Attachment C

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
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Dear Members of the California Healthcare Workforce Policy Commission:

The California Academy of Family Physicians (CAFP), representing almost 11,000 family physicians and medical students throughout the state, appreciate the opportunity to provide feedback to the California Healthcare Workforce Policy Commission and Office of Statewide Health Policy and Development (OSHPD) about the Song-Brown Healthcare Workforce Training Program Primary Care Residency (PCR) application. CAFP has been a champion of the Song-Brown Healthcare Workforce Training Program since its inception. We appreciate and share your dedication to ensuring primary care access for underserved patient populations and recruiting underrepresented minority residents.

We respectfully submit the following recommendations for consideration by the Commission at its upcoming policy meeting. These recommendations were developed with the goal of increasing the effectiveness of incentives for residency programs to better align with the Song-Brown program's statutory objectives.

Recommendations

1. Increase the number of points for programs whose graduates remain in primary care
2. Ensure primary care shortage area (PCSA) methodology remains physician-focused when used to score PCR applications
3. Ensure applicants are identifiable when announcing recommended and final scores
4. Measure the volume of training that takes place at continuity clinics and weight scores for payer-mix accordingly
5. Explore the effects of scoring 'inputs' in addition to 'outputs' of training investments
6. Explore the effects of moving the 'funding bump' among quintiles
7. Establish bridge funding for new programs as they become existing programs
8. Remove or replace the narrative component of the application
9. Explore contracting issues for new program awards
10. Direct funds in a manner that ensures they are controlled by the residency Program Director

Recommendations

1) Increase the number of points for programs whose graduates remain in primary care

When the Song-Brown program was established, it was intended only for family medicine graduate medical education. Because only a very small percentage of family physicians go on to sub-specialize outside of primary care, there was no need to define in statute the parameters of what was meant by primary care, or to track if and how applicants contributed to the primary care workforce. When the $100 million allocation to Song-Brown was made in 2015, however, eligibility to apply for Song-Brown PCR grants was opened to internal medicine, pediatric, and obstetrics and gynecology residency programs. Evidence suggests that approximately 80 percent of internal medicine graduates and 50 percent of pediatrics graduates go on to sub-specialize, at which point they cease to provide primary care.

To ensure that Song-Brown funds are directed to programs that train residents who remain in primary care, the Commission introduced scoring criteria 2.2: "Percent and number of graduates in primary care ambulatory settings five years post residency." This is worth 15 out of a possible 115 points, or 7.5 percent of the available points for a criterion representing a fundamental aspect of the Song-Brown program, which is to sustain and expand primary care graduate medical education in the state.

Recommendation: We strongly urge the Commission to increase the number of points for criteria 2.2 to at least 20 points out of 115 so that it is weighted equally to statutory criteria 1.1, 1.2, and 1.3.

2) Ensure primary care shortage area (PCSA) methodology remains physician-focused when used to score PCR applications

We noted that during the Registered Nurse Funding Meeting of April 4, 2019, OSHPD staff made preliminary recommendations related to defining areas of unmet need. On slide 18 of the presentation, the staff recommended that the Commission vote to "Modify PCSA [primary care shortage area] methodology to include nurse practitioners and physician assistants (unified provider ratio)."

We are concerned that implementing this recommendation would treat the physician, nurse practitioner and physician assistant professions as interchangeable and may result in programs located in areas with a shortage of physicians, but no shortage of NPs and PAs, receiving fewer points in the PCR scoring criteria. Given the PCR application is designed to address primary care physician supply issues, we do not believe that OSHPD's PCSA methodology should incorporate the supply of NPs and Pas when assessing if an area is underserved.

Recommendation: Maintain the current PCSA methodology to focus on physician supply when scoring applicants for PCR grants.

3) Ensure applicants are identifiable when announcing recommended and final scores

It is customary for OSHPD to publish the recommended and final scores for applicants on its website, including the breakdown of those scores by applicant across each criterion. This has proven helpful for the public to identify issues with scores and highlight them for OSHPD staff and the Commission. For example, programs known to have a significant Medi-Cal patient caseload have in the past received a preliminary score of zero for payer mix. By highlighting this issue for the Commission, we, together with OSHPD staff, discovered instances in which the applicant accidentally omitted their payer-mix information, and their application was corrected in time for the Commission's funding meeting.

In 2018, the names of the applicants were removed from the published scores. Applicants were only identifiable by their application number, which was known only to the applicant and OSHPD. This made it impossible for any member of the public to read and interpret preliminary scores to understand where funds might be directed or identify issues with scoring. Furthermore, applicants were unable to understand how they compared to other specific applicants, potentially reducing the effectiveness of incentives to compete against other programs in or near one's geographic area.

Recommendation: That applicants be identifiable by the name of the residency program on all public postings of recommended and final scores.

4) Measure the volume of training that takes place at continuity clinics and weight scores for payer-mix accordingly

Applicants are currently required to list all of the facilities at which training takes place, to indicate which of those training sites are an accredited continuity clinic at which residents serve a dedicated panel of patients, and to provide the payer-mix at those continuity clinics. This question is vital when determining if residency programs are providing primary care to underserved patient populations. However, this section of the application does not currently take into account the volume of training that takes place at each continuity clinic. For example, a residency program can list two continuity clinics – one at which the bulk of training hours take place but where few underserved patients are cared for, and a second episodic rotation where few hours of training take place but the patient population is mostly underserved – and receive an average score for the payer-mix across those sites. This can result in a payer-mix score that does not accurately reflect the residency program's overall provision of care to underserved populations.

Recommendation: That the Commission direct OSHPD staff to collaborate with stakeholders to assess the feasibility and measure the effects of requiring applicants to list the number of hours of training that take place at each continuity clinic and weight the payer-mix scores for each facility accordingly.

5) Explore the effects of scoring of 'inputs' in addition to 'outputs' of training investments

The following scoring criteria depend on measuring the outcomes of residency program policies and investments:

- 1.2 - Percent and number of underrepresented minority graduates and/or economically disadvantaged graduates
- 2.2 - Percent and number of graduates in primary care ambulatory settings five years' post residency
- 2.3 - Percent and number of underrepresented minority students and/or economically disadvantaged students.

OSHPD tracks and scores outputs in these categories. However, issuing a standardized range of scores for these categories can ignore regional characteristics and challenges. For example, a program located in an area with a relatively low number of underrepresented minorities may struggle to recruit underrepresented minority residents despite having adhered to best practices and made significant investments in recruitment. Other applicants, having made no such investments, may see a more favorable outcome based on where they are located. Finally, applicants who usually have success in this area may experience a temporary downturn in such recruitment, which in turn may lead to variations in Song-Brown funding from year-to-year despite comparable adherence to best practices and investments over that period.

We understand that these grants are meant to incentivize programs to make investments in practices that will align them with the goals and objectives of the Song-Brown program. We believe OSHPD, in collaboration with stakeholders, can assist programs in understanding what those practices are and award points on the application for investing in those practices, regardless of or in addition to the outcome. Some examples of best practices related to the recruitment of underrepresented minorities, as identified by UC Davis research, include:

- Formal policy and/or mission statement that promotes diversity in residents and the provision of primary care
- Recruitment and outreach materials that promote diversity and primary care (e.g. brochures, flyers, presentations, website, etc.)
- Actively participate in outreach efforts that promote diversity and primary care (e.g. conferences, pipeline program participation, etc.)
- Engages residents in diversity-related and primary-care related activities (e.g. resident-led groups, peer counseling, mentorship opportunities, etc.)

Recommendation: We urge the Commission to direct OSHPD staff to collaborate with stakeholders to explore if and where best practices exist to produce the objectives articulated in scoring criteria 1.2, 2.2, and 2.3. Should they exist, we recommend that applicants be asked to attest and provide evidence of their investment in these practices and receive points on the Song-Brown application for those investments regardless of or in addition to the points assigned for the outcomes.

6) Explore the effects of moving the 'funding bump' among quintiles

The size of Song-Brown awards for existing programs are currently organized into 'quintiles':

- Tier One: five slots funded at $125,000 each for $625,000
- Tier Two: three slots funded at $125,000 each for $375,000
- Tier Three: two slots funded at $125,000 each for $250,000
- Tier Four: one slot funded at $125,000 for $125,000
- Tier Five: no slots funded
    - No program scoring fewer than 50 percent of the available points, regardless of where they land relative to other applicants, may receive an award.

This structure is meant to incentivize programs to make investments to better align with Song-Brown's goals and objectives. However, placing the 'funding bump' near the top of the structure, where all applicants are relatively high-scoring and where additional investments are costly but less effective, lessens the influence of these incentives. Research on the effectiveness of 'pay-for-performance' programs has found that they are most effective when targeting underperforming individuals and/or organizations in order to make additional investments to meet a certain baseline standard.

For example, the placement of the bump may be more effective as follows:

- Tier One: five slots funded at $125,000 each for $625,000
- Tier Two: four slots funded at $125,000 each for $500,000
- Tier Three: three slots funded at $125,000 each for $375,000
- Tier Four: one slot funded at $125,000 for $125,000
- Tier Five: no slots funded
    - No program scoring fewer than 50 percent of the available points, regardless of where they land relative to other applicants, may receive an award.

Alternatively, the number of tiers could be reduced and the spread of each tier across applicants increased in order to minimize the variation in funding from year-to-year, as follows:

- Tier One: five slots funded at $125,000 each for $625,000
- Tier Two: three slots funded at $125,000 each for $375,000
- Tier Three: one slot funded at $125,000 for $125,000
- Tier Four: no slots funded
    - No program scoring fewer than 50 percent of the available points, regardless of where they land relative to other applicants, may receive an award.

Recommendation: We urge the Commission to direct OSHPD staff to collaborate with stakeholders to explore the effects on the number of applicants that can be funded and the effects on applicant behavior of moving the 'funding bump' among the quintiles.

7) Establish bridge funding for new programs as they become existing programs

New programs are eligible for up to $800,000 in one-time funding, after which they are considered an 'existing' program and may apply for funding in that category. However, for the first three years of their existence, family medicine residency programs do not yet have graduates. Because the Song-Brown application gathers graduate data, existing programs without graduates are given a 'normalized' score in those categories relative to how other programs score in those categories. In the past two years, this has resulted in programs new enough to not yet have graduates receiving a relatively low score in those categories and usually receiving funding for one slot, or $125,000.

The period during which a program transitions from being 'new' to 'existing' is a fragile one, during which they may still be attaining ongoing funding from other sources. The sudden drop in funding from up to $800,000 to $125,000 can be destabilizing. Given the significant investment in new programs made by the Commission, it may wish to establish a more generous score for programs during this period.

Recommendation: We urge the Commission to direct OSHPD staff to collaborate with stakeholders to explore the effect on the number of applicants that can be funded of increasing the number of points awarded to programs without graduates in 'normalized' categories. For example, programs who match this description may receive the average number of points received in graduate data categories by programs in the upper scoring quintiles.

8) Remove or replace the narrative component of the application

Applicants are asked to include a short narrative description of their program as a part of the Song-Brown application. This component of the application does not factor into the scoring of the application. Applicants may dedicate significant time to crafting this section of the application. Furthermore, we believe that narrative components should not be scored on the application because introducing qualitative elements reduces standardization in application information and scoring while increasing the potential for scoring bias, both in terms of favorability towards certain types of applicants and towards inclusion of certain kinds of work that, though worthwhile, may not relate to statute.

Recommendation: We encourage the Commission to direct OSHPD staff to remove the narrative component of the application or replace it with qualitative text fields beneath each section of the application (e.g. payer mix) to ask if there is any additional information not already covered by the quantitative, standardized questions in that section. This will ensure that any information provided relates to issues that are relevant in the context of statute.

9) Explore contracting issues for new program awards

Some family medicine residency programs that were awarded grants as a new residency program report that they have had difficulty producing the necessary paperwork (e.g. receipts) in order to receive the funding. In conversation with these programs, they revealed that the methods used by residency

programs and/or their sponsoring institutions to track expenses can differ widely and do not always reflect OSHPD requirements.

Recommendation: We urge the Commission to direct OSHPD staff to review the requirements of new residency programs to produce specific types of paperwork in order to receive their funding, with the objective of simplifying the process, increasing flexibility for applicants and OSHPD staff, and releasing the funding in a timelier manner.

10) Direct funds in a manner that ensures they are controlled by the residency Program Director

Should it be determined that an applicant is eligible to receive a grant, it is our understanding that OSHPD will contract with a residency program's sponsoring institution instead of directly with the residency program. In some cases, this has resulted in the sponsoring institution subsuming the grant funds into its general fund, beyond the discretionary control of the residency Program Director for use in direct training. We believe that there are alternatives to contracting with a sponsoring institution. Many residency programs have a 501 c.3 non-profit foundation that could potentially act as a receiving agency. Alternatively, funds could be directed into a protected account that can only be drawn down by mutual agreement between the program and the sponsoring institution. Even signaling to sponsoring institutions they are accountable for ensuring the funds are spent on direct training costs as they are intended would improve upon the process as it currently exists.

Recommendation: Direct OSHPD staff to collaborate with applicants to explore the feasibility of contracting with an organization other than the sponsoring institution.

Conclusion

CAFP deeply appreciates the opportunity to collaborate with the Commission and OSHPD staff to improve the Song-Brown program and ensure its ongoing success in training new primary care physicians. We are especially appreciative of the hardworking OSHPD staff and their willingness to engage with stakeholders. We remain eager to contribute to any and all stakeholder consultations and would be happy to answer any questions you may have about our recommendations. Please direct any questions regarding our submission to Conrad Amenta, Director of Policy at CAFP, at camenta@familydocs.org.

Thank you, as always, for your time and consideration.

Sincerely,

Walter Mills, MD, MMM, FACPE
President, California Academy of Family Physicians

June 5, 2019

C.J. Howard
Deputy Director
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RE: 2019 Song-Brown Healthcare Workforce Training Programs Policy Meeting

Dear C.J. Howard and Members of the California Health Workforce Policy Commission:

The California Primary Care Association (CPCA) appreciates the opportunity to provide feedback in preparation for the June 2019 policy meeting. We remain committed to working with the Commission and OSHPD team to ensure the Song-Brown Healthcare Workforce Training Program meets its goal of training physicians who serve medically underserved areas and populations.

As the statewide leader and recognized voice of over 1,300 non-profit community health centers (CHCs) and their 6.9 million patients, CPCA recognizes the monumental impact residency programs have on addressing physician shortages in underserved communities. We are fortunate to have seven HRSA-funded Teaching Health Center Graduate Medical Education (THCGME) programs across five community health center organizations, three newly accredited CHC residency programs, and two CHC residency programs in the process of obtaining ACGME accreditation.

In advance of the June policy meeting, we would like to share with you a series of recommendations based on our involvement in the stakeholder and Commission meetings. We believe that the implementation of these ideas could lend themselves to a program that is well designed to meet its goals:

- **RECOMMENDATION #1: Discuss proposed policy changes at the annual policy meeting. Use the PDSA model and tools to document the process and ensure a systematic approach to continuous quality improvement.**
- **RECOMMENDATION #2: Remove the term "economically disadvantaged" from the statutory evaluation criteria for primary care residency programs. Collect data on "environmentally/educationally disadvantaged" students to observe trends and identify scoring weight.**
- **RECOMMENDATION #3: Maintain Existing Methodologies for Areas of Unmet Need.**
- **RECOMMENDATION #4: Maintain existing Primary Care Shortage Area methodology and identify shortage areas with physician supply when scoring applicants for primary care residency grants.**
- **RECOMMENDATION #5: Utilize data funds to enhance Teaching Health Center funding.**

In the paragraphs that follow we provide greater detail on CPCA's recommendations.

RECOMMENDATION #1: Discuss proposed policy changes at the annual policy meeting. Use the PDSA model and tools to document the process and ensure a systematic approach to continuous quality improvement.

The Fiscal Year (FY) 2017-2018 $100M state investment in primary care workforce development opened a window of opportunity to reevaluate Song-Brown program criteria and grants for primary care residency (PCR) programs. Over the last two years when the first and second $33M installments were allocated, over one dozen policy changes were made to the PCR program via a series of funding and policy meetings. This process was effective in making timely and critical changes to ensure funds were dedicated to programs meeting program statute. However, this process also required Commissioners, OSHPD staff, and stakeholders to discuss challenges, evaluate options, and make final decisions within a short timeframe. It did not promote a consistent application of program criteria over the last two years, nor did it enhance the ability to evaluate quality improvement.

Given these challenges, we recommend that the Commission move forward with concentrating all policy decisions to an annual policy meeting. This solidified process will ensure that Commissioners, OSHPD staff, and stakeholders alike have ample time to review policy considerations and discuss them thoroughly before making official decisions on program implementation. Maintaining an annual policy meeting will continue to be effective for needed policy changes and may increase participation from applicants and stakeholders given that decisions will be made annually instead of at quarterly meetings. These benefits, along with the ability to implement the *Plan, Do, Study, Act (PDSA)* process will ensure that decisions are evaluated thoroughly and in a timely manner.

Recommendation #2: Remove the term "economically disadvantaged" from the statutory evaluation criteria for primary care residency programs. Collect data on "environmentally/educationally disadvantaged" students to observe trends and identify scoring weight.

The Song-Brown Program statute states that the Commission shall give priority to programs that have demonstrated "success in attracting and admitting members of minority groups to the program" and "individuals who were former residents of medically underserved areas." The statue contains an expanded view on diversity, therefore, it is critical that the evaluation criteria reflect the intent and goal developing a diverse healthcare workforce. Currently, criteria 1.2 measures "percent and number of underrepresented minority graduates and/or economically disadvantaged graduates" and criteria 2.3 evaluates "percent and number of underrepresented minority students and/or economically disadvantaged students." While the evaluation criteria is set up in this way, only "underrepresented minority" backgrounds are evaluated in these criteria because no definition exists under the Song-Brown Program for "economically disadvantaged." This topic has been a discussion item with the Song-Brown Commission for two years, and CPCA was happy to participate in a concentrated conversation about this in the January 2019 Song-Brown Program stakeholder meeting. In evaluating the data presented by OSHPD staff, we acknowledge that there is significant overlap between economically disadvantaged students and those from underrepresented backgrounds. Adding a definition for "economically disadvantaged" may not allow us to capture the greater depth of diversity we are collectively looking for.

Similar to the OSHPD staff's recommendation, we urge the Commission to remove the term "economically disadvantaged" from the statutory criteria for primary care residency programs and collect data on "environmentally/educationally disadvantaged" students to observe trends and identify scoring weight. More specifically, we advocate that the Commission adopt the measurements below for "environmentally/educationally disadvantaged" because they include a holistic view of diversity and align with HRSA's evaluation of this term for their grant programs. We support the inclusion of these measurements in the data collection process to observe trends and identify scoring weight.

- Person from high school with low average SAT/ACT scores or below the average State test results.
- Person from a school district where 50 percent or less of graduates go to a four-year college

- Person who has a diagnosed physical or mental impairment that substantially limits participation in educational experiences.
- Person for whom English is not his or her primary language and for whom language is still a barrier to academic performance.
- Person who is first generation to attend college.
- The individual comes from a family that receives public assistance (e.g., Temporary Assistance to Needy Families, Supplemental Nutrition Assistance program, Medicaid, and/or public housing).
- The individual graduated from (or last attended) a high school with low per capita funding.
- The individual graduated from a school where 50% of the student population received free and reduce lunch rates.

RECOMMENDATION #3: Maintain Existing Methodologies for Areas of Unmet Need.

Criteria 1.1 measures "percent and number of clinical training sites in areas of unmet need" and criteria 1.3 evaluates "percent and number of graduates in areas of unmet need." Five different definitions of areas of unmet need are currently utilized when scoring primary care funding applications: primary care shortage areas (PCSA), health professions shortage areas (HPSA), medically underserved area (MUA), medically underserved population (MUP), and site designations (i.e. Federally Qualified Health Centers, County Clinics, Teaching Hospitals, etc.). The goal in including these shortage designations is to reward programs with clinical training and/or graduates in areas with the greatest need. Each methodology contains different criteria and data, therefore, brings a unique perspective on the need for more physicians in certain areas of the state.

Geographic and population HPSAs are national benchmarks that are commonly used by the Health Resources and Services Administration (HRSA) to grant awards for workforce development programs. They are also based on a verified provider-to-population ratio. Site designations, such as Auto-HPSAs which are utilized by community health centers, evaluate need for health organizations serving vulnerable patient populations. PCSAs are annual designations that are based on poverty and estimated provider-to-population ratios. Finally, MUAs/MUPs measure the degree of underservice for an area or population. While we recognize that these are lifetime designations, and in some cases, have been in existence for many years; these designations help ensure, for example, that complex, urban areas with continued unmet needs are not left without resources and support.

Each methodology offers a significant value to the Commission because they collectively break down the need for additional physicians according to national and state data and benchmarks. There is no one shortage designation that contains all of the desired traits and is 100% accurate, therefore, it is critical that the Commission continue to utilize a combination of different methodologies to evaluate areas of unmet need. Removing any one of these methodologies could negatively impact an existing program's ability to access these funds given that criteria 1.1 and 1.3 collectively represent 40 out of a total of 115 points in the PCR application. We recommend that existing unmet need methodologies continue to be used in PCR criteria.

RECOMMENDATION #4: Maintain existing Primary Care Shortage Area methodology and identify shortage areas with physician supply when scoring applicants for primary care residency grants.

On April 4, 2019, the Commission discussed preliminary staff recommendations on areas of unmet need. Item #13, slide 18 included a recommendation to modify the PCSA methodology to include nurse practitioners and physician assistant to create a unified provider ratio when evaluating underserved areas. The intent, as we understand it, is to closely resemble the PCSA methodology with the care team structure utilized in various health systems.

We acknowledge the intention, however, are concerned about the implications this change could have. The PCR funding cycle is separate from RN and NP/PA funding, therefore, it is critical that we evaluate only the profession under consideration when measuring areas of unmet need for a specific funding cycle. The goal of

separating these applications in part is to promote growth in the different professions and not treat them as interchangeable professionals. Each is needed to enhance the care team, but not replace one for the other. If the Commission were to include NPs and PAs in the PCSA methodology to evaluate areas of unmet need for PCR funding, there could be a significant change in outcomes. Programs located in areas with a shortage of physicians, but a small or no shortage of NPs and PAs could receive fewer points in the PCR scoring criteria. Since the profession under evaluation in the PCR application is physicians, it does not make sense to penalize a program that is trying to solve the physician shortage. For these reasons, we do not believe that NPs and PAs should be included in the PCSA methodology. Instead, we urge the Commission to maintain existing Primary Care Shortage Area methodology and identify shortage areas with physician supply when scoring applicants for primary care residency grants.

RECOMMENDATION #5: Utilize data funds to enhance Teaching Health Center funding.

Medicare GME funding has historically provided payments to teaching hospitals to compensate for "Medicare's share" of the costs directly related to the training of residents. This funding accounts for over 70% of the total federal investment in GME nationally While Medicare does impose a limit on the number of residents it supports, these funds provide stability for a large segment of residency programs and leave out a number of critical and innovative programs, including Teaching Health Centers. HRSA funded residency programs, like the Teaching Health Center Graduate Medical Education Program, are subject to acts of Congress at any given time and require constant dedicated advocacy to secure funding year by year.

Teaching Health Center funds available through the Song-Brown Program have been critical in stabilizing existing THCGME programs that embody the community-based primary care training highlighted by the Song-Brown statute. The amount of funding allocated to that bucket was based on the number of allocated THCGME slots in 2017. The availability of "expansion" and "new program" Song-Brown grants was very successful in expanding HRSA-funded THC programs and developing new non-HRSA funded GME programs in community health centers. These non-HRSA funded GME programs meet the definition set forth for Teaching Health Centers, which include "community-based ambulatory patient care centers that operate a primary care residency program." This signifies that there are currently not enough funds to sustain existing THCs and new CHC GME programs at the same award level that has been granted per slot over the last two years. For this reason, we urge the Commission to utilize data funds to enhance THC funding. These additional funds will be critical to stabilizing critical community-based primary care programs dedicated to training physicians in underserved areas and with underserved populations.

CPCA and California's CHCs are committed to increasing the training of primary care providers that are well prepared to practice in community settings and serve underserved populations. We thank you in advance for considering this feedback and welcome an opportunity to discuss further. We also look forward to continue working closely with the Advisory Council. If you have any questions, please do not hesitate to contact Nataly Diaz, CPCA Associate Director of Workforce Development, at ndiaz@cpca.org or 916-440-8170.

Respectfully,

Carmela Castellano-Garcia, Esq.
President & Chief Executive Officer
California Primary Care Association