is the second time that substance use has been left out entirely in our discussion. There seems to be a pattern of not recognizing the importance of substance use providers in the same way that we are recognizing the other professions.
Spetz, UCSF: Noted. Through UCSF, we just received funding from SAMHSA to look at substance abuse providers. We will be collecting data and we will include data on this.

Patricia Tanquary, Contra Costa Health Plan: Did you intend to omit LCSWs, as these are more likely now to work in mental health and substance abuse.
Mutha, UCSF: They are not included and this is a good reminder of who is excluded. There is some data

Corinne Eldridge, California Long-Term Care Education Center: Piggy backing on Tom's comment, long-term care is another area of workforce that is excluded.
Mutha, UCSF: There may not be perfect data. We want to focus on where we want to go.

Gary Passmore, Congress of Seniors: Long-term care consumes something like one quarter of our Medi-Cal spending. UCSF did a good job in identifying that about 70% of residents will require long-term care some time in their life. It isn't just IHSS, but there is a significant workforce in the skilled nursing facilities and they face their own challenges.
Spetz, UCSF: Long-term care is the primary focus of our workforce research, everything from palliative care to nursing homes to LVNs and others in long term care. As this group moves forward, to the extent that this national data and research is involved, we can work with you to make sure that these are included.

Dev Gnanadev, California Medical Association: I don't see PAs which is a rapidly growing workforce in California. They also fit well into the team model.

Leah Newkirk, California Academy of Family Physicians: Has anyone been able to measure the impact of the increased reimbursement for PCPs on growth in the network?
Patricia Tanquary, Contra Costa Health Plan: Since the funding has been so slow in coming, I have not been able to add one provider based on the increase and the funding sunsets this year.
Soe, DHCS: I think part of the challenge was the time it took for CMS to approve the PCP bump in our managed care program. It took well into the first year for CMS to approve it. CMS had some challenges understanding the sub-delegated environment of California and this hindered our ability to distribute the funds.
Patricia Tanquary, Contra Costa Health Plan: It may not be the fault of the state, but we still have no dollars so the plans cannot act until we get funding and we haven't been able to expand the network.

Bill Barcelona, California Association of Physician Groups: Because of the delay in payment, some of the docs are getting big delayed lump sum payments and they say thanks so much, now you have funded my retirement and I will drop out of practice. So it may have had the complete opposite impact from what was intended. If the program continues, we may get to the intended impact.

Dev Gnanadev, California Medical Association: IEHP set aside $8M to recruit new primary care and specialty care providers. They are willing to put their money where their mouth is and we are willing to work with them to recruit new providers.

Sandra Shewry, California HealthCare Foundation: What is the distinction between decreasing practice limitations (scope expansions) and the piloting/having new

categories of service providers? I view these as the same approach - all part of one bundle of today's changing scope and licensure landscape. It seems like different words for the same concept. I would encourage us to look at these together.
Mutha, UCSF: It's a great question. It's a fine line about what a new strategy is and when it is about scope. Probably the best distinction is bringing in a whole new workforce to help care for a population. Are the categories mutually exclusive, do we need to edit them? That's a conversation we can have this afternoon.
Spetz, UCSF: We tried to create a list of all the terms that are used for some of the new workforce categories, like CHWs. It is all moving so fast, that none of them fall into scope of practice areas. Also, some work settings do not allow practice at the top of the scope of practice. Even when it is legal to do certain things, they are not allowed.

Ann Kuhns, California Children's Hospital Association: In terms of whole person care, it's important to think about what we can accomplish in terms of workforce, and what needs to be addressed through other barriers like categorical funding and the divisions in different systems of care. If we go through this whole exercise to expand the workforce, but don't deal with the underlying structures then it will be back to having authority but not having structures to achieve the goal of whole person care.

Dev Gnanadev, California Medical Association: How are we going to pay for all these things we want to create? There isn't enough money in Medi-Cal right now to pay for what we need right now. That's why we need to look at team-based care, rather than creating new categories and taking money from places that make things worse.

Related Workforce Efforts and Issues for Consideration: OSHPD and CalSIM
Presentation slides available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Sergio Aguilar presented information about current workforce development efforts and issues for consideration in California's section 1115 waiver renewal. He provided slides on work force distribution and shortages, incentives and programs designed to expand new and existing workforce to work in underserved areas and to address language and cultural diversity. He presented issues for consideration by the workgroup and examples from other states for discussion.

Questions/Comments from Members:

John Blossom, California Area Health Education Centers: Can you explain the importance of the shortage designations?
Aguilar, OSHPD: Yes, there could be increased funding and ability of providers to get loan repayment if they practice in these areas. There are two ways to get designated, some are done by the designating agency or someone in the area can request designation. Just because they are not designated does not mean they are not shortage areas.

Corinne Eldridge, California Long-Term Care Education Center: I appreciate that any data is a snapshot in time. Based on these designations, do you have any predictions about shortages in 2020? The reason I ask is because of the aging of the baby boomers and need for care, particularly long term care and the shortage of home care workers.
Aguilar, OSHPD: We unfortunately don't have any projections.

Patricia Tanquary, Contra Costa Health Plan: This is a very good report. One of the things you could help this committee with is what kind of retention, over time, have Indian health centers had with strategies to repay loans and support education? What we hear anecdotally is that this works for 2-3 years but then they lose the providers.
Aguilar, OSHPD: We will put together some of the outcomes from some of our financial incentive programs.
Dodson, DHCS: Earlier we talked about data from the mental health side.
Aguilar, OSHPD: Yes, we have five different reports we can provide.

Dev Gnanadev, California Medical Association: We don't have information on the ethnic disparity of the physician population. The Inland Empire is 40-50% Latinos and the physician workforce is 5% Latino. This workforce can help create new residency programs in these areas. There is a 50-75% chance that they will stay in the area where someone does a residency. The ethnic disparity is serious so we need to work at it.
Aguilar, OSHPD: We don't have it for all professions because we get data from the licensing boards and not all collect this information. But we'll share what we do have.

Gary Passmore, Congress of Seniors: I would like to see numbers on gender disparities among the professions. I know that this is changing but I would like to see if there are perceived barriers.

Bill Barcelona, California Association of Physician Groups: Health Affairs published an article on HPSA in the US and we were very interested in the results. We engaged consultants to focus on the HPSA areas that were 10% off of the benchmarks (32 in CA). Interestingly, Inglewood was the biggest one in CA. Then we plotted in who could help plug these immediate gaps. Even in Inglewood, I had 16 medical groups that I could tap to fill those gaps. We didn't even tap the children's hospital, integrated systems or FQHC networks. You could plug a lot of these gaps if we focused on the medical group models in these communities. We tend to look at this on the individual physician level but we have a managed care delivery model. Our existing groups are good at hiring to meet access needs. If we provide incentives to medical groups, they can move quickly.

Ann Kuhns, California Children's Hospital Association: To follow up on Indian Health Service, has anyone actually done a literature search to actually know what is effective?
Kevin Grumbach, UCSF Center for Excellence in Primary Care: We've done a whole lot of work on this and the answer of course is that there is no single answer. You have to move people into the pipeline, incentivize them to join and use incentives to keep them

there. There's no magic bullet but there is literature on what makes a difference. People stay for loan repayment – some for a long time, some for 3-4 years. The evidence shows that those going through the CHC system will stay in the arena for most of their career even if not at the exact same setting.

Ann Kuhns, California Children's Hospital Association: It might be helpful if we were looking at what Sergio put up about different strategies and what we know about the results in terms of tactics for reaching those goals. What does the literature say are the 3 most effective things?

John Blossom, California Area Health Education Centers: In addition to Indian Health Service, there is data from the National Health Service.

Dev Gnanadev, California Medical Association: We have all the data as a medical board on ethnicity, location, etc. You can get the data if you request it from us.

Michelle Cabrera, SEIUL I want to restate how happy I am that we are having a robust workforce conversation in the waiver. I have similar thought as others on workforce, how do different strategies perform in terms of ROI? I have a question about resources, I know TCE money is in the mix but how do other sources, federal sources, come into play. In terms of access for Medi-Cal patients, we have to think about how Medi-Cal managed care is going to work for complex populations and how to ensure care coordination, which is not reimbursed. It seems that in the context of a new waiver, figuring out what works and how to pay for it, it's important to incorporate care coordination for everyone. This links with IHSS, CHWs, team care and other elements.

Thomas Freese, UCLA: I thought the presentation was very interesting, particularly around the shortages. Is there similar data for substance use providers? One of the things we hear when communities are interested in expanding substance abuse services is that if someone needs specialty substance use services, they don't have anyone to refer to. It is important to think about specialty substance use services in loan repayment. They are generally excluded, are paid less and are an older workforce.

Gary Passmore, Congress of Seniors: As we have shifted to Medi-Cal managed care and care coordination at the heart of things – there was never reimbursement for care coordination, except as it is lumped into rates. In this next waiver I hope we pilot what good care coordination is, who should be doing it and reimburse the plans to engage in it. I'm an old budget guy and nothing exists if we don't know how much it costs.

Patricia Tanquary, Contra Costa Health Plan: I agree and I appreciate your support and you were correct until about a year ago. Now, case management and even utilization management are included under the medical care side because there is recognition that if you don't include these supports for clinical care then you won't be effective.

Bill Barcelona, California Association of Physician Groups: We are focusing on supply side but if we focused on demand side and risk stratified the Medi-Cal population based on acuity levels, we could better model capacity needs.

Corinne Eldridge, California Long-Term Care Education Center: I would just echo that, we do know a lot about long-term care needs in the future.

Barbara Masters described the CalSIM application and workforce components.
The slides and diagram from the presentation is available:
http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Barbara Masters provided an overview of the CalSIM application. It was guided by a design grant received last year, grounded in the triple aim and the six goals of the 2012 Let's Get Healthy California report. The overall grant is for $100M and we should hear this month about whether we will receive the grant. It would begin in January 2015 with one year planning and three years of implementation. The overall grant has four initiatives and six building blocks. One of the building blocks across the initiatives is the workforce component, to build the community health worker workforce. A workforce workgroup was convened last year and is now concluding its work. Ms. Masters reviewed the definition used for CHWs by the workgroup, the key roles, functions, training and settings for CHWs. Other topics such as funding, certification and how to educate providers about the role of CHWs was also discussed.

Questions/Comments from Members:

Wunsch, PHCG: Part of the purpose of this presentation is to brief the workgroup so you know you how the efforts are connected and working together. Can DHCS comment?
Soe, DHCS: CalSIM really is in alignment with the goals of the waiver. That said, the projects are working on two separate timelines. The efforts of the waiver can support the goals of CalSIM.

Michelle Cabrera, SEIU: Just one clarification, CalSIM is aimed at changes in the entire health care system and the waiver is focused on changes in Medi-Cal and how we fund and structure Medi-Cal. We definitely see that the goals are complimentary but also there is plenty to be done on the Medi-Cal side.
Masters: That's an important point. The CalSIM effort involves all payers to improve health across the population. CHW's do tend to work in low income areas and so there is greater alignment with this element.

Bill Barcelona, California Association of Physician Groups Do we know how many of these complex chronic health homes we need and where they should be placed? Do we know where the clusters of these patients exist?

Masters: There has been a whole effort by DHCS to start identifying where these health homes would be located. The current plan is for this to be identified by the plans.

Patricia Tanquary, Contra Costa Health Plan: We would be remiss in not acknowledging that public health has a tremendous amount of the data. We need to overlay this data with some of the data from the public health departments.

Role of Workforce in Other States' 1115 Waivers
Presentation slides available at: http://www.dhcs.ca.gov/provgovpart/Pages/Waiver-Renewal-Workgroup-Workforce.aspx

Joanne Ketz and Sunita Mutha provided an overview of how other states have used the Medicaid Waiver to push forward this issue of workforce. They noted that some of these programs are extremely new, some have not even been approved so we have no data on their success or impact other than prior data supporting these approaches. Six states have approved or pending workforce elements in their waivers. The topics in other states focus on:

- Train more health professionals
- Innovative ways to address whole person care
- Create incentives for health professionals to serve Medicaid beneficiaries and other underserved populations

Many states focus on loan repayment programs in their waivers. NY included education and training related to scope of practice elements (not the legal issues) and whole person care. NY and New Hampshire included behavioral health professions and substance use disorders.

Questions/Comments from Members:

Thomas Freese, UCLA: The NH project on SUD training is only just getting off the ground but is one of the few projects that is thinking innovatively about SUD education/training.

Gary Passmore, Congress of Seniors: Could you provide or send links to the NY waiver, including where it is on the timeline.

Dev Gnanadev, California Medical Association: Everyone needs to remember, the California FMAP payment is totally different than NY.

Kevin Grumbach, UCSF Center for Excellence in Primary Care: It helpful to hear what other states are planning to do. Have we actually done an assessment of what California is doing with Medicaid dollars? In previous waivers? What is the extent of Medicaid involvement? Is any Medicaid funding invested in workforce?
Dodson, DHCS: We have information we can bring together.
Aguilar*, OSHPD:* We can provide information on funding of workforce.
Wunsch, PHCG: We will get information for the next meetings.

Michelle Cabrera, SEIU: This gets to the question previously about how to leverage funding depending on the source. There have been efforts in the past to invest in workforce. One of the past (2005) 1115 waivers was used to invest seed funding in the LA County "WORK" program. This is limited to public sector workforce needs for the most part.
Soe, DHCS: There is also a component of the safety-net care pool that allows us to invest in UC and CSU programs that serve the underserved. We're not taking advantage of that right now.

Leah Newkirk, California Academy of Family Physicians: We had the same question and in looking at the last waiver, we noted that the DSRIP allowed for expanded PCP residency slots and that is one place we want to continue. We want to continue to focus on the primary care workforce. We were very attracted to the Illinois waiver as it addressed that question, although it is still pending.

Dev Gnanadev, California Medical Association: The biggest bottleneck on the physician side is the residency programs. The federal funding caps have not expanded since 1997. We have too few medical schools for the population. If you want to keep students here and you want to train primary care, we need medical schools and residency programs here. That's my main interest for being on the workgroup is to invest in residencies in their communities.

Ideas for 1115 Waiver related to Workforce
What did you learn this morning? What was not addressed this morning that you thought or hoped would be addressed?

Comments from Members:

Gary Passmore, Congress of Seniors: We are looking at a waiver that will run from 2015-20 but I am assuming we are making recommendations that will have a longer life. I'm interested in getting some good demographic information on who we are going to be serving in 2020 forward. If we base our ideas for change just on the population we'll see today we will miss the mark.
Wunsch, PHCG: We will talk with DHCS about data on the current Medi-Cal population and if they've done any projections on how those demographics are going to change.

Patricia Tanquary, Contra Costa Health Plan: Many of the plans are looking at the Medi-Cal expansion population and those that were already eligible. We did an analysis and there is a shift. No longer is the majority of members are children but growing in adults. You also have some shifts in visits/utilization. There will be much more focus on adults and those that are aging.

Mutha, UCSF: One thing that we haven't discussed today is oral health.

John Blossom, California Area Health Education Centers: Not just changes in age but changes in geographic distribution. And, the language and cultural characteristics of the population we will have to serve and will need to recruit into the professions.

Dev Gnanadev, California Medical Association: I would like expansion from DHCS and OSHPD on the mix of providers. Medi-Cal managed care made a lot of difference compared to FFS, not just payment and utilization. It took away a lot of bureaucracy. We need to work hard to get rid of more bureaucracy and more doctors will be interested.

Thomas Freese, UCLA: Medication assistance for addiction has not yet been brought up. There is also the problem of reimbursement for critical medicines. They are not on the formulary so you have to do TARs etc. It would be interesting to see what other states have done in terms of uptake and provider training.

John Blossom, California Area Health Education Centers: What didn't come up: Area Health Education Centers (AHECs) have been a very valuable tool to recruit, train and retain an appropriate health professions workforce. AHECs are modeled on the agricultural extension program. Started in 1971, it has over its lifespan created hundreds of health workforce education programs (e.g. CA preparedness education network, nurse career ladders, etc). AHECs get about $1 million per year from HRSA and give it to 14 centers (mostly within consortia of CHCs) where they use money on recruitment, training and retention in primary care.

Bill Barcelona, California Association of Physician Groups: We didn't talk about disease states, about mapping out clusters of populations and about transitioning from moms and kids to adult groups. The plans delegate to the medical groups and we stratify and organize care. A lot of our Medi-Cal groups have been caring for moms/kids and now are seeing duals and SPDs. They are ill equipped. I have lots of medical groups that have been focused on Medicare Advantages with enormous capacity and they are now on the sidelines. We need to match disease state with capacity.

Sandra Shewry, California HealthCare Foundation: I appreciate learning more about what the state has in mind for training and other long term strategies. I'm hopeful we'll turn our attention to additional alternative ideas that will give us some gains during the life of the waiver. I like the idea of aligning our workforce proposals with the state initiatives and pulling in the same direction. Investing in health homes and care coordination ala the workforce needed for that appeals to me a lot. Behavioral health – peer support specialists, medication support – I'd like to see us look at some of those concepts. CalSIM has a focus on palliative care. We should consider the workforce needs in the palliative care space. I like the idea of aligning our recommendations to the state's goals for the waiver and for CalSIM. I also like the idea of understanding where rules, policies or laws are in the way of existing health professionals practicing "at the top of their scope". Perhaps we could use the waiver to empower existing categories of

health professionals to more expansively do the things the legislature has already approved.

John Blossom, California Area Health Education Centers: We have not heard from the CHCs, and they are taking care of a lot of the patients. We need to have short term and long term strategies for how to capitalize on the resource of CHCs.

What is your idea that this group could start thinking about for an 1115 waiver?

Leah Newkirk, California Academy of Family Physicians: They did a great job of laying out the future PCP shortage and the future doesn't look good with retirements and an aging patient population, so that is our priority. We see GME as an important component here and residencies are an important short and long term part of the solution. We want to see increased funding for residency programs – family practice residency programs produce 90% of family physicians. We're also interested in loan repayment programs – we like the Illinois waiver. We want to see the residency slots at public hospitals funded by DSRIP continued.

John Blossom, California Area Health Education Centers: How about teaching health centers?
Leah Newkirk, California Academy of Family Physicians: We definitely would support expanded support for teaching health centers. They are doing a great job and their funding ends in 2016 so we need to think about the cliff that they are facing.

John Blossom, California Area Health Education Centers: We started a teaching health center in Fresno with 600 applicants and we have 3 slots. The teaching health center dollars come from HRSA and they've been cut. The program nationally is under a lot of pressure federally.

Leah Newkirk, California Academy of Family Physicians: The residency programs do retain residents where they are – they stay where they train. The assumption is that they'll continue to work in CHCs because that is where they trained.

Thomas Freese, UCLA: Much of our workforce is inadequately prepared so looking at the pre-service education and making sure the fundamentals are taught. Addiction medicine is perhaps the most glaring example. Unless you are focused on addiction, the amount of training you get in a medical program is frightening. That's one area we could focus on – developing professionals that are prepared for the integration we are talking about. But, we have a huge number of professionals in the field now and are inadequately trained to take on this responsibility. I like the NY model. We are doing a joint program right now primarily on alcohol screening with CHCF and DHCS and it is surprising how resistant some providers are in participating in these trainings. The amount of training is inadequate. I hope there is a focus on building the skills and also technical assistance to implement in the setting.

Michelle Cabrera, SEIU: I really like the NY workforce component and I think it's important from the perspective of the incumbent workforce and the cultural competence of existing providers. Many are already in the workforce but if there is not training for them, then it will not be successful.

Dev Gnanadev, California Medical Association: One of the biggest areas of concern at the medical board level is prescription drug abuse. We are doing a lot to train doctors, especially PCPs. PCPs are struggling and they need training to help appropriately care for these patients with addiction help rather than prescriptions.

John Blossom, California Area Health Education Centers: We have scarce resources, we also have scarce education resources. It's also important to find providers who are in a position where they could really use that skill. CHCs have various levels of provider workforce, how could we define education programs that could go in those settings?

Thomas Freese, UCLA: I think that's the beauty of the NY waiver, they really are identifying those who want a particular skillset. Those are the aspects that are really exciting. MH/SUD issues are very common in the population we are serving and impact everything we do. A basic level of competence and multiple tiers of training.

Patricia Tanquary, Contra Costa Health Plan: There are two issues: we have not talked about the skill set that could be aided through technology. Some examples, I have contracted with CHCs who have no idea when their patients delivered or were in the ER or discharged from the hospitals. We have got everyone on EPIC and have cut hospital admissions through information sharing. Another missing piece, if we are going to push some care down to others beyond physicians, I want to make sure that they have physician oversight. How do we utilize all of these skills AND the technology to manage care. We can't wait for three years to see the CCI outcomes. If we are going to use CHWs and promotores we are going to need the technology to oversee the care they do and the funding so we can use them. How can technology help us, how do we shape the funding so we are protected, what are the skill sets.

Kevin Grumbach, UCSF Center for Excellence in Primary Care: The challenge with this is we cannot boil the ocean. It's such a big state and the money is never enough. The challenge for us is we have to prioritize where we put the nickel. I'm going to encourage us to pick a few things. A starting point is what Medicaid could do to sustain or augment programs that really work and are vulnerable because of declining federal funds or could expand. The residency programs are on very shaky ground. You can also build loan programs without creating new programs. The last thing, how do you redeploy the workforce to be more effective? I think a major thing is integrated behavioral health and coordinated care; complex care; IHSS workers and promatores. I'm not just talking MDs and NPs, but the MAs, RNs, CHWs and others as part of the care team.

Sandra Shewry, California HealthCare Foundation: I think the state could play a pivotal role in using the waiver to accelerate Telehealth, e-referral and other tools to expand access. The state prisons are the largest users of Telehealth because they organize the use of this tool. We can't expect local safety net providers to do this – there is too much involved in the act of transforming practice patterns. The state can play a role in supporting the use of technology in order to expand access to Medi-Cal members. The technology is never the barrier – it is the changes in how care is delivered that take time. We may be able to use waiver funds to accelerate dispersion of Telehealth.

John Blossom, California Area Health Education Centers: There may be an opportunity for the waiver to assist with the Health Care Interpreters Network.

Bill Barcelona, California Association of Physician Groups: We have a group in Silicon Valley that delivers 9K specialty Telehealth visits per year and they do it by reaching out to semi-retired specialists that do 6 hours per week via a home office. How can we do more than that?
Aguilar, OSHPD: There is not a program that currently exists for retired health professionals (run by OSHPD) but there is something within the statute that gives us authority to facilitate some sort of process that may aid retired health professionals– but since there was no funding, it was never followed through. It could be built on.

Gary Passmore, Congress of Seniors: His comment combines two things of concern to me. One, despite all the focus on primary care, my population utilizes mostly specialty care (seniors). This idea is based on changing the working environment so that we could take advantage of seniors, not to deploy them as volunteers, we need to deploy them for pay. The cheapest, most likely group we could get to are the 30% we are going to lose if we don't engage them. I think this is an important way to leverage the manpower, especially for specialty.

Dev Gnanadev, California Medical Association: If you look at Kaiser, people at 65 have to retire (or can go on per diem). For those that want to continue we should pay for their malpractice insurance. Many of these people are highly trained specialists. My primary aim are PCPs but we need specialists too. They are willing to pay the license fee but they can't pay the malpractice insurance.

John Blossom, California Area Health Education Centers: I would add licensure in addition to malpractice and continuing education for those that are retiring. Also, is there something we could do to engage them in teaching?

Thomas Freese, UCLA: The California Telehealth Resource Centers may be an important area to see if we can leverage and take advantage of them.

Erin Kelly, Children's Coalition: Our coalition represents 2K pediatric sub-specialty physicians caring for our sickest children. 70% of our patient population are Medi-Cal.

Our MDs have benefited from the primary care increase. But our affiliates have continued challenges in terms of continued recruitment and retention of specialty providers. We wanted to have a seat at this table to hear what is being discussed.
Ann Kuhns, California Children's Hospital Association: Our eight hospitals train over half of the pediatricians in the state and see 80% Medi-Cal and these are extremely sick kids. We're very sympathetic to the idea that children need access to primary care. And, the aging of the population is significant. At the same time, this population of very sick kids is a population that can get lost in this effort. That's important to remember because these are niche hospitals but a critical niche. We do so much training and when you need this service you are really happy it is there. There isn't enough to support a public and private system – they exist together.

Gary Passmore, Congress of Seniors: I want to advocate for investment in geriatric care. With an aging population, we should look at workforce needs that also serve the Medicare population. I think geriatrics is a specialty that needs some conversation.

Corinne Eldridge, California Long-Term Care Education Center: It is important to shine a light on the non-licensed support workers – home health workers. It is a huge population that needs care and a workforce to provide that care. Currently, it is an uncertified workforce. I mentioned the funding we got from the federal government and there is a lot of value in looking at the role of the home care worker, who is in the home of someone with co-morbidities up to 65 hours per week. They have a very unique position to be able to fill a significant number of needs and understand patient needs. This is a unique opportunity to look at training for this workforce that is already in the home and, comparatively speaking, are very cheap. There's a lot they could do in the homes with more training. We can enhance their role to become part of the care team.

Patricia Tanquary, Contra Costa Health Plan: 60% of IHSS workers are family members. Their motivation is to advocate and care for their family – so we're building a skill, building a workforce. We are investing in the future.

Gary Passmore, Congress of Seniors: This issue is the reason I wanted to be in this workgroup. We have to focus on the training challenge of home care workers. There is a whole set of tasks that can be trained for and they can play a very critical role in the coordinating teams for managed care. I hope we will take the time to talk through how they will be a part of the solution.

John Blossom, California Area Health Education Centers: One of our AHECs in Santa Cruz is very active in training in home care workers.

Dev Gnanadev, California Medical Association: An important issue we did not talk about, is that if you look at a traditional Medi-Cal provider it's mostly solo and small group

practice by ethnic physicians (Chinatown in SF, Southeast LA) providing care. They need support like technology connection – not money, but services.

Ann Kuhns, California Children's Hospital Association: Adding to Corinne's statement, one thing that would really be helpful is to build the capacity of family members. What can we do to really build the capacity of those that are the family caregivers?

Corinne Eldridge, California Long-Term Care Education Center: Roughly 65% of all homecare workers are a family provider, that doesn't distinguish if they're a mother or cousin or living in the home or out.

Bill Barcelona, California Association of Physician Groups: The delegated medical groups are now 5+ million Medi-Cal lives. We need to tackle integrated behavioral health in our groups. The current model where the group would refer to the plan and the plan refers to a mental health network doesn't work. We need to train some level of behavioral health professional to be in the group. There are models in Medicare where we do integrate behavioral health well and we need to do this in Medi-Cal.

Gary Passmore, Congress of Seniors: We need to look at the managed care organizations as a way to change some of the compensation and incentives. Maybe not just cash payment, maybe payment and other things like CME, liability. They may be in a better place than the state to find ways to better incentivize providers.

Thomas Freese, UCLA: BH integration is critical but we need to ward against BH being a euphemism for mental health and ensure that substance abuse is included.

PUBLIC COMMENT

Sherry Daley, CA Consortium of Addiction Programs and Professionals: We represent 12K professionals. The one disease that has been most frequently mentioned today is addiction and we are here to ring some alarm bells because the expansion population has such large addiction issues. Expanding coverage without expanding the workforce is a dead end. We are here to help in whatever way possible. We support the New Hampshire waiver model. We would like to see pilot projects co-locating addiction providers in the primary care setting.

Tim Shannon, Children's Specialty Care Coalition: I also represent MD malpractice. In 2010, Senator Corbett sponsored a bill to allow the medical board to run a volunteer medical malpractice coverage. It is a knotty issue and looking at this bill could help.

Diane Factor, LA County Health County Services Workforce Program – We were funded through the last waiver not directly through waiver funds but through a clever use of language that allowed the priority made for the largest provider of Medicaid services in the state. I'm very heartened by what I heard here. On the demand side, we are in a

different labor market than 10 years ago. This is a historical moment where we can reach out and treat the complex patients and we need to find priority projects that will deliver some results while we have this window of opportunity.

Workforce Expert Stakeholder Meeting Dates:

- Meeting #2 – December 11, 2014
- Meeting #3 – January 7, 2015